# This week in BMJ

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## Low blood pressure, low mood?

In many European countries it is common for general practitioners to diagnose and treat hypotension. In Britain, however, such a diagnosis is rare, suggesting that doctors do not consider it to be clinically important. However, recent studies have provided some evidence for the existence of a hypotensive syndrome. On page 75 Pilgrim *et al* investigating over 10 000 male and female civil servants found that two of the components of this syndrome, dizziness and unexplained tiredness, were indeed more prevalent in those with lower blood pressures. They also found that these subjects were much more likely to experience anxiety or depression, psychological states which are known to be linked with physical symptoms such as those found in the hypotensive syndrome.

## What happens to the homeless mentally ill?

Increasing numbers of mentally ill people are homeless, but little is known about the outcome in such people. On p 79 Marshall and Gath report an 18 month follow up of 48 mentally ill residents in hostels for the homeless in Oxford. The findings were discouraging—at the time of follow up only a fifth had been rehoused, most of whom were in bedsits or family homes. A fifth had been admitted to psychiatric hospitals and a third had a generally poor outcome as shown by long term admission to hospital, deterioration in behaviour, sleeping rough, death, or disappearance.

## Alcohol and cardiovascular risk factors in women

Data on levels of risk factors for coronary heart disease in British women are scanty, and the nature of the links between alcohol consumption and coronary heart disease are controversial. On p 80 Razay *et al* report on the relation between alcohol consumption and risk factors for coronary heart disease in a stratified random sample of British women. The data suggest that compared with non-drinkers women who drink moderately (1-20 g/day) have lower concentrations of plasma insulin, total triglyceride, and total cholesterol and lower body mass index as well as higher total high density lipoprotein cholesterol and $HDL_3$ cholesterol concentrations; all these changes favour a lower incidence of coronary heart disease. The study supports and possibly explains reports that women drinking moderate amounts of alcohol are less likely to die of coronary heart disease.

## Fast track admission for myocardial infarction

Although clinical and experimental studies have confirmed that prognosis after an acute myocardial infarction is critically dependent on the duration of myocardial ischaemia, practical systems for minimising inhospital delays have not been evaluated or widely implemented. Pell *et al* have evaluated the impact of a "fast track" admission system for patients with suspected acute myocardial infarction (p 83). They report that patients fulfilling clear clinical and electrocardiographic criteria can be given rapid access to the cardiac care team by bypassing the medical registrar, resulting in a halving of inhospital delays to thrombolytic treatment.

## Irritable bowel syndrome in the general population

Up to a third of the general population may have symptom complexes compatible with the clinical diagnosis of irritable bowel syndrome, but, as Jones and Lydeard show (p 87), only a third of patients with these symptoms seek medical advice. Their questionnaire survey found that a quarter of patients randomly selected from the lists of eight general practitioners reported six or more episodes of abdominal pain in the preceding year; 85% of these patients had symptoms consistent with a diagnosis of irritable bowel syndrome, a population prevalence of 21·6%. Over a third of patients with the syndrome and 10% of those without reported rectal bleeding. The low consultation rate suggests that some patients with symptoms that may indicate serious bowel disease are not seeking medical attention.

## General practitioner skin surgery

Skin surgery by general practitioners has many advantages, but changes in contractual requirements encouraging GPs to do more skin surgery have not been accompanied by a good educational structure. Priorities for further training are likely to emerge slowly, however, because individual general practitioners perform few operations and may not appreciate overall trends or problem areas. The paper by Cox *et al* (p 93) examines the impact of skin surgery in general practice on the workload of a pathology laboratory and sets out to identify changes which have occurred since the new contract for GPs and also areas where further training may be helpful.

## Diagnostic value of the "microtymp"

Otitis media with effusion occurs frequently in young children but is difficult to diagnose in primary care. On page 96 de Melker evaluates the new hand held "microtymp" in a primary care setting, comparing it with a conventional tympanometer. The interobserver reliability of two independent measurements with the microtymp is high, and results with the microtymp are highly comparable with conventional tympanometry. The microtymp can be used in primary care: it is child friendly and easy to handle. Tympanometry, especially judging tympanograms, needs training and experience. Microtympanometry could improve diagnosis in primary care and referrals for otitis media with effusion.

# GUIDELINES FOR PAPERS SUBMITTED TO THE *BMJ*

## General points

- All material submitted for publication is assumed to be submitted exclusively to the *BMJ* unless the contrary is stated and should conform to the uniform requirements for manuscripts submitted to biomedical journals (the Vancouver style; *BMJ* 1991;**302**:338-41).
- All authors must give signed consent to publication.
- The editor retains the customary right to style and if necessary shorten material accepted for publication.
- Type all manuscripts (including letters and obituaries) in double spacing with 3 cm margins.
- Number the pages.
- Give the name and address of the author to whom correspondence and proofs should be sent.
- Do not use abbreviations.
- Express all scientific measurements (except blood pressure) in SI units.
- Keep one copy of the manuscript for reference.

## Points specific to each section

PAPERS, GENERAL PRACTICE, EDUCATION & DEBATE

*Papers* report original research relevant to clinical medicine. They are usually up to 2000 words long with up to six tables or illustrations (short reports are up to 600 words with a maximum of one table or illustration and five references).

*General Practice* covers matters relevant to primary care.

*Education & Debate* includes reports (up to 2000 words) on the organisation or assessment of medical work and on sociological aspects of medicine or the organisation, financing, and staffing of health services.

- Give the authors' names and initials, their posts when they did the work, and one degree each.
- Papers and General Practice articles should conform to the conventional format of structured abstract (maximum 250 words), introduction, methods, results, discussion, and references.
- Include a paragraph (maximum 150 words) for the This Week in *BMJ* page.
- Send three copies (if the paper is rejected these will not be returned; after three months they will be shredded).
- Whenever possible give numbers of patients or subjects studied (not percentages alone).
- Any article may be submitted to outside peer review and assessment by the editorial committee as well as statistical assessment; this takes about eight weeks.
- Manuscripts are usually published within three months of the date of final acceptance.

LETTERS

- Should normally be a maximum of 400 words and 10 references.
- Must be signed by all the authors.
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MATERIA NON MEDICA

- Should be a maximum of 400 words.
- Authors do not receive proofs.

MEDICINE AND THE MEDIA

- Authors should discuss a proposed contribution with one of the editors before submitting it.
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PERSONAL VIEW

- Should be a maximum of 1200 words.

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- Should normally be a maximum of 250 words.
- Authors should summarise the person's career in a separate paragraph and not repeat these details in the main text.
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## Tables

- Should be on separate sheets of paper from the text.
- Should not duplicate information given in the text of the article.
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- If a table has been published previously written consent to republication must be obtained from the copyright holder (usually the publisher) and the author(s).

## Figures

- Should be used only when data cannot be expressed clearly in any other way.
- Should not duplicate information given in the text of the article.
- The numerical data on which graphs, scattergrams, and histograms are based should be supplied.
- Whenever possible, when relevant, numbers of patients or subjects studied should be given (not percentages alone).
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LINE DRAWINGS

- Should be presented clearly to aid redrawing.

FIGURES THAT ARE NOT LINE DRAWINGS

- Should usually be glossy prints.
- Should be no larger than 30×21 cm (A4).
- Important areas should be indicated on an overlay.
- The top should be marked on the back.
- Photomicrographs should include an internal scale marker.
- Labelling should be on copies, not on the prints.
- Patients shown in photographs should have their identity concealed or give written consent to publication (*BMJ* 1991;**302**:1194).
- Staining techniques for photomicrographs should be stated in the legend.

## References

- Should be numbered in the order in which they appear in the text.
- Should give the names and initials of all the authors (unless there are more than six, when the first six should be given followed by *et al*); the title of the article or chapter; *and* the title of the journal (abbreviated according to the style of Index Medicus), year of publication, volume number, and first and last page numbers *or* the names of any editors of the book, title of the book, place of publication, publisher, and year of publication, and first and last pages of the article.
- Information from manuscripts not yet in press, papers reported at meetings, or personal communications should be cited in the text, not as formal references.

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