This week in BMJ

Transurethral microwaves can produce symptomatic improvement in benign prostatic hypertrophy

Transurethral microwave treatment is a minimally invasive treatment for patients with benign prostatic hypertrophy whereby the prostate is heated with a transurethral microwave catheter. Earlier trials have shown good symptomatic improvement after microwave treatment, but there is little information on the placebo effects of the treatment. To address this problem Bdesha et al (p 1293) performed a clinical trial in which patients were randomly allocated to microwave treatment or sham treatment. They found little improvement after sham treatment, but after microwave treatment patients experienced significant symptomatic improvement and improved bladder emptying with few side effects.

Vertically transmitted HIV infection is increasing

Vertically transmitted HIV is a growing problem, particularly in England. The report by Ades et al on p 1296 supports the recent Department of Health guidance aimed at encouraging voluntary antenatal testing for HIV in high prevalence areas. In Scotland and the Irish Republic, where 97% of maternal infection has been in injecting drug users or their partners, fewer children are now being born to infected women. The trends are increasing, however, in England and Wales, where heterosexual transmission is more common, and nearly 50% of infected women were from sub-Saharan Africa. A further concern is that while maternal infection, based on anonymous neonatal serosurvey, is still rising in south east England, less than a fifth of infected mothers are known to the obstetric services.

Nicotine patches increase smoking cessation rates

Are those people paying nearly £200 for three months’ treatment really helping themselves to stop smoking or would sticking plaster be just as good? On p 1304 a general practice research group of the Imperial Cancer Research Fund reports the results of a placebo controlled trial of transdermal nicotine patches in 1686 heavy smokers from 19 general practices in Britain. At the end of three months’ treatment 19-4% of patients using nicotine patches and 11-7% of patients using placebo had not smoked for the previous month. The research group points out that this modest but important success was achieved in the context of sustained nursing support in general practice. Hence the effectiveness of patches sold as over the counter products remains questionable.

Another evaluation involved 30 general practices in 15 English counties. Russell et al (p 1308) assessed nicotine patches as an adjunct to brief advice and support targeted specifically at dependent heavy smokers. The patches reduced craving and adverse mood changes of withdrawal and doubled the rate of initial and long term cessation: 9-3% of patients in the nicotine patch group maintained continuous abstinence for up to one year compared with 5-0% of controls.

Epidural anaesthesia increases backache after childbirth

Backache often affects women after childbirth, and it has been postulated that long term backache after epidural anaesthesia is related to stressed positions in labour and muscle relaxation. On p 1299 Russell et al report the replies of 1015 primiparous women to a postal questionnaire. Over half the women with backache lasting more than six months had had no back problems previously; a quarter of these women responded to an invitation to attend an outpatient clinic, and most had a postural backache which was not severe. Women who had received epidural analgesia in labour were significantly more likely to report new onset backache than those who did not.

New approaches needed to reduce cardiovascular death

On p 1313 Yudkin compares the likely benefits of different approaches to reducing cardiovascular deaths, using a combination of observational data on 347 978 middle aged men and meta-analyses of intervention studies. He calculates that stopping smoking is two to three times more effective than all other approaches in reducing deaths from coronary heart disease and at least four times as effective for total mortality. He also estimates that smoking has a greater effect on life expectancy than hypertension—and a substantially greater effect than hypercholesterolaemia—and the deleterious effect is also more completely reversible. The figures also suggest that treating hypercholesterolaemia has no clear benefit on mortality.

Time to stop using the Hawksley sphygmanometer

Although the Hawksley random zero sphygmanometer is widely used in blood pressure research it was first reported to be inaccurate in 1970, and a large body of evidence has since accumulated confirming this. Despite this, its popularity shows no signs of waning. Conroy et al (p 1319) review the consequences of continuing to use an inaccurate instrument in blood pressure research. In population surveys and prospective studies the errors in the Hawksley would not have led to substantially misleading results. But in the interpretation of blood pressure treatment trials and the evaluation of electronic blood pressure recorders the consequences are more serious. In particular, the results of several major hypertension trials may be in serious doubt. How much data have we lost already, and who will say stop before more is lost?
NOTES

• At the request of the Department of Health the Royal College of Nursing and the British Association of Emergency Medicine have set up a working party to study the treatment in accident and emergency departments of people who are suddenly bereaved. The working party would like to hear from readers who have information or knowledge of the subject. They should contact Mrs Rosemary Wilkinson, adviser in nursing practice, Royal College of Nursing, 20 Cavendish Square, London W1M 0AB (tel 071 409 3333 ext 265).

• The International Society for the Study of the Lumbar Spine has established the International Fellowship Fund to identify appropriate individuals in underrepresented or underdeveloped areas and sponsor them to attend the society's meetings.

• Applicants who have a demonstrated interest in clinical spine or non-clinical spine related research may apply to attend meetings in Seattle, United States, and should apply to the society, Sunnybrook Medical Centre, 2075 Bayview Avenue, Toronto, Canada M4N 3M5.

• The society also has a research fellowship awarded annually to promote research activities into the cause and cure of low back pain. Applications for the 1994 award, $15,000, should be received by the 30th September 1993.

• The Royal College of Anaesthetists has announced that successful candidates in the college's fellowship examinations who receive the diploma of fellowship are entitled to use the letters FRCA to describe their qualification. FRCA will accordingly replace the designation FRCAAnaest.

The change was approved by the Privy Council last year and the college policy will be to encourage all fellows to use the new designation in future. For the time being, however, the use of one of the earlier designations will not be improper.

COMING EVENTS

University College London: Inaugural lecture. Professor John Yudkin, "Ideas about our station—science and health care on Highgate Hill," Thursday 20 May, 5.30 pm, Biological Science Building, UCL, Gower Street, London WCI.


British Society for Allergy and Environmental Medicine: Meeting, "Environmental factors in asthma," Friday 18 June, London. Details from Mrs Irene Mansell, administrator, British Society for Allergy and Environmental Medicine, Averard Hotel, 6 Rozney Road, Cadsden, Southamptom SO 4NE (tel 0300 812124).

University of Southampton Faculty of Law: Conference, "Children's evidence in the court," Thursday 24 June, Newport, County Down. Details from Jill Elliott, continuing education manager, Faculty of Law, University of Southampton, Highfield, Southampton SO 5HN (tel 0703 925376).


Department of Epidemiology and Public Health, University of Newcastle: Conference, "Inequalities in health:where to now?" Wednesday 7 July, Newcastle upon Tyne. Details from Dr Jackie Greep, Department of Epidemiology and Public Health, School of Health Care Sciences, The Medical School, University of Newcastle upon Tyne NE2 4HH (tel 091 222 6000 ext 7211).

University of Leeds: Conference, "Child abuse: improving professional practice," 7 to 9 July, University of Leeds, Department of Community Professional Education, Continuing Education 11th Floor, St George's Hospital, Leeds LS2 9NG (tel 0532 433253).

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* The editor
* Express all
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Instructions to authors

General points

• All material submitted for publication is assumed to be submitted exclusively to the BMT unless the contrary is stated and should conform to the uniform requirements for papers submitted to biomedical journals. (See Vancouver style; BMT 1991;382: 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 5 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 staff of health services.

Give the authors' names and initials and their address posts when they did the work.

Papers report original research relevant to the clinical condition or disease. They should be structured abstract (maximum 250 words), introduction, methods, results, discussion, and references. Education & Debate articles should have an unstructured summary (maximum 150 words).

Include a paragraph (maximum 150 words) for the This Week in BMT page.

Send through any paper is rejected this will not be returned, after three months they will be shredded.

Whenever possible give numbers of patients or subjects studied (not percentages alone).

Any trouble with the pages 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 five references.

• Must be signed by all the authors.

• Only one copy should be sent.

• Preference is given to those that take up points made in articles published in the journal.

• Authors do not receive proofs.

MEDICINE AND THE MEDIA

• Authors should discuss a proposed contribution with one of the editors before submitting it.

• Authors do not receive proofs.

PERSONAL VIEW

• Should be a maximum of 1100 words.

OBITUARIES

• Should normally be a maximum of 250 words.

• Should be received within three months of the person's death.

• Authors should summarise the person's career in a separate paragraph and not repeat these details in the main text.

• Only one copy should be sent.

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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.

• Where possible, when relevant, numbers of patients or subjects studied should be given (not percentages alone).

• 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.

• Original data on which abstract histograms are based should be supplied.

• Where possible, when relevant, numbers of patients or subjects studied should be given (not percentages alone).

• Figures should be on separate sheets of paper from the text.

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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 x 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.

• The title should be on copies, not drawn on original.

• Patients shown in photographs should have their identity concealed or give written consent to publication (BMT 1991;382:116-17).

• Sizing techniques for photomicrographs should be stated in the legend.