thetic control¹¹—atropine substantially reduces nocturnal bronchoconstriction.¹² Non-adrenergic, non-cholinergic nerves also directly innervate bronchial smooth muscle. Capsaicin, a non-adrenergic non-cholinergic stimulant, is less effective at night¹³; nocturnal inhibition of non-adrenergic, non-cholinergic nerves seems to contribute modestly to bronchoconstriction.

Corticosteroids, adrenaline, and histamine have substantial effects in asthma. Could their plasma concentrations, which exhibit circadian rhythm, be important in nocturnal asthma? Abolishing plasma cortisol's circadian rhythm does not affect the nocturnal fall in peak flow: changes in concentration may represent the body's defensive response to nocturnal asthma rather than be part of its cause.¹⁴ Catecholamines seem of little relevance to nocturnal asthma. Although plasma catecholamine concentrations fall at night and the sensitivity of β adrenoceptors varies throughout the day,¹⁵ infusing adrenaline does not improve nocturnal asthma,¹⁶ and adrenalectomy has no effect. The plasma concentration of histamine is raised at night, but its role is unclear: antihistamines are ineffective.⁵

Asthma is being increasingly regarded as an inflammatory disease; could the inflammation of airways vary diurnally? Martin and colleagues suggest that it does.¹⁷ Fluid obtained by bronchoalveolar lavage from patients with nocturnal asthma contained significantly more neutrophils, eosinophils, lymphocytes, and epithelial cells at 0400 than at 1600. This difference was not found in asthmatic patients without nocturnal asthma. Inflammatory cells could therefore flow into and out of the bronchial tree, producing cyclical epithelial damage. This might explain how increased bronchial reactivity, enhanced late asthmatic response, and reduced mucociliary clearance occur in nocturnal asthma.

Despite all its idiosyncracies nocturnal asthma may represent a cyclical flare up in the activity of asthma. As with asthma itself we are progressively discovering how nocturnal asthma happens. The challenge now is to understand why.

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Duplicate publication

If in doubt ask the editor

Readers, researchers, and editors frown on the publication of the same scientific information in different journals. It clogs up the already congested scientific literature without adding new information and may keep someone else's work out of print. It complicates the process of retrieving information and wastes time and money. An average scientific paper published in the *BMJ* will have been read by eight people, taken up about eight hours of a technical editor's time, and cost around £1300 to process, print, and distribute.

On p 1029 Waldron shows that duplicate publication is common.¹ Doctors are now under such pressure to publish—to impress appointments and grants committees—that the temptation to milk as many publications as possible out of a piece of research is strong. Often this leads to salami publication (submitting small slices of the work as separate papers), but sometimes authors try to get substantially the same paper published more than once. Authors may be ignorant of the rules, even though the main principle is enshrined in the instructions to authors of this and most other journals.

Editors have no desire to stifle scientific communication. Their aim is to ensure that information first appears publicly in a form that has undergone scrutiny so that as many ambiguities and inconsistencies as possible have been ironed out. Rather than keeping knowledge from the public this scrutiny reduces the risk of misleading information causing unnecessary alarm and ensures that the full story is available. This was why the *BMJ* refused to consider further a paper that had been issued to newspapers suggesting that toxic

fumes from mattresses might contribute to cot deaths.²

The *BMJ*, like many other journals, subscribes to the rules on duplicate publication set out by the Vancouver group of medical journal editors.³ Essentially these say that articles cannot be considered for publication, either in print or in electronic form, if they are under consideration or have been published elsewhere.⁴

Some exceptions allow for the normal processes of scientific communication. Full details may be reported after publication of a preliminary report, usually an abstract. Information presented at a meeting may be published later so long as a full report has not appeared in the proceedings. Journalists at a meeting can't be prevented from reporting the findings, but speakers should not hand over written copies of their data or amplify them afterwards. The Vancouver guidelines also give clear advice on secondary publication in another language.³

An increasing number of cases do not, however, fall neatly into one of the Vancouver categories. The annual reports of directors of public health, for example, often describe work that the investigators later want to write up for a professional journal. Some large funding bodies produce annual reports that are widely circulated. And in some countries government researchers are required to publish their reports as official documents.

The *BMJ* has decided that difficult cases will be settled by two criteria: how close the previous version is to the paper submitted to us and how retrievable it is. Many briefing reports written for government departments, for example,

would not preclude later publication of a scientific paper because the presentation would be different and the original source not easily retrievable. Like other forms of "grey literature" these reports do not appear in widely available databases and indexes, and the information would be virtually unobtainable by someone who did not already know it existed—particularly someone outside Britain. Annual reports of directors of public health are also unlikely to cause problems, for similar reasons.

For the *BMJ* to consider publishing a paper both these criteria will normally have to be met. We will, however,

continue to consider each case on its merits, and the prime requirement is that authors should tell us if there is any possibility of duplicate publication.

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By their own young hand

Suicide is increasing rapidly in young men

Increasing numbers of young men in the United Kingdom are committing suicide. Rates of suicide among men aged 15 to 44 in England and Wales rose by a third between 1980 and 1990.^{1,2} Most of this change was due to an increase of 78% in those aged 14 to 24. Rates of deaths due to undetermined causes (which are often suicides³) have changed similarly. Suicide statistics for young men in Scotland and Northern Ireland have changed in parallel with those in England and Wales. In contrast, the suicide rate for women in England and Wales fell by nearly half between 1980 and 1990.^{1,2}

Although the reasons for these changes are unclear, some of the factors known to be associated with suicide may be relevant. These include unemployment, family breakdown, alcohol and drug misuse, AIDS, and the availability of methods of committing suicide.

The association between unemployment and suicide is well known,⁴ although the nature of the relation is probably complex.⁵ Unemployment is not, however, a sufficient explanation for the recent increase in suicides by young men because rates of unemployment fell substantially in the late 1980s while those for suicide continued to increase. Since suicidal behaviour can be linked to family breakdown⁶ the increasing divorce rate during the 1960s and 1970s, which affected the parents of many of those who are now young adults, may be a cause. Rising divorce rates in the young themselves could also be relevant.¹ Alcohol and drug misuse have increased in young people in recent years, and both are strongly linked with suicide in the young.⁸

Although the risk of suicide is greatly increased in people with AIDS,⁹ the disease became a major problem well after the rise in the number of suicides began. AIDS itself is unlikely to contribute substantially to the current number of suicides among young men,¹⁰ although this could change as the number of cases of AIDS increases. The availability of methods of committing suicide affects rates, the best example being the large fall in suicides that paralleled the introduction of non-toxic North Sea gas during the 1960s.¹¹ Nowadays car exhaust poisoning is the method of suicide used most often by men aged 15-44.² This might be linked to the steady increase in the availability of cars together with the publicity about such deaths.

Given our current level of knowledge, establishing with any certainty which variables are associated with the increase in suicides by young men is impossible. The most puzzling aspect of the problem is that possibly all factors relevant to men apply in varying degrees to young women, yet their rates of suicide have fallen. For explanation we may have to turn to sociological theory.¹² Changes in society may have resulted in young men becoming less integrated with and supported

by those around them with the reverse pattern in women.

We need more research on these changing patterns. The most productive approach would be an extensive study of recent suicides of young men with the difficult but highly informative psychological postmortem technique.^{13,14} This should be supplemented by epidemiological and sociological investigation of the factors associated with the changing rates of suicide and the different rates in young men and women.

While we await the results of such research can anything be done? Firstly, ways should be found of improving the detection and treatment of psychiatric disorder, particularly depression, in young people. An educational programme about affective disorders directed at general practitioners in Gotland, Sweden, provides encouragement. This resulted not only in better detection and treatment of depression but was followed by a fall in the local suicide rate, a change that differed from both the long term trend in Gotland and trends in Sweden as a whole.¹⁵ Secondly, further campaigns should be directed at reducing alcohol and drug misuse in the young. Thirdly, the design of car exhausts might be altered so that it is harder to attach tubing.

The Health of the Nation did not set clinical objectives in mental health,¹⁶ but there is a good case for including a fall in the numbers of suicides as a target. This would stimulate the coordinated research and planning necessary to tackle the problem of suicide in young men.

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