

14th century and became commonplace during the 1800s when manufacturing processes improved.⁷

Knives were used to spear meat, lifting it from plate to mouth, so pointed tips were vital for this function. Also, with repeated sharpening of a flat blade, a pointed tip inevitably develops. However, now domestic knives do not need sharpening, and numerous other kitchen utensils can be used to spear food. The current practice of eating with forks and blunt ended table knives was introduced in the 18th century to reduce the injuries resulting from arguments in public eating houses. In 1669, King Louis XIV of France noted the association between pointed domestic knives and violence and passed a law demanding that the tips of all table and street knives be ground smooth.⁸ Today many households have a block of kitchen knives of which several will be of the long pointed variety.

Perhaps the pointed kitchen knife has a culinary purpose that we have failed to appreciate? We contacted 10 chefs in the UK who are well known from their media activities and chefs working in the kitchens of five leading London restaurants. Some commented that a point is useful in the fine preparation of some meat and vegetables, but that this could be done with a short pointed knife (less than 5 cm in length). None gave a reason why the long pointed knife was essential. Domestic knife manufacturers (Harrison-Fisher Knife Company, England, personal communication, 2005) admit that their designs are based on traditional shapes and could give no functional reason why long pointed knives are needed. The average life of a kitchen knife is estimated to be about 10 years.

Many assaults are impulsive, often triggered by alcohol or misuse of other drugs, and the long pointed kitchen knife is an easily available potentially lethal

weapon particularly in the domestic setting. Government action to ban the sale of such knives would drastically reduce their availability over the course of a few years. In addition, such legislation would make it harder to justify carrying such knives and prosecution easier.

The Home Office is looking for ways to reduce knife crime. We suggest that banning the sale of long pointed knives is a sensible and practical measure that would have this effect.

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Next steps in trial registration

Minimum criteria have been agreed, and intentions restated

Last year medical journals responded to the growing clamour for greater transparency in the conduct of clinical trials by deciding to require registration of trials that are submitted for publication.¹ Various groups have proposed criteria to clarify the implementation of this policy.^{2,3} These moves have received a mostly positive response from the public, regulators, and industry. Associations of pharmaceutical companies have signalled their support for registration of trials and recording of results although, regrettably, registration will only be voluntary.⁴ Individual pharmaceutical companies have announced their own initiatives, albeit under pressure from lawmakers and the needs of the market.⁵

Now the International Committee of Medical Journal Editors (ICMJE) has announced further guidance on trial registration.⁶ In essence, the guidance restates that trials that begin enrolling patients from 1 July 2005 must be registered in a public trials registry—at or before the onset of enrolment—to be considered for

publication in the journals edited by members of the committee. In addition, trials that began enrolling patients before 1 July 2005 must register before 13 September 2005 to be considered for publication. This is also the *BMJ's* policy.^{1,7}

The latest guidance from the ICMJE outlines the information that investigators of trials will need to make available to the public, and this minimum dataset has 20 fields. All trialists will have to disclose all of this information to be considered for publication in the *BMJ*. Pharmaceutical companies regard some of this information to be commercially sensitive, particularly for trials that, as the ICMJE puts it, are designed to “investigate the biology of disease or to provide preliminary data that may lead to larger, clinically directive trials.” Journal editors are given discretion by the ICMJE to consider trials for publication that are in this category and unregistered. The *BMJ* does not expect to allow any exceptions because we seek to publish only those trials that will influence clinical practice.

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The *BMJ* has not signed the ICMJE's latest statement because we still disagree with the committee's policy on one issue that prevented us from signing the previous version. According to the statement, both public ownership and not for profit status are essential for a suitable trial registry. Our view is that, although public ownership is valuable and use of publicly owned registries is to be encouraged, this stipulation is unnecessarily restrictive and should not be an essential criterion. The emphasis, we argue, should remain on registered information being publicly and freely accessible. In addition, to be suitable a registry should identify trials with a unique identifier, the information should be searchable and include all 20 fields, registration should be free or minimal cost so as not to exclude researchers from poorer countries, and the information in the registry should be validated.

We are encouraged that the World Health Organization is bringing stakeholders together to agree on the next steps in this process, and that it plans an initiative to certify registries that meet these agreed standards, in particular to ensure that the information in those registries is reliable and that individual trials can be identified via an international numbering system.⁸ Within a year WHO intends to provide a web based portal to all these certified registries. As the ICMJE statement rightly implies, it will be at least two

years before we know whether this move by journal editors is a success or failure.

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Competing interests: FG attended the meeting of the ICMJE where the statement on trial registration was discussed. She was formerly editorial director of Current Controlled Trials and helped create its clinical trials registry.

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Excess coronary heart disease in South Asians in the United Kingdom

The problem has been highlighted, but much more needs to be done

Health inequality between ethnic groups in the United Kingdom is widening.¹ Death rates from coronary heart disease in South Asians (immigrants from India, Pakistan, Bangladesh, and Sri Lanka) have declined at a slower rate than in the indigenous population.² Accumulating evidence shows that second and third generation South Asians seem to be displaying many of the same risk characteristics that make them prone to coronary heart disease as their parents and grandparents.³ The first published evidence of elevated risk of coronary heart disease in South Asians appeared as early as 1959—from a study based on expatriate Indians in Singapore.^{w1} Numerous subsequent studies corroborated the findings. However, the topic of ethnicity and disparities in outcomes from coronary heart disease in the United Kingdom has only recently been given the importance it deserves.^{w2}

We still do not have an explanation for excess deaths from coronary heart disease in South Asians, but several plausible hypotheses have been generated (box).^{w3-w4} The increased prevalence of the metabolic syndrome (comprising insulin resistance, hypertension, central obesity, and hyperlipidaemia) and diabetes mellitus in this population is the most convincing and consistent explanation to date.^{w3} None of the

Factors contributing to excess risk of coronary heart disease in South Asians

- Migration
- Disadvantaged socioeconomic status
- "Proatherogenic" diet
- Lack of exercise
- High levels of homocysteine and LP(a) lipoprotein
- Endothelial dysfunction
- Enhanced plaque and systemic inflammation

hypotheses has been studied systematically, and current understanding is based on case-control studies and cross sectional studies. Moreover, information related to cerebrovascular disease is particularly lacking.

The recently published INTERHEART study shows that more than 80% of the global burden of coronary heart disease, irrespective of the ethnic origin, can be attributed to five main conventional cardiac risk factors—abnormal lipids, diabetes mellitus,