Notice to contributors

Thorax is the journal of the British Thoracic Society. It is intended primarily for the publication of original work relevant to diseases of the thorax. Contributions may be submitted by workers who are not members of the society. The following notes are for the guidance of contributors. Papers may be returned if presented in an inappropriate form.

Submission and presentation The original typescript and two copies of all papers should be sent to the Executive Editor, Professor A E Tattersfield, City Hospital, Nottingham NG5 1PB. Editorial and historical articles are normally commissioned but the Editor may accept uncommissioned articles of this type. Manuscripts must be accompanied by a declaration, signed by *all* authors, that the paper is not under consideration by any other journal at the same time and that it has not been accepted for publication elsewhere. The typescript should bear the name and address of the author who will deal with editorial correspondence. Authors may be asked to supply copies of similar material they have published previously. Papers are accepted on the understanding that they may undergo editorial revision. In the event of rejection one copy of the text may be retained for future reference.

Authors should follow the requirements of the International Steering Committee of Medical Editors (*Br Med J* 1979;i:532–5). Papers must be typed in double spacing with wide margins for correction and on one side of the paper only. They should include an abstract on a separate sheet of no more than 250 words stating clearly why the study was done, how it was carried out (including number and brief details of subjects, drug doses, and experimental design), results, and main conclusions. Papers should contain adequate reference to previous work on the subject. Descriptions of experimental procedures on patients not essential for the investigation or treatment of their condition must include a written assurance that they were carried out with the informed consent of the subjects concerned.

Statistical methods The Editor recommends that authors refer to Altman DG, Gore SM, Gardner MJ, Pocock SJ. Statistical guidelines for contributors to medical journals. *Br Med J* 1983;**286**:1489–93. Authors should name any statistical methods used and give details of randomisation procedures. For large numbers of observations it is often preferable to give mean values and an estimate of the scatter (usually 95% confidence intervals) with a footnote stating from whom the full data may be obtained. The power of the study to detect a significant difference should be given when appropriate and may be requested by referees. Standard deviation (SD) and standard error (SEM) should be given in parenthesis (not preceded by ±) and identified by SD or SEM at the first mention.

SI units The units in which measurements were made should be cited. If they are not SI units the factors for conversion to SI units should be given as a footnote. This is the responsibility of the author.

Illustrations Line drawings, graphs, and diagrams should be prepared to professional standards and submitted as originals or as unmounted glossy photographic prints not smaller than 14 × 10 cm. Particular care is needed with photomicrographs, where detail is easily lost—it is often more informative to show a small area at a high magnification than a large area. Scale bars should be used to indicate magnification. The size of the symbols and lettering (upper and lower case rather than all capitals) and thickness of lines should take account of the likely reduction of the figure—usually to a width of 70 mm. Three copies of each illustration should be submitted. Each should bear a label on the back marked in pencil with the names of the authors and the number of the figure, and the top should be indicated. Legends should be typed on a separate sheet. Authors must pay for colour illustrations.

References Responsibility for the accuracy and completeness of references rests entirely with the authors. References will not be checked in detail by the Editor but papers in which errors are detected are unlikely to be accepted. Reference to work published in abstract form is allowed only in exceptional circumstances—for example, to acknowledge priority or indebtedness for ideas. References should be numbered in the order in which they are first mentioned and identified in text, tables, and legends to figures by arabic numerals above the line. References cited only (or first) in tables or legends should be numbered according to where the particular table or figure is first mentioned in the text. The list of references should be typed in double spacing and in numerical order on separate sheets. The information should include reference number, authors' names and initials (all authors unless more than six, in which case the first three names are followed by *et al*), title of article, and in the case of journal articles name of journal (abbreviated according to the style of *Index Medicus*), year of publication, volume, and first and last page numbers. The order and the punctuation are important and should conform to the following examples:

1 Anderson HR. Chronic lung disease in the Papua New Guinea Highlands. *Thorax* 1979;**34**:647–53.
2 Green AB, Brown CD. *Textbook of pulmonary disease*. 2nd ed. London: Silver Books, 1982:49.
3 Grey EF. Cystic fibrosis. In: Green AB, Brown CD, eds. *Textbook of pulmonary disease*. London: Silver Books, 1982:349–62.

Short reports Short reports of experimental work, new methods, or unique cases that illustrate an important principle may be accepted. These may be published as two page reports, in which case the report must be limited to 850 words, a maximum of two tables or illustrations, and no more than 10 references. Occasionally a one page short report is appropriate and this will need to be limited to 400 words, one table or illustration, and 10 references. Short reports should normally have a one or two sentence abstract at the beginning.

Correspondence The Editor welcomes letters related to articles published in *Thorax*. These should not exceed 300 words or contain more than three references, which should be listed at the end of the letter. Letters should be typed in double spacing with wide margins and must be signed by all authors.

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Indexes and contents lists for volume 44 1989

MAIN INDEX OF AUTHORS AND TITLES (EXCLUDING ABSTRACTS) *page 1*

INDEX OF BRITISH THORACIC SOCIETY ABSTRACTS *page 19*

CONTENTS LISTS

BRITISH MEDICAL ASSOCIATION · TAVISTOCK SQUARE · LONDON WC1H 9JR

Thorax

The Journal of the British Thoracic Society

(*President:* M W McNICOL)

Thorax 1989;**44**:80

Correspondence

Spontaneous pneumothorax due to metastatic carcinoma of the rectum

The paper by Mr PE Bearn and Mr OJ Lau (June 1988;**43**: 496) mentions that pneumothorax can be produced by metastasis from osteogenic sarcoma, Ewing's tumour, Wilm's tumour, melanoma, and endometrial adenocarcinoma, and that metastatic carcinoma of the rectum has previously not been reported as a cause of pneumothorax. We wish to add that various other primary malignancies, including fibrosarcoma, angiosarcoma, synovial cell sarcoma, leiomyosarcoma, etc, have also been reported to result in pneumothorax.[1] Although breakdown of the tumour directly into the pleural space, as mentioned by the authors, can result in pneumothorax, alternative mechanisms of pneumothorax formation have also been reported. These include tumour embolus and subsequent infarction and necrosis of the lung with air leak,[2] and rupture of lung tissue due to secondary deposits beneath the pleura, producing free interstitial air that may trek along the vascular sheaths to the mediastinum and rupture through the mediastinal pleura.[3] The occasional association of pneumomediastinum and the spontaneous resolution of pneumothorax in some patients strongly support the latter hypothesis of pneumothorax formation in metastatic lung disease.[1,2]

SANJIV SHARMA
MIRA RAJANI
Department of Radiodiagnosis
Cardiothoracic Centre
All India Institute of Medical Sciences
New Delhi, India

1 Sharma S, Rajani M, Aggarwal S, Puri S, Baijal VN. Spontaneous pneumothorax and pneumodiastinum in metastatic lung disease. *Indian J Chest Dis Allies Sci* 1988;**30**:125–32.
2 Dines DE, Cortese DA, Brennan MD, Hahn BG, Payne WS. Malignant pulmonary neoplasms predisposing to spontaneous pneumothorax. *Mayo Clin Proc* 1973;**48**:541–4.
3 Spittle MF, Heal J, Harmer C, White WF. The association of spontaneous pneumothorax with pulmonary metastases in bone tumours of children. *Clin Radiol* 1968;**19**:400–3.

Bilateral empyema and purulent pericarditis due to *Haemophilus influenzae* capsular type b

Drs R Iggo and R Higgins (July 1988;**43**:582) have reported a case of bilateral empyema and purulent pericarditis due to *Haemophilis influenzae* capsular type b, stating that it was the first published case that they are aware of in this country. We have previously described a similar case of epiglottitis and pericarditis in a previously fit 26 year old woman in the UK.[1]

Our patient also developed a pericardial effusion and signs of pericardial tamponade and required pericardiotomy and drainage of the pericardial effusion. She also had no underlying immunological deficit and made an uneventful recovery.

The organism in our case was resistant to ampicillin but sensitive to chloramphenicol. The organism in the case described by Drs Iggo and Higgins was sensitive to ampicillin, but resistance of *H influenzae* type b to ampicillin has been reported at about 14%.

It is therefore important that all serious infections suspected to be due to *H influenzae* should be treated with chloramphenicol rather than with ampicillin.

ANNE MIER
Department of Medicine
Charing Cross and Westminster Medical School
London W6 8RF

1 Mier A, Shanson D. Ampicillin-resistant *Haemophilus influenzae* epiglottitis and pericarditis in an adult. *Lancet* 1984;ii:817.

Book notice

Gastroesophageal Reflux. GG Jamieson, A Duranceau. (Pp 281; £31.) Philadelphia: Saunders, 1987. ISBN 0-7216-2319-0.

This excellent review of gastro-oesophageal reflux is essential reading for anyone with an interest in heartburn. From 5% to 10% of us are likely to experience these symptoms at some time during our lives. Apart from these personal reasons physicians with an interest in respiratory disease should have a professional concern with gastro-oesophageal reflux. At the conclusion of their book the authors have dealt with the potential pulmonary complications of reflux, in particular bronchial asthma. The work is extensively and well referenced with work published as recently as 1987 included. The pathophysiology of gastro-oesophageal reflux is discussed in the early chapters together with clinical symptoms and diagnosis. The difficult topic of staging is covered in detail in chapter 8 and the author's reiterate the plea of Dr Ingelfinger, the father of oesophageal research, that standardised methods must be used in this area. Later chapters deal with controversial aspects of oesophageal structure, function, and management. Barrett's oesophagus is considered in detail and its malignant potential acknowledged. Schatzki's ring excites radiologists and disappoints endoscopists, but the author's review tempts me to consider active treatment of this condition. Gastro-oesophageal reflux is an important phenomenon that should concern respiratory physicians, gastroenterologists, and surgeons alike. It can cause considerable morbidity for patients. This review by Jamieson and Duranceau is clear, well written, and well worth reading and should clarify our approach to treatment.—JFM

Notice

Critical care in the 1990s congress

A congress entitled "Critical Care in the 1990s" will be held at Erasmus University, Rotterdam, from 22 to 28 April 1989. Information about invited speakers and free papers, registration, and travel arrangements may be obtained from Dr Omar Prakash, Thorax Centre, Erasmus University, PO Box 1738, 3000 DR Rotterdam, The Netherlands (tel 31-10-4635230, telex 25267, telefax 31-10-4362841).