Notice to authors

Structured abstracts

Those who regularly read the *BMJ* and some other medical journals will have noticed that a number of abstracts have become "structured." This change in requirement has taken place in an attempt to make abstracts more informative and to allow readers quickly to judge the applicability and validity of the results of the findings of a piece of research to their own interests.[1] You do not have to scan many papers to realise that for most authors the preparation of the abstract is a chore and that it is often produced by stringing together sundry pieces of text from within the main body of the paper; the word processor has helped with this irksome task enormously. Many authors seem actively not to give too much away in the abstract just to make the reader go to the main paper; others, in the hope that readers will *not* be bothered to read on, make claims in the abstract that are by no means justified in what comes later.

To try to encourage more thought in the preparation of abstracts, we invite authors to submit their abstract in structured form. Whether or not you do so will not jeopardise the chances of your paper being accepted but it seems inevitable that structured abstracts will become a requirement for more and more journals and the *BJIM* is likely to fall in line with this in due course.

Instructions for the preparation of structured abstracts are as follows:

The abstract should be of no more than 250 words and contain the following headings and information:

Objective—State the main question or objective of the study and the major hypothesis tested, if any.

Design—Describe the design of the study indicating, as appropriate, use of randomisation, blinding, criterion standards for screening or diagnostic tests, whether the study was retrospective or prospective, and so on.

Setting—Indicate the study setting, whether it was factory, clinic, or laboratory based, for example.

Subjects—State selection procedures, entry criteria, numbers of subjects entering and completing the study.

Interventions—Describe the essential features of any interventions, including their form and duration.

Main outcome measure(s)—The primary study outcome measures should be indicated as planned before data collection began. If the hypothesis being reported was formulated during or after data collection, this should be clearly stated.

Results—The main results of the study should be given. Describe measurements that are not evident from the nature of the main results and indicate any blinding. If possible, the results should be accompanied by confidence intervals (most often the 95% interval). For comparative studies confidence intervals should relate to the difference between groups. Absolute values should be indicated when changes in risk or sizes of effect are given.

Conclusions—State only those conclusions that are *directly* supported by the data and indicate their significance to the field of study. Equal emphasis should be given to positive and negative findings of equal scientific merit.

Abstracts of *review articles* should have the following headings and informaton:

Objective—State the primary objective of the review.

Data sources—Describe the data sources that were searched, including dates, terms, and constraints.

Study selection—Identify the number of studies reviewed and the criteria used for their selection.

Data extraction—Summarise guidelines used for abstracting data and how they were applied.

Data synthesis—State the main results of the review and the methods used to obtain these results.

Conclusions—State the primary conclusions of the review and their application to the field of study; overgeneralisations should be avoided. Suggest areas for further research.

1 Haynes RB, Mulrow CD, Huth EJ, Altman DG, Gardner MJ. More informative abstracts revisited. *Ann Intern Med* 1990;113:69–76.

fertility of male rodents and is toxic for early rodent embryos is convincing.[10 13]

The strength of the present study compared with others might come partly from the fact that it was specifically designed for spontaneous abortions, with a precise questionnaire describing the way the pregnancy was diagnosed, the need for hospital care and the number of weeks of pregnancy, and taking into account known risk factors for spontaneous abortions. The major point is probably the fact that individual urinary measurements were available allowing precise exposure assessments before pregnancy and this made possible the study of a dose response relation.

In a future study one way to help identify the mechanism responsible for these effects in man would be to measure the mercury concentrations in the urine of workers' wives.

The present results give indications that paternal exposure to mercury might increase the risk of spontaneous abortion, a conclusion that could be of practical importance and should therefore be further documented.

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Correspondence and editorials

The *British Journal of Industrial Medicine* welcomes correspondence relating to any of the material appearing in the journal. Results from preliminary or small scale studies may also be published in the correspondence column if this seems appropriate. Letters should be not more than 500 words in length and contain a minimum of references. Table and figures should be kept to an absolute minimum. Letters are accepted on the understanding that they may be subject to editorial revision and shortening.

The journal now also publishes editorials which are normally specially commissioned. The Editor welcomes suggestions regarding suitable topics; those wishing to submit an editorial, however, should do so only after discussion with the Editor.

BK, Hobbs MST. The natural history of asbestosis in former crocidolite workers of Wittenoom Gorge. *Am Rev Respir Dis* 1986;**133**:994–8.
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31 McDonald AD, Fry JS, Woolley AJ, McDonald JC. Dust exposure and mortality in an American chrysotile textile factory. *Br J Ind Med* 1983;**40**:361–7.
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33 Peto J. Some problems in dose-response estimation in cancer epidemiology. In: Vouk VB, Butler GC, Hoel DG, Peakall DB eds. *Methods for estimating risk of chemical injury: human and non-human biota and ecosystems.* New York: Wiley and Sons, 1985.
34 Doll R, Peto R. Cigarette smoking and bronchial carcinoma. *J Epidemiol Community Health* 1978;**32**:303–13.
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Vancouver style

All manuscripts submitted to the *Br J Ind Med* should conform to the uniform requirements for manuscripts submitted to biomedical journals (known as the Vancouver style).

The *Br J Ind Med*, together with many other international biomedical journals, has agreed to accept articles prepared in accordance with the Vancouver style. The style (described in full in *Br Med J*, 24 February 1979, p 532) is intended to standardise requirements for authors.

References should be numbered consecutively in the order in which they are first mentioned in the text by Arabic numerals above the line on each occasion the reference is cited (Manson[1] confirmed other reports[2–5] . . .). In future references to papers submitted to the *Br J Ind Med* should include: the names of all authors if there are six or less or, if there are more, the first three followed by *et al*; the title of journal articles or book chapters; the titles of journals abbreviated according to the style of *Index Medicus*; and the first and final page numbers of the article or chapter.

Examples of common forms of references are:

1 International Steering Committee of Medical Editors. Uniform requirements for manuscripts submitted to biomedical journals. *Br Med J* 1979;**1**:532–5.
2 Soter NA, Wasserman SI, Austen KF. Cold urticaria: release into the circulation of histamine and eosino-phil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;**294**:687–90.
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inexperienced to insist on further histology and so I lost my opportunity of fame, as he and doubtless many others did too.

We were interested in occupational cancer and we, too, had read Hueper, who, according to Merewether, was a cancerphile. I never met him, but he was obviously a very nice man. If you fire off in every direction, you are bound to hit something some time, as he did. We had a job to do and we couldn't afford to use our limited resources in following up all Hueper's claims.

It was for this reason that I wrote in my reply to Huncharek, that the reaction of the asbestos industry was not as reprehensible as has been made out by Castleman and Brodeur. This seems to have raised the hackles of Castleman. But I ask him, if we were not *sure* that asbestos was a carcinogen (and by "we" I modestly include Merewether and Doll), why should industry assume the responsibility? And I ask again as I did in my reply to Huncharek, what was the American government doing? Did they shuffle off their responsibilities on to the states? And what were the unions doing? Where were the great champions of workers' rights? When the American government admits that it recommended, for perfectly legitimate reasons, the use of asbestos in navy and merchant ships, then I will listen to complaints against employers. The US Department of Health, Education, and Welfare knew as much as anybody about the dangers of asbestos, but there is no evidence of them having recommended any restrictions on its use.

I am no expert in animal studies, but I have the greatest reservations in extrapolating animal results to man. Once again, it is a cause for suspicion, but not for precipitate action. So I do not roundly condemn the asbestos industry for what they did, or did not, do. After all, the industry in the United Kingdom established the Asbestosis Research Council, which has probably done more to reveal the problems of asbestos than any other body.

Every good Victorian novel had its death bed scene and Castleman's description of the death of Tony Lanza, via Harriet Hardy, is no exception. Who among us, with hindsight, does not have regrets about his sins of omission or commission?

So, Castleman, criticise if you like, but have the grace to admit that other people have the right to criticise your criticisms.

1 Brown K, Murray R. Asbestos and the Romans. *Lancet* 1990;336:445.

NOTICE

Spirometry: Pulmonary Function Testing in Occupational Health (NIOSH Course 097) 1991 Long Beach, California, USA, 10–11 October 1991.

This workshop will provide instruction in all aspects of spirometry through lectures, practicums, and testing. Training is intended for occupational health nurses, physicians, technicians, industrial hygienists, and others responsible for performing accurate pulmonary function testing of employees. This NIOSH-approved workshop has been developed according to American Thoracic Society standards for pulmonary function testing. As a result of attending these workshops, you should be able to:

- Describe the value of spirometry testing in clinic and work settings
- Describe and instruct on the basic anatomy and physiology relevant to spirometry
- Perform tests and interpret results
- Calculate correctly FVC, FEV_1, $FEF_{25-75\%}$, FEV_1, and predicted normals

The programme is under the direction of John Howard, MD, MPH, Assistant Professor and Acting Director of the Occupational Medicine Residency Training Programme at University of California College of Medicine, Irvine. Dr Howard has conducted similar workshops for the University of California, Irvine, for several years. This programme has been approved by the California Board of Registered Nursing, BRN Provider No. 07784 for 15 hours. In addition, MBA Inc offers 1·5 continuing education units for successful completion of each workshop. Approval is pending from the American Board of Industrial Hygiene for CM points. Course hours are 8:00–5:00 daily. The tuition fee of $375.00 includes refreshments and instructional materials. Enrolment is limited to 25. The fee, less a 20 per cent administration charge, is refundable if written cancellation is received two weeks prior to the programme date. For further information contact: McIntyre, Birkner, and Associates, 5865 Dovetail Drive, Agoura Hills, California 91301, UA.