Unreviewed reports

Assemble editors of biomedical journals together and it will not be long before they start discussing an old conundrum: what should be done with the anecdotal contribution—the interesting case or event that may be important but may also be coincidence? To print these in a section largely devoted to peer reviewed reports of rigorous scientific research may overinflate their importance and, by association, may devalue the reliability of the research studies; equally, to reject anecdotal reports for publication may deprive the community of important information.

Some editors devote much of the correspondence columns to these contributions; nevertheless, how many of their readers realise that usually these have not been peer reviewed and carry little of the weight of the Letters to the Editor in a journal such as, say, *Nature*? The confusion has been compounded by data bases such as *Index Medicus* which give letters, whatever their provenance, equal ranking with the formal scientific articles.

To make the distinction plain we have largely reserved the correspondence columns of the *BMJ* for comment on published work, creating a separate section of (peer reviewed) Short Reports. Though in theory such an arrangement is tidy, in practice problems remain. When is an event in a patient taking a drug possibly a true side effect, and when should it be printed as a Short Report rather than reported only to the drug manufacturer and regulatory authority? Should journals print negative results of minor importance? Should a small scale follow up study appear in the same journal that printed the original work? To try to solve some of these difficulties we are starting this week a new occasional column, called Unreviewed Reports. Given that the emphasis here will be on brevity and quick publication, the limitations on format will be considerable (p 1028), even though the articles will still be subject to selection by the editorial committee, containing two hospital consultants, which meets weekly. We hope that the new section will help solve some of the difficulties of both editors and authors.

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Regular Review

Artificial nutrition in hospital

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The nutrition of patients in hospital has only recently become of much interest to the doctors looking after them. As is often the case with subjects newly recognised as important, enthusiasm has (to an extent) taken precedence over evaluation, and treatments have tended to become standard for no very clear reasons. In some ways the pharmaceutical industry has a lot to answer for in its uncritical promotion of nutritional products. Its interest has, on the other hand, also produced technical advances in the presentation of nutrients and administration systems for enteral and intravenous feeding which have at least reduced the dangers of artificial nutrition, even if its value in different clinical settings is still uncertain.

Evidence directly linking malnutrition with increased morbidity and mortality is not difficult to find. Loss of weight and nitrogen may be rapid after injury or during any illness with a combination of increased breakdown of body tissue and insufficient intake of food.¹ A study reported in 1965 showed that in a group of patients with severe complications of abdominal surgery and virtually no intake of nutrients, all those who had lost 30% or more of their original weight died.² The outcome of elective operations may be compromised if the surgery is preceded by weight loss. In 1936 Studley observed that patients with peptic ulceration who had lost more than 20% of their mass in the preoperative period stood a one in three chance of dying postoperatively, whereas only 3.5% of those who had lost less weight succumbed.³ Today patients with peptic ulcer do not normally become so ill before coming to surgery, and smaller degrees of loss of weight may not have quite the same prognostic significance, but the general relation is undeniable. Immune mechanisms

function less effectively and resistance to bacterial infection is impaired in undernourished states,^{4 5} and wounds heal poorly when albumin concentrations are low.⁶

Clear though these associations generally are, they do not prove that artificial nutritional support will be effective in countering the excess morbidity. Possibly poor nutrition and high morbidity might each be associated independently with more severe disease or more extensive surgery. There is, however, some circumstantial evidence of the potential benefit of giving nutrients. Immune competence returns on refeeding,⁵ and higher albumin concentrations lead to better healing of wounds and anastomoses.⁶ Survival from episodes of acute renal failure is greater when patients are given essential amino acids in addition to fulfilling energy requirements,⁷ but this may reflect only the potential dangers of producing something akin to kwashiorkor by administration of glucose with no source of nitrogen.^{7 8} Nevertheless, these observations give some encouragement to the proponents of artificial nutritional support—but firmer and more convincing evidence is needed and can come only from controlled clinical trials.

Evidence from controlled trials is sadly lacking, perhaps because of the practical difficulties of carrying out studies of this type. The degree of benefit (if any) is unlikely to be the same in groups of patients with widely different disease processes. Unless sizeable improvements result from administration of nutrients many patients need to be studied to give a trial enough statistical power to detect any advantage, so that either the study will take a long time or a multicentre investigation—with all its problems—must be set up. These