destroy the identity of individual journals is more an indictment of the journal than a sensible excuse. No journal should have to rely on editorial style to make its mark. One hopes that there will be uniform and rapid support for the Declaration of Vancouver by all concerned in journal editing. We could then all concentrate more on the subject matter of papers and worry less about irritating minutiae.

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SIR,—The citing of references is a valuable way of drawing attention to additional information or discussion without lengthening a text. But it is not unknown, even in journals of the highest repute, for authors to misinterpret or even falsify data taken from their cited references. When reference is made to work "in press" or awaiting acceptance the reader cannot check or follow up this at all.

Surely the International Steering Committee of Medical Editors (20 May, p 1334) should acknowledge that their readers take precedence over their authors' convenience and should refuse to accept work citing references which readers cannot easily consult. After all, if the information or discussion alluded to in an unpublished reference is at all relevant it can be incorporated in the text of the article, where the reader can assess its worth.

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Interrelated factors in hypertensive patients

SIR,—The summary and conclusions of the paper by Dr D Ballantyne and others (8 April, p 880) may suggest that findings in a hospital sample of hypertensive patients could challenge the validity of epidemiological relations established in properly drawn samples of the general population.¹ Apart from what must be an error in the standard deviation (SD) for systolic blood pressure in female non-smokers (and possibly smokers), the SDs are larger rather than smaller than those in samples of

people at work in the general population and this slightly questions the quality of the data. Bias due to selection of the sample is perhaps indicated by differences of +6% and -19% in the numbers of male and female smokers respectively compared with employed members of the general population.

Table I shows significantly lower levels of diastolic blood pressure (phase V, seated, mean of two readings) in relation to the aggregated values of the 80th and 95th percentiles of the age and sex distributions by five-year intervals for men and women examined at work in the west of Scotland, for male and female smokers. In our study cigarette smoking is also correlated strongly with alcohol consumption and high alcohol consumption in turn to high blood pressure, a relationship noted by other workers.^{2,3}

Table II shows the relation of blood pressure to obesity measured by Quetelet index ((weight × 100) ÷ (height × height)) at the 20th and 80th centiles of the QI distribution. Obesity is also related to alcohol, but the interaction of all three even after removal of the age effect is another question and one to which we have not yet the answer.

Characterisation of disease rather than patients can be determined more certainly in the general population.

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¹ Hawthorne, V M, *et al*, *British Medical Journal*, 1969, 4, 651.

² Ramsay, L E, *Lancet*, 1977, 2, 111.

³ Beevers, D G, *Lancet*, 1977, 2, 114.

SIR,—We were interested to read the report by Dr D Ballantyne and his colleagues (8 April, p 880) showing no relation between adiposity and blood pressure, except in male non-smokers, in a study of untreated hypertensive patients with diastolic blood pressures greater than 90 mm Hg.

In the Whitehall study of cardiorespiratory disease in 18 403 London male civil servants aged 40-64 years¹ blood pressure was measured on a single occasion and smoking habits recorded. As in the Glasgow study, there was no significant difference in mean blood pressure

(systolic or diastolic) between current cigarette smokers and non-smokers in those subjects with diastolic blood pressures greater than 90 mm Hg. However, contrary to the Glasgow findings, in this hypertensive subgroup there was a significant positive relationship between blood pressure and body mass index (weight/height)² regardless of smoking status.

It is possible that the negative Glasgow results might be due to differences between our studies in the length of time elapsed between the smoking of the last cigarette and the measurement of blood pressure. Alternatively their patients' smoking habits might have changed during the period of the three visits over which blood pressure was averaged.

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¹ Reid, D D, *et al*, *Lancet*, 1974, 1, 469.

The Stomach Cancer Group

SIR,—Stomach cancer is the third most common cancer in Britain. At present only one in six of those in whom the growth is radically resected will be alive in five years' time and, overall, the five-year survival is less than 10%. Appalled by the outlook for such patients, this group of interested clinicians has been meeting in an attempt to improve the treatment of stomach cancer.

For the past 18 months we have entered patients after gastrectomy to a multicentre controlled trial of cytotoxic chemotherapy. Drug therapy is given for two years after operation. The regimen of 5-fluorouracil and mitomycin-C given once every three weeks is well tolerated by the patients and the incidence of side effects is low. All patients are being closely monitored, in particular for biochemical and haematological changes.

So far eight centres are involved and 137 cases have been entered into the study. We would welcome to this group others keen to study this disease and its treatment. The next meeting of the group will be held in June 1978. All communications should be addressed to the secretary.

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VICTOR BROOKES
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Television medicine

SIR,—Sir Michael Swann's bedside manner deserves a tribute, and his imperturbability in a controversial situation should neutralise some circulating antibodies. Now that he has joined in the discussion (13 May, p 1274) I feel I can follow without any imputations.

While I was a member of its General Advisory Council (GAC) I came increasingly to respect the BBC, a body that is widely recognised as among the most praiseworthy of all British institutions, and my criticisms are those of a sincere and friendly admirer.

TABLE I—Cigarette smoking related to 80th and 95th percentiles of age-standardised diastolic blood pressure distributions in 5680 men and 987 women

Smoking category	Men				Women			
	n	80th	80th and 95th	95th	n	80th	80th and 95th	95th
Smoker	2794	2370 (84.8)	315 (11.3)	109 (3.9)	571	487 (85.3)	61 (10.7)	23 (4.0)
Non-smoker	1259	1039 (82.5)	160 (12.7)	60 (4.8)	343	267 (77.8)	48 (14.0)	28 (8.2)
Ex-smoker	1627	1259 (77.4)	293 (18.0)	75 (4.6)	73	58 (79.5)	12 (16.4)	3 (4.1)

Figures in parentheses represent percentages of totals

TABLE II—Blood pressure (mm Hg) related to obesity in 5686 men and 986 women

Obesity level by QI distribution	Men					Women				
	n	Systolic		Diastolic		n	Systolic		Diastolic	
		Mean	SD	Mean	SD		Mean	SD	Mean	SD
Low (<20%)	1057	128.5	16.2	79.1	10.1	268	130.2	16.7	78.2	9.6
Medium (≥20%)	3467	133.1	17.2	83.3	9.8	535	137.5	19.5	82.7	10.9
High (≥80%)	1162	139.1	18.7	88.6	11.2	183	146.7	20.8	89.1	12.2