unacceptable to us. These patients have tended to be more time consuming and to require additional resources and support, but we have found that many have become manageable in general practice over time, and we have had successes, in terms of both stabilisation of lifestyle, with improved health, and reduced criminal activity. This has led us to define the criteria for monitoring and supervision that some specialist agencies have been so reluctant to provide.

We recognise that methadone is only one of a range of interventions that may be appropriate to manage drug users who are dependent on opiates. In our view, dependence is a long term, relapsing condition, and one of the consistent characteristics of drug users presenting for help is their ambivalence about their drug use. Methadone seems to be more effective at keeping drug users in contact with health services than many other interventions that are proposed. If we acknowledge that drug users who are in contact with health services engage in less risky behaviours than those who are not it seems appropriate to support James L Sorensen² in his reference to Newman's article about the increase in the availability of methadone: "What is needed today is ... a firm commitment to make treatment available on request to every addict willing to accept it."³

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- 1 Strang J, Sheridan J, Barber N. Prescribing injectable and oral methadone to opiate addicts: results from the 1995 national postal survey of community pharmacies in England and Wales. *BMJ* 1996;313:270-2. (3 August.)
- 2 Sorensen J. Methadone treatment for opiate addicts. *BMJ* 1996;313:245-6. (3 August.)
- 3 Newman RG. Another wall crumbled—methadone maintenance treatment in Germany. *Am J Drug Alcohol Abuse* 1995;21:27-35.

Clinical judgment is important

EDITOR,—As private providers of oral and injectable methadone maintenance, we read John Strang and colleagues' paper about the prescribing of injectable and oral methadone to opiate addicts with concern but also some irritation at its occasional unrealities.¹ Many of our patients have steady and responsible jobs, often in changing locations. For such people, to pick up methadone mixture daily is difficult. Even in the United States, where daily pick up is almost mandatory, some demonstrably stable patients can collect 28 days' supply.²

Furthermore, although 50 mg methadone ampoules retail for as little as £2, private daily dispensing and controlled drug fees can easily reach £25 a week, especially if both oral and injectable methadone are prescribed. In a relatively low cost maintenance programme we have to take this into account. Once patients graduate to less frequent pick up the threat of daily pick up is a useful sanction.

Why is the average NHS oral methadone dose only 44.3 mg/day when a paper from the National Addiction Centre recommended doses of 50-120 mg daily?³ We know that our patients can tolerate the doses we prescribe because we assess their response after they have swallowed or injected the drug under supervision. We test hair for drugs of misuse. This is probably the best technique for monitoring use of non-prescribed drugs,⁴ and we are evaluating its effectiveness for monitoring compliance with methadone treatment. Few NHS clinics take these precautions.

Much could be done to deter and detect diversion of injectable methadone. We introduced 50 mg and 35 mg ampoules. One manufacturer was willing to number ampoules consecutively

and indelibly so that their origin could be traced if they were diverted, but we were officially told that numbering ampoules would undermine the government's policy of reducing bureaucracy. This is dogma gone mad.

Methadone programmes have the highest retention rates of any treatment for dependence on opiates⁵ but need to be flexible. Over the years we get to know our patients fairly well. Inevitably, we are sometimes too suspicious or too trusting, but the alternative is a rigid American-style system of daily supervision, which is sometimes appropriate but "actually hamper[s] the personal and career development of socially rehabilitated patients."² A few irresponsible doctors give private prescribing of methadone a bad name. The Stapleford Centre detoxifies, as inpatients, many more people who are dependent on opiates than it starts on methadone. We hope that the concerns raised by Strang and colleagues will not prevent us from exercising the clinical judgment that is as necessary to the practice of medicine as the research that should inform it.

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- 1 Strang J, Sheridan J, Barber N. Prescribing injectable and oral methadone to opiate addicts: results from the 1995 national postal survey of community pharmacies in England and Wales. *BMJ* 1996;313:270-2. (3 August.)
- 2 Novick DM, Joseph H, Saltsitz EA, Kalin MF, Keefe JB, Miller EL, et al. Outcomes of treatment of socially rehabilitated methadone maintenance patients in physicians' offices (medical maintenance). *Journal of General Internal Medicine* 1994;9:127-30.
- 3 Farrell M, Ward J, Mattick R, Hall W, Stimson GV, Des Jarlais D, et al. Methadone maintenance treatment in opiate dependence: a review. *BMJ* 1994;309:997-1001.
- 4 Brewer C. Hair analysis as a tool for monitoring and managing patients on methadone maintenance. A discussion. *Forensic Sci Int* 1993;63:277-83.
- 5 Brewer C. On the specific effectiveness, and under valuing, of pharmacological treatments for addiction: a comparison of methadone, naltrexone and disulfiram with psychosocial interventions. *Addiction Res* 1996;3:297-313.

Treating hypertension in elderly people

Statistics cannot eliminate weaknesses in study design

EDITOR,—The main question studied by Juan Merlo and colleagues was: Did treatment of hypertension in elderly men (whose blood pressure was measured at one examination in 1982-3 and was classified as being ≤ 90 mm Hg or > 90 mm Hg) lead to more ischaemic cardiac events during follow up of 10 years?¹ In the study hypertension was treated as a point exposure. With a complex health disorder such as hypertension, in which the time from the onset of an increase in blood pressure to diagnosis and treatment varies, such an approach introduces so much insecurity that it cannot be handled by statistical analysis. The treatment of individual patients as well as the effect on blood pressure might have changed several times during follow up, with varying effects on the result.

Table 1—Incidence of ischaemic cardiac events per 1000 person years. Figures on square braces are unadjusted rate ratios (95% confidence intervals)

		Diastolic blood pressure (mm Hg)				
		≤90	>90		All subjects	
Treated	61*	3.9 (2.1 to 7.1)	35*	2.0 (1.1 to 3.6)	42	2.6 (1.7 to 3.9)
Not treated	16		18		17	

*Proposed analysis would determine relative risk in these two groups.

The authors state that confounding by indication (severity) was handled by the statistical analysis. However, adjustment for cardiovascular disease as investigated in this study does not exclude, for instance, the possibility that patients with initially higher blood pressure or symptoms or with pathological findings on echocardiography were treated more aggressively. It is not surprising that men given antihypertensive treatment who had a normal blood pressure had a higher risk than healthy normotensive untreated men, because hypertension is a risk factor for cardiovascular disease and we know nothing about how well the hypertensive subjects were treated during the follow up.

The important question for clinicians is whether antihypertensive treatment leading to a low diastolic blood pressure increases the risk of ischaemic cardiac events. If the aim of the study was to investigate the possibility that the negative effects of antihypertensive treatment outweigh the benefits then a comparison of the two treated groups would have been more interesting. Table 1 is a modification of the authors' table 3; our proposed analysis would determine the relative risk of ischaemic cardiac events in men receiving antihypertensive treatment in whom a diastolic pressure of ≤ 90 mm Hg was achieved compared with men in whom the diastolic pressure remained > 90 mm Hg. Such an analysis would be expected to yield a relative risk lower than 1. If it does not then we do more harm than good with our treatment. In this case the unadjusted relative risk is approximately 1.7 and probably significant. The most plausible explanation for this, however, is weaknesses in the study's methodology and the problem of confounding.

We agree with the authors that there is much in support of the hypothesis that lowering blood pressure below an optimal level increases the risk of myocardial infarction. We do not, however, fully agree with the authors' conclusions.

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- 1 Merlo J, Ranstam J, Liedholm H, Hedblad B, Lindberg G, Lindblad U, et al. Incidence of myocardial infarction in elderly men being treated with antihypertensive drugs: population based cohort study. *BMJ* 1996;313:457-61. (24 August.)

Editorial should have given more pragmatic goals for primary health care teams

EDITOR,—Although the trend towards evidence based medicine and consensus statements is to be commended, the guidelines that are issued can often be divorced from the realities of working in primary care. I would make a plea for pragmatic and robust guidelines that can be implemented in general practice: guidelines that take into account the variability of a non-selected population, problems of patients' compliance