Peptic ulceration has always been a clear contra-indication to working on an offshore installation, and ready access to H₂ antagonists over the counter would have two consequences: firstly, people would treat symptoms without a definitive diagnosis being made, and, secondly, people would not take the drug properly even when the treatment was correct.

These facts would increase the risks of employees continuing to work offshore with undiagnosed or masked peptic ulceration. The incidence of medical evacuations for gastrointestinal emergencies is not insignificant, and if the patient is in the remoter regions of the North Sea, for example, evacuation may result in considerable danger to the many people involved.

J R B COOPER
Chairman, medical advisory committee,
UK Offshore Operators Association

Mobil Oil,
Medical Department,
London SW1E 6QB

1 Andersen M, Schou JS. Are H₂ receptor antagonists safe over the counter drugs? *BMJ* 1994;309:493-4. (20-27 August.)

Issuing private prescriptions to non-exempt patients

Legal loophole exists

EDITOR,—We wish to add a few points to Iona Heath's editorial on the creeping privatisation of NHS prescribing.¹ While the option exists for NHS "non-dispensing patients" (registered with prescribing or dispensing practices) who pay prescription charges to be issued with a private prescription at their request or with their consent, NHS "dispensing patients" (registered with dispensing practices) who pay prescription charges may not be issued with private prescriptions except for blacklisted drugs or drugs to take abroad in anticipation of illness.

This new legal interpretation (yet to be tested) seems an option to be exercised at the patient's request or with the patient's consent after discussion during the consultation. Since it is not a requirement, general practitioners may exercise judgment about the circumstances in which they use this interpretation of the regulations. In all cases in which discussion takes place general practitioners will need to record in the patient's notes full details of the advice given and the option chosen. General practitioners will also need to ensure that recall arrangements for reviews operate for private as well as NHS repeat prescriptions.

The main practical difficulty seems to be that the cost of a private prescription dispensed by a community pharmacist is not fixed to NHS costs. Pharmacists charge for the cost of the drug(s) and in addition are entitled to add a private dispensing fee. The final cost may therefore be higher than the NHS prescription cost, and close liaison with local pharmacists is required.

Finally, we wish to emphasise the importance of Heath's last sentence. General practitioners may wish to consider the long term implications of issuing private prescriptions regularly to NHS patients: in so doing they will in effect be removing a proportion of present NHS prescribing to the private sector. Understandable short term expedience may produce unfortunate long term sequelae.

NEAL MASKREY
Medical director
SIMON GRANT
Pharmaceutical adviser

North Yorkshire Family Health Services Authority,
York YO1 1PE

1 Heath I. The creeping privatisation of NHS prescribing. *BMJ* 1994;309:623-4. (10 September.)

Causes loss of legal rights

EDITOR,—I wish to add two further items to Iona Heath's list of potential difficulties caused when private prescriptions are issued to non-exempt patients.¹ The first is that prescribers cannot accurately know the cost to patients unless they direct them to a pharmacy from which they have a price list. The second is the loss to the patient of some legal rights under NHS terms and conditions of service. To whom can the patient complain?

PETER H FITTON
Medical adviser

Barnsley Family Health Services Authority,
Barnsley S75 2PY

1 Heath I. The creeping privatisation of NHS prescribing. *BMJ* 1994;309:623-4. (10 September.)

Effect of dietary mineral salt on blood pressure

Study methods flawed

EDITOR,—In their paper on the effect of a reduced sodium and increased potassium and magnesium intake on blood pressure J M Geleijnse and colleagues do not adequately deal with several methodological issues which could potentially confound their findings.¹

Firstly, the authors reported that, when asked to identify the mineral salt diet after the trial, 72% of the intervention group correctly did so because of the taste. This raises the question of the effectiveness of the blinding process. This is important because it could have influenced the subjects' reaction to the trial and therefore their blood pressure, as it is common knowledge that a low salt diet reduces blood pressure.

Secondly, the study did not have a long lead in period, suggesting that normotensive subjects could have been falsely recruited. Blood pressure tends to fall in this period without any intervention² because of regression to the mean.³ The effectiveness of the intervention may have been diluted by the inclusion of normotensive subjects.

Finally, the authors adjusted their findings for body weight. We were therefore surprised to note that they did not use different sized cuffs for different body weights.

The population approach to shift the mean blood pressure downward by a dietary method is attractive. This paper, however, has not convincingly shown the value of this mineral salt. Further studies are required to take into account not only the effectiveness of the salt but also its cost and availability.

HILARY FIELDER
Registrar in public health medicine
SU VUI LO
Senior registrar in public health medicine

West Glamorgan Health Authority,
Swansea SA1 5AQ

- Geleijnse JM, Witterman JCM, Bak AAA, den Breeijen JH, Grobbee DE. Reduction in blood pressure with low sodium, high potassium, high magnesium salt in older subjects with mild to moderate hypertension. *BMJ* 1994;309:436-40. (13 August.)
- Grobbee DE, Hofman A. Does sodium restriction lower blood pressure? *BMJ* 1986;293:27-9.
- Daly LE, Bourke GJ, McGilvray J. *Interpretation and uses of medical statistics*. Oxford: Blackwell Scientific, 1991.

Authors' reply

EDITOR,—We have emphasised previously the importance of methodological standards in studies of diet and blood pressure,^{1,2} but methodological needs to be considered in terms of validity. Hilary Fielder and Su Vui Lo address methodological problems but fail to indicate the nature of the confounding they suggest. In our view the trial

amply meets standards of intervention research within the limits inherent to the intervention applied and none of the issues raised invalidates the inference.

All possible measures were taken to perform the study blinded. Yet, while half of the participants would be expected to guess the allocation by chance, 72% of the group given the mineral salt correctly identified the intervention. Nevertheless, blood pressure responses did not differ between those who identified the salt correctly and those who did not. To prevent biased assessment of blood pressure an automated device was used.

With regard to the authors' second comment, the subjects had been diagnosed as having mild to moderate hypertension in a population survey, as we clearly outlined in the paper. For the trial, blood pressure was measured again one year later, and criteria for mild to moderate hypertension had to be met again at two visits one week apart. Any misclassification or further regression towards the mean could not have affected the validity of our results because subjects were randomised and such phenomena will apply to both groups.³

The cuff that we used comfortably encircled the arm in virtually all participants. Here again the comment suggests confounding, but this is not an issue as it was adequately prevented by randomisation. Moreover, analyses were based on change in blood pressure, and a potential systematic difference between the true and measured blood pressures in individual subjects was therefore cancelled out.

Finally, the authors seem to confuse the population approach and the risk approach.⁴ We examined blood pressure responses to a change in the composition of dietary salt in older subjects with mild to moderate hypertension. We did not speculate on the implication for the population at large. Yet the effects will probably be the same but of smaller magnitude in groups with a lower blood pressure. We agree with the authors' final remark that costs should be considered in any recommendation. While our data convincingly show a reduction in blood pressure when older mildly hypertensive subjects used the mineral salt, a cost-effectiveness analysis was not part of the trial.

J M GELEIJNSE
Research fellow
J C M WITTEMAN
Assistant professor
D E GROBBEE
Professor

Department of Epidemiology and Biostatistics,
Erasmus University Medical School,
Rotterdam,
Netherlands

- Grobbee DE, Hofman A. Does sodium restriction lower blood pressure? *BMJ* 1986;293:27-9.
- Grobbee DE. Methodology of sodium sensitivity assessment: the example of age and sex. *Hypertension* 1991;17(suppl 1):109-14.
- Miettinen OS. The need for randomization in the study of intended effects. *Stat Med* 1983;2:267-71.
- Rose G. Strategy of prevention: lessons from cardiovascular disease. *BMJ* 1981;282:1847-51.

Should obesity be treated?

Obesity is an anaesthetic risk

EDITOR,—Peter C Rubin's commentary on the two articles on whether obesity should be treated gives the wrong message.¹ Leaving appreciable obesity uncorrected not only creates cardiovascular risk factors but denies to the patient the future benefits of weight loss and has other adverse consequences.

The recently published triennial report on maternal mortality makes interesting reading.² The occurrence of only four deaths directly attributable to anaesthesia during the period covered is reassuring, but a feature common to three of the four, unfortunately not mentioned in discussion in the report, is obesity. Appreciable