Key messages

- Energy reducing diets often work poorly in obese outpatients, although they are effective for inpatients
- In this study patients put on a milk only diet had significant weight loss
- Weight loss was comparable with that achieved by drugs
- Patients are more likely to respond to a simple diet which they have not tried before than to advice on conventional diets

"diets do not work," at least as far as the conventional balanced reducing diet is concerned. The milk only diet was simple and patients had not tried it before. Patients completing the trial in this group achieved the highest overall mean weight loss (11.2 kg in 16 weeks), which is greater than the mean weight loss in one year in trials of dexfenfluramine,[8] sibutramine,[9] or orlistat.[10 11] Patients consuming only milk might be expected to become deficient in some vitamins and iron, but this was not found in another longer trial[4]; constipation was the only serious side effect reported.

We expected that patients on the milk plus diet would have a greater weight loss than those on the milk only diet as it was still simple but much less boring and patients were more likely to comply with it. The milk plus diet is also theoretically superior as it provides a greater variety of nutrients and an energy deficit of about 4 MJ/day instead of a 7 MJ/day deficit on milk only, which would cause an excessive loss of lean tissue.[4] Analysis of compliance (not reported) showed that it was similar for the two milk diets but much lower for the conventional diet.

We are not advocating milk only as a general long term reducing diet for obese outpatients, because in the long term it will cease to be novel and compliance will fall. Probably the best strategy is to rotate diets, just as rotation of anorectic drugs achieves greater long term weight loss than continuous use of a single drug.[12]

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Effect of government recommendations on methadone prescribing in south east England: comparison of 1995 and 1997 surveys

John Strang, Janie Sheridan

On instruction from the Minister of Health, the Department of Health in England convened a task force on the effectiveness of treatment services for drug misusers, and widely distributed its recommendations in 1996.[1] Methadone constituted 96% of all opiate prescriptions dispensed to drug misusers.[2 3] The task force specifically recommended that (*a*) methadone tablets should no longer be prescribed for the treatment of drug misuse; (*b*) daily dispensing should be used to prevent diversion of drugs; and (*c*) the optimal dosage for methadone maintenance treatment was probably between 50 mg and 100 g daily.[1]

Much of the drug problem of England and Wales is concentrated in London,[4 5] with 23% of all methadone prescriptions in the area being from the Thames regions.[3] We report the extent to which changes in line with the three recommendations of the task force occurred in the Thames regions between 1995 and 1997.

Methods and results

Data were collected nationally on prescriptions dispensed to drug misusers by community pharmacists in 1995[2 3] and for south east England again in 1997 (first mailshot only)—that is, one year before and one year after the publication of the task force's recommendations. One in four community pharmacies was randomly selected for the 1995 national

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Comparison of methadone prescribing data for 1995 and 1997, south east England. Values are percentages (numbers) of prescriptions except when stated otherwise

	1995 (n=584 prescriptions)	1997 (n=864 prescriptions)	Statistics (χ^2 or 95% CI of difference)
Dosage form			
No of prescriptions	580	861	
Tablets	12.1 (70)	9.5 (82)	Dosage form by year: χ^2=4.04, df=2, P=0.13
Ampoules	9.8 (57)	8.1 (70)	
Oral mixture	78.1 (453)	82.3 (709)	
Dispensing interval			
No of prescriptions	572	837	
Daily (5, 6, 7 days a week)	52.1 (298)	55.8 (467)	Daily *v* not daily by year: χ^2=1.87, df=1, P=0.17
2, 3 or 4 days a week	15.6 (89)	18.6 (156)	
Weekly or less	32.3 (185)	25.6 (214)	
Methadone daily dose—all prescriptions			
No of prescriptions	577	837	
Mean (SD) dose (mg)	52.0 (34.4)	51.2 (35.8)	–4.6 to 2.9
Interquartile values (mg)	30, 45, 65	30, 45, 60	
Percentage in 50-100 mg range	43.8 (253)	44.3 (371)	
Percentage >100 mg	5.2 (30)	4.4 (37)	
Different dosage forms			
Tablets:			
No of prescriptions	69	80	
Mean (SD) dose (mg)	58.0 (47.8)	53.7 (40.9)	–18.8 to 10.0
Interquartile values (mg)	20, 40, 75	30, 40, 60	
Ampoules:			
No of prescriptions	56	68	
Mean (SD) dose (mg)	88.9 (56.7)	94.2 (69.8)	–17.7 to 28.2
Interquartile values (mg)	50, 80, 100	50, 50, 150	
Oral mixture:			
No of prescriptions	448	688	
Mean (SD) dose (mg)	46.4 (23.8)	46.6 (26.2)	–2.8 to 3.2
Interquartile values (mg)	30, 45, 60	28, 45, 60	
Percentage in 50-100 mg range	44.2 (198)	44.8 (308)	
Percentage >100 mg	1.6 (7)	1.6 (11)	

survey[2] and one in two for the 1997 Thames survey; they were stratified by health authority in both surveys. Overall response rates were 75% and 65% respectively. To achieve comparability, data on methadone prescriptions from community pharmacies in the Thames regions were retrieved for the first mailshot only, giving 584 and 864 methadone prescriptions in 1995 and 1997 respectively.

The table shows differences in the distribution of dosage form, dispensing interval, and dose between 1995 and 1997. The proportion of methadone prescriptions in tablet form was reduced from 12.1% to 9.5%—a reduction in the same direction, but greater than that for methadone ampoules. The mean number of dispensings per week increased from 3.85 (SD 2.37) to 4.22 (2.43) (Mann-Whitney U test = 209374; $P < 0.0001$). The proportion of these prescriptions issued for daily dispensing as recommended increased only minimally (52.1% to 55.8%), although the proportion of prescriptions being dispensed weekly or less frequently decreased from 32.3% to 25.6%. There was no evidence of any increased use of methadone dosages sufficient to achieve "blockade": mean daily dose changed from 52.0 mg to 51.2 mg. For the oral mixture (to which the higher recommended maintenance dose related) the mean also remained unchanged (46.4 mg to 46.6 mg). There was also no increase in the proportion of methadone prescriptions for the recommended dose of 50-100 mg daily.

Comment

The ministerial mandate and the financial expenditure on the preparation of the task force's report were unprecedented in the United Kingdom. Three of the task force's recommendations about methadone prescribing were amenable to study from data sets recently collected. We found only scant evidence of change that might have been prompted by these recommendations. Although tablet prescribing had reduced in line with the recommendations, this reduced proportion is against a backdrop of an annual increase of 20% per annum in the number of opiate addicts presenting for treatment.[5] In other words, the annual number of prescriptions for methadone tablets has still increased. If the net result of an expensive review is a modest proportionate reduction (but absolute increase) in tablet prescribing, only a slight increase in the proportion of prescriptions dispensed daily, and little change in the mean daily dose, then the likelihood of substantial change in clinical practice following recommendations alone within the Department of Health's guidelines seems slim. If planners are awaiting major change in methadone prescribing as a result of central exhortation, they should not hold their breath.

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Endpiece

Of great place

Men in great place are thrice servants; servants of the Sovereign or State, servants of fame, and servants of business. So as they have no freedom, neither in their persons, nor in their actions, nor in their times. It is a strange desire to seek power and to lose liberty: or to seek power over others and to lose power over a man's self. The rising unto place is laborious; and by pains men come to greater pains; and it is sometimes base; and by indignities men come to dignities. The standing is slippery, and the regress is either a downfall or at least an eclipse, which is a melancholy thing.

Francis Bacon, *Bacon's Essays* (1612)