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New email list a great success

A world first?

Saltmatters is a new email discussion list. We think this is the world's first internet support group for people who want help with controlling their salt intake.

Every frustrated shopper trying to buy low salt foods can get a lot of help by joining. Just send a blank email to: **saltmatters-subscribe@ozdocit.org**

The letters *ozdocit* stand for Australian Doctor Information Technology, the website of two busy New South Wales general practitioners who have generously volunteered to help us by hosting this discussion list.

What we talk about

The permanent focus is shopping for good salt control. Already we have learnt more about bread, with several members sharing with us the direct correspondence they have had with Baker's Delight and Brumbys.

Baker's Delight baked goods have had a discrepancy between the sodium content given in their leaflets and the figures published on their website.

The Head Office says the website is correct, and Baker's Delight have no low salt products except when a franchisee will take a special order for salt free (meaning NAS) bread. Head Office discourages special orders (but without prohibiting them).

Brumbys Head Office has the company's own recipe for salt free bread, and individual franchisees have free access to it.

Forget about serving sizes

The biggest issue discussed so far was the common mistake of quoting **servicing sizes**—they are never any use for identifying low salt foods. Trevor Beard goes into the details on pages 3 and 4.

The future potential

We hope this group will grow large enough to increase the number of low salt foods and improve the choice. A big membership may well be feasible—see page 2.

At some point we should be able to start a database of subscribers and their postcodes, so that—with an agreed policy on individual privacy—we can identify clusters of postcodes revealing a few Australian suburbs where a **group** could wield far greater purchasing power than an individual.

One shop in one suburb could stock the same low salt products for 10 or more regular customers, and the group would be delighted to have a local shop at last that always kept them in stock.

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New email list—continued

More on the future potential

Clustering of postcodes could apply to restaurants as well as shops. Parties of 25 to 100 could organise regional low salt dinners. We did this in Canberra 20 years ago—ABC TV filmed a memorable Salt Skip meal at The Lakeside Hotel and broadcast it nationally. The discussion list could revive this idea Australia-wide.

A bigger demand could make low salt holidays easier to book at selected Australian and New Zealand destinations.

Online shopping could come soon. Peter Chamberlain has asked Coles On Line to sell all the Coles NAS products—don't ask why they were not doing that before. We can send questions to food manufacturers and ask them to reply to (and join) the *saltmatters* list.

How many subscribers?

If we recruited every Australian with a salt-related illness we would get 6 million subscribers—half the adult population.

The largest group (3 million) have **prehypertension** (blood pressure 120/80 and above). This is a new word.

When doctors were calling it **high normal blood pressure** the only word the patient heard was **normal**, so JNC-7 (the 7th report of the US Joint National Committee on Hypertension) announced last year that it was high time we did some straight talking.

At 120/80 the blood pressure has risen with age—far enough to double the risk of hypertension. Above 120/80 the doctor has discovered a health problem that needs treatment and can make a positive diagnosis—prehypertension.

We have no drugs for this. It requires a better diet and lifestyle, in which good salt control is essential. Practical help is available from *Salt Matters* (the book)

'If we recruited every Australian with a salt-related illness we would get 6 million subscribers—half the adult population.'

and *saltmatters* (email discussion list).

Another 2 million (the second largest group) have **hypertension**. Good salt control enables up to 40% of patients to avoid drugs and gives most of the others better control of their blood pressure using fewer drugs, at lower doses, with less side effects. But salt control needs to be good, with no room for mistakes. Get help from *Salt Matters* and *saltmatters*.

The 5% of women aged 15–45 with **severe premenstrual syndrome** (PMS) numbering a quarter of a million can note the Hobart results—they can abolish their PMS with good salt control—with 250 000 women joining us at *saltmatters*.

A much smaller but very important group (40 000) have Meniere's Disorder with severe vertigo. They are important because the vertigo is so unbearable, yet it is unusual to have severe vertigo when the 24-hour urinary sodium excretion rate confirms that salt control is good.

Chapter 13 of *Salt Matters* describes the dozen other salt-related illnesses afflicting the remainder of the six million. It is obvious to readers that they would get a lot of help if they subscribed to the *saltmatters* discussion list.

So how many can we expect?

To be realistic, how many of these people would actually join? If 6 million heard about us and one in 1000 joined us, we could expect 6000 subscribers. One in 100 would be 60 000. It is hard to see why we should settle for less than 6000.

Serving sizes make salt control too difficult

Ask 100 doctors

Ask 100 doctors if it is worth advising their patients to control their salt intake, and 95 will say it is a waste of time—they find it makes no measurable difference to the clinical outcome. There may be many reasons. Two of the main ones are:

1. Patients and doctors share the illusion that salt control begins and ends with table salt and cooking salt;
2. Nearly all the cookbooks are based the traditional low sodium diet with a daily limit of 1500, 1000 or 500 mg of sodium per day, depending on the severity of the illness.

The first problem is that 75% of the salt most people eat is in processed foods and the second very serious problem is that the traditional advice on low sodium diets sets them up for failure.

Why low sodium diets so often fail

Patients on the traditional advice must use food labels to check the sodium in a stated serving size, then measure and eat fractions or multiples of that serving size of every food on the plate and count up the milligrams of sodium per serving, write it down for every serving of every food in every meal they eat, and keep a cumulative total for the day. It is bad luck and bad management if they reach 1000 mg at lunch-time when their goal for the whole day is 1000 mg, but that's their problem.

Take pity on the sick folk who aim at 500 mg/day. and understand why a Lancet editorial in 1979 bewailed 'the misery of lifelong salt restriction'.

Understand also the joy and jubilation that greeted the arrival of thiazide diuretics in 1958. Diuretics alone can control fluid retention by forcing the kidneys to excrete sodium faster than normal, and this has relegated the 500 mg diet to the sickest of the sick, such as patients with life-threatening heart failure.

One of Australia's ENT specialists asserted before *Salt Matters* was published that most of his patients with Meniere's Disorder were incapable of good salt control, no matter who advised them. What could he do? He just told them to do the best they could and take a diuretic.

A two-page article by Trevor Beard on one of the fundamental problems he meets when trying to help people to take control of their salt intake—and get the satisfaction of controlling it well enough to get good clinical results

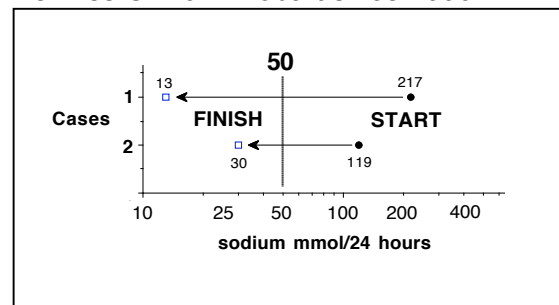
This ENT specialist's problem was that the **traditional advice** available locally was ineffective—it was **too difficult to follow**.

Australian Dietary Guidelines

For 26 years the Salt Skip Program has promoted an easier, more natural and more effective alternative to the traditional advice. The Australian Dietary Guidelines (ADGs) now promote it. A population of 20 million is advised to choose foods low in salt, and the ANZ food regulations limit the sodium content of low salt foods to 120 mg/100g. Many dietitians now use the ADGs and the 120 rule clinically.

Clinical effect of the 120 rule

This picture illustrates two case histories out of about 1500 patients referred to the Menzies Clinic in Hobart since 1990.



Case 1 was a man of 46 with Meniere's Disorder and severe vertigo. His baseline 24-hour sodium excretion was 217 mmol (4991 mg). Living on low salt foods exclusively his next sodium excretion rate was 13 mmol (299 mg). **He took no notice of serving sizes and he counted nothing.** Since 1997 he has had no vertigo except after one of his rare dietary mistakes.

Case 2 was a man of 58 hoping to avoid medication for high blood pressure. The ADGs changed his sodium excretion from 119 mmol (2737 mg) to 30 mmol (690 mg). He is still off medication 11 years later.

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Salt Skip News will continue to be distributed in hard copy in The BP Monitor (QHA newsletter)

Serving sizes too difficult—continued

Fluid retention

When a rising salt intake raises sodium excretion above 50 mmol (1150 mg) the first salt-related illnesses appear. The earliest is fluid retention, which may cause or aggravate health problems such as swollen ankles, PMS, Meniere's Disorder, or dropsy accompanying heart failure. **Everyone** with sodium excretion above 50 mmol is slightly bloated with up to 2 kg of excess water.

The 50 mmol boundary	
below 50 NORMAL if low from birth, and at least partial return to normal if used as a medical treatment	above 50 FLUID RETENTION 1–2 litres of water weighing 1–2 kg above 70 OTHER salt related health problems

You may look better without this bloating, and a well-known cricketer took a diuretic when his mother wanted him to lose 2 kg before his portrait was taken. With sodium below 50 mmol he would already have been 2 kg lighter and diuretics would not make him shrink any further.

Serving sizes and milligrams seem to be immortal

The first 9 chapters of *Salt Matters* were meant to emancipate readers from the tyranny of serving sizes and milligrams, but there are subscribers to the discussion list on whom the book has completely failed to have that effect. The position however is this:

1. on NAS fresh foods the salt free societies stay healthy
2. meals made of fresh plus unselected processed foods are causing or aggravating the salt related diseases;
3. with meals based on the ADGs—fresh plus **selected** (low salt) processed foods—the salt related diseases usually recover;
4. the average patient finds traditional low sodium diets much more difficult and much less effective. They have been superseded.

Restaurant meals

Restaurants cannot cope with serving sizes, milligrams, or low salt meals—it is salt or no salt. I find nearly all restaurants very obliging, but seldom well informed. They usually need help.

With help (a half-hour visit discussing the options) a Vietnamese chef in Hobart supplied a very good spicy low salt Asian meal. I made three consecutive 24-hour urine collections on the day before, the day of the meal and the day after, and my results were:

1. 20 mmol (460 mg);
2. 16 mmol (369 mg);
3. 12 mmol (276 mg).

I think this is a testimonial for the restaurant and for the Australian Dietary Guidelines.

There is just no comparison

Let me stress again that the conversation in that Asian restaurant was all about food, with no mention whatsoever of serving sizes or milligrams of sodium.

Look by contrast at a popular low sodium recipe book that gives the sodium content of every ingredient of every dish to 3 decimal places. One recipe tells us for example that the **sodium content of a tablespoonful of pink peppercorns is 2.816 mg**. Australia has no use for that information.

I should add that I have a high regard for this author but—as an American writing for Americans—this is the best he can do for a readership with no access to the Australian Dietary Guidelines.

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