makes it probable that the excess cardiovascular mortality in TOLB is attributable either to the drug itself or to unconsidered and unknown factors. In the absence of evidence for the latter, suspicion would naturally attach to tolbutamide.

The mortality study is at least suggestive enough to put a damper on what appears to be the indiscriminate use of all oral hypoglycemic agents in the treatment of mild or moderate, adult-onset diabetes. Although tolbutamide, for practical reasons, has been the only sulfonylurea drug investigated by UGDP.

This is 4 years ago.

The chance that other compounds of this family may be similarly involved cannot be dismissed despite differences in molecular structure.

It would not be justifiable at this point, however, to prohibit the manufacture and use of sulfonylurea drugs, for they will probably continue to fill a need in special circumstances.

If these drugs are dangerous, what course should we take? You have just heard that their manufacture of the drug should not be forbidden, and for reason. For example, how do we treat a diabetic patient who ought to be taking insulin but is living alone with a broken, or amputated, or paralyzed arm that prevents him from using a syringe and needle? One who is blind and cannot measure his dose of insulin? One who is old and tremulous? One who is mentally disturbed? And finally, one who refuses to take insulin.

In another vein, there are diabetics who are engaged in hazardous occupations and ought not to take insulin for fear of reactions.

We ought to make allowance for these patients, even though the oral agents are not very effective and, I believe in the long run, may be harmful.

The CHAIRMAN. Does this list of exceptions include most or all of the exceptions that you could think of?

Dr. RICKETTS. Well, I think so, yes. I might think further, but that is quite a number.

The CHAIRMAN. All right, please go ahead.

Dr. RICKETTS. But if we continue to make these agents available, as I think we must, how do we protect other diabetics who would like to use them but should not?

Insulin comes to the patient with a package insert that carries a great deal of information, including certain warnings. The oral agents come to the patient in silence because they have been regarded as innocuous, needing no instructions except the doctor's directions for dosage and timing. This must change.

But it is the physician who should lead the way, and I hope that the report of the Biometric Society will in time convert the many current unbelievers. Meanwhile—and this might seem to be preposterous—it might not be too radical to ask the FDA, under proper authority, to transfer the oral hypoglycemic agents to the circumscribed schedule II of dangerous drugs along with barbiturates, amphetamines, and certain narcotics.

Physicians might learn that the oral agents are not exactly safe, and the requirements of BNDD prescriptions, if for dubious need, might become a salutary nuisance. This arrangement, of course, would have holes in it—and I can see some—but it might have the effect of helping to reduce the use of a product that too many patients could well do without.