On the one hand, amphetamine, methamphetamine, phenmetrazine, and methylphenidate are recognized as having similar abuse potential, and as such have been placed in schedule II.

On the other hand, a number of other appetite suppressants have not been extensively abused to date. These drugs have been placed in schedules III or IV.

Mr. GORDON. Doctor, you mentioned attitudes, they can change, can they not?

Dr. JASINSKI. Yes, sir.

Mr. GORDON. I understand that Preludin has become one of the most widely used drugs in the District of Columbia area.

The price in the street is about $10 per pill.

We received a call from the Police Department of Louisville, Ky., that Preludin is the most popular street drug there, also.

The price is about $8 per pill.

In an undated FDA document, we have statements that documentation of abuse lags markedly behind abuse, and when it appears, is only the tip of the iceberg.

My question is, why wait until there is an epidemic, why not use pharmacologic and chemical data to predict abuse before it occurs?

Dr. JASINSKI. I think this may be justified in certain instance from a historical perspective. It depends on how one directs one's thinking, and one's bias in the particular area.

My particular bias is toward the practice of medicine, and making a rational scheduling policy such that scheduling does not affect the patient who may be using the drugs in legitimate circumstances and for legitimate needs. We know many drugs which have required uses in medicine, and which benefit the patients, also have other properties leading to self-ingestion. At times the people will use these drugs to such a point that they will experience toxic effects, or will engage in behaviors which our society condemns.

In these instances we must, in my opinion, be as much concerned about not removing drugs from patients inappropriately. We must make decisions on a relatively rational basis.

I think from a historical perspective, we have had a number of drugs which have been pharmacologically equivalent, but which have been used by physicians, and in a sense by people without creating major public health problems.

Mr. GORDON. But it is not an antiobesity drug, so you are really creating a straw man.

We are talking about antiobesity drugs. We are not talking about that type of a drug.

Now, given the very limited use, the FDA says that the benefits are clinically trivial, those were the exact words used by the FDA, by the advisory committee. Given these trivial benefits, and given the abuse potential, and other side effects, how do you figure the benefit-to-risk ratio?

Dr. JASINSKI. What I am talking about is the relative risk.

The data which I have bears on relative risk from a particular toxic effect, which is the ability to induce and maintain self-ingestion behavior.

Now, this is a risk which occurs with all the compounds.