high quality, but nevertheless it was diethylpropion. The synthesis is apparently easy for anybody with some knowledge of chemistry.

So we are indeed seeing abuse of at least one of these congeners which was legally marketed for obesity. I think it is quite obvious that no one will market an illicit drug if there is no "street" market for it.

The stimulant properties of some of these congeners seem to be leading to nonmedical use of them. Therefore, there is now justification in Canada to reexamine whether or not the extent of our restrictions has been adequate, or now needs further tightening.

We cannot really ignore the fact that drug abuse is beginning to appear with some of these amphetamine congeners.

Senator NELSON. Are all of the congeners imported into Canada, or are some of these manufactured?

Dr. HENDERSON. None being manufactured that I know of.

Senator NELSON. Does the Canadian Government limit the amount imported?

Dr. HENDERSON. No, to my knowledge, it does not impose any quota on amounts.

They are controlled by the schedule which limits them to prescription, and other than over-the-counter sales that is about the loosest kind of control that exists!

Senator NELSON. And all of these in the colored section of the graph are specifically indicated only for obesity?

Dr. HENDERSON. Yes, they are approved for that purpose only; that is correct.

Senator NELSON. If some of them are being used, as you put it, for nonmedical purposes, and if in fact it is found that they are widely used for that purpose, does their use for controlling obesity have a benefit-to-risk ratio sufficient to leave it in the market for that purpose? Or are the costs, so to speak, in the ratio too great to allow it to be in the market?

Dr. HENDERSON. In my own opinion, Senator Nelson, the risks are higher than the benefits. I would state however, that it is difficult to assess accurately the risk benefit, for in most cases medical opinion is divided.

We have not been teaching a methodology of risk-benefit for drugs to our students or to our practicing physicians. It seems obvious that we should in the future.

The only drug I prescribe for obesity is fenfluramine. I think its potential for abuse is very small. After trying it patients prefer not to continue with it for long, but it does act as an anorectant for several weeks or a month or two.

I use it for people who have said they have tried all sorts of diets. Some have been in Weight Watcher-type organizations, but for one reason or other they have not succeeded in losing weight. Nothing has worked for them and they are depressed people.

They do not like themselves as obese people. They really do want to lose weight, but they "cannot." Therefore they are, in their own eyes, failures, and they come virtually with tears in their eyes.

It becomes important to try to persuade these patients, that it is a question of food intake that creates obesity. If one can demonstrate that he/she can lose weight, even a few pounds a week, if he sticks to