Making the drugs is ours they said. Now, that is a paraphrase, but very close.

Mr. RODY. Methylphenidate—Ritalin—differs from the other substances under consideration here today.

It is not indicated as an antiobesity drug. Ritalin is described as "effective" in the treatment of minimal brain dysfunction in children and in the treatment of narcolepsy, a form of sleeping sickness.

It is considered "possibly effective" for mild depression. It is ironic that under the heading "Adverse Reactions" in the Physicians' Desk Reference the manufacturer of Ritalin warns against loss of appetite in children leading to "weight loss during prolonged therapy."

Between July 1, 1973, and July 31, 1976, there were more Ritalin related abuse episodes reported in DAWN than any one of the 10 brandname amphetamines or nonamphetamine antiobesity products surveyed. The profile of Ritalin abuse is unlike the others. The great majority of the amphetamine and nonamphetamine anorectic reports come from crisis centers, the usual haven for street abusers in various phases of illness. Two-thirds of the Ritalin episodes were reported from hospital emergency rooms to which the more seriously ill are most often taken. Illicit sources such as street buys, forged prescriptions, stolen dosage units or gifts were listed in over half the episodes.

Mr. Chairman, before summarizing the information on the nonamphetamine anorectics, let me say that one of them, fenfluramine—Pondimin—may possibly be improperly described as a stimulant. Since coming on the market in 1973 fenfluramine has been reported as showing the indicia of a depressant causing some of the responses of an hallucinogen such as PCP.

The nonamphetamine, antiobesity products have received far fewer mentions in DAWN than the amphetamines, Ritalin, or Preludin. The anorectics are reported primarily from crisis centers as opposed to emergency rooms or medical examiners. Over 75 percent of the incidents involve legal prescriptions as the source. As with the amphetamines, the suggestion is implicit that significant numbers of physicians are prescribing and dispensing well over their patients' actual medical needs.

Mr. Chairman, Benjamin Gordon of the subcommittee staff has asked DEA for a more detailed report on one nonamphetamine anorectic, Ionamin. I have been told that Mr. Gordon's concern with this substance is not based on any known significant differences between Ionamin and most of the other nonamphetamine anorectics. Rather, Mr. Gorden's concern is predicated on the past history of the Pennwalt Corp., manufacturer and distributor of Ionamin.

In May 1971, as earlier noted, Pennwalt requested a hearing on the proposed transfer of its amphetamine product, Biphetamine, from schedule III to schedule II. That request was subsequently withdrawn and on August 19, 1971, the drug became subject to the Attorney General's power to limit manufacture by setting production quotas.

Mr. Chairman, the dates in this matter are most important. Until some time in June 1971, Pennwalt exported to Mexico City large quantities of the resin complex from which Biphetamine is manufactured. In Mexico City at a Pennwalt subsidiary, the resin complex was encapsulated and sold under the Mexican trade name Bifetamina.