with the benefit of hindsight, over three years after the fact. I believe that the basic efficacy decision remains a good one. Obesity remains a chronic disease, extremely difficult to treat, and even the limited efficacy of anorectic drugs is better than nothing. The safety decisions appear in need of revision. It is my understanding that you will hear Government data suggesting or showing that amphetamines remain the leading stimulant drug of abuse - with the possible exception of cocaine - in spite of the most restricted measures. If so, it would seem reasonable to withdraw approval of amphetamines for use in obesity, for which safer drugs are available. In a parallel fashion, the use of any other Schedule II drugs in obesity should be examined to see if there may be a similar abuse problem.

The other anorectics were quite difficult to evaluate for abuse or abuse potential in 1972. Data were scanty, and none had been subject to epidemic abuse. We nonetheless recommended control on grounds of abuse potential. It is my understanding that in the interval, some of these drugs have been better tested, with confirmation of their abuse potential, and that observers of patterns of abuse have seen abuse potential turn into actual abuse in the street for some of these drugs. You