nonetheless leave the oldest and best known anorectics available for the practitioners who believe they possess special efficacy. It would prevent charges of overreacting which have been voiced in advance by well-known academic clinical pharmacologists when the possibility was suggested that amphetamines might no longer be available. This action might be coupled with a commitment to review the situation again at some future period, e.g., in a year. This action, together with further reductions in the quota when indicated, continues to make appropriate use of the Controlled Substances Act as a response to the safety problem of drug abuse.

Eliminating the use of amphetamines for the treatment of obesity as a mechanism for controlling drug abuse would represent utilization of the Food, Drug and Cosmetic Act to control the type of safety problem for which the Controlled Substances Act was promulgated.

CON: Data are anecdotal or lacking that amphetamines do in fact work in patients refractory to other drug therapy. The labeling would imply relative efficacy and/or risk without clear-cut evidence to back up the implications. The labeling would be a somewhat unsatisfactory compromise which would not end controversy on the use of amphetamines in obesity.

3. Continue current labeling for amphetamines, i.e., for narcolepsy for minimal brain dysfunction and for short term, adjunctive use in obesity.

PRO: Amphetamine labeling is already restrictive. Evidence does not exist for efficacy in patients refractory to other drugs. If other drugs are placed in Schedule II, this assumes equal abuse potential, and labeling should not be discriminatory.

CON: The history of amphetamine abuse is so distinctive that amphetamines should receive special labeling. Maintaining the status quo appears completely to underestimate the problem.

C. With respect to abuse potential

The third major in which alternative courses of action should be distinguished concerns abuse potential of anorectic drugs. The four alteratives are considered mutually exclusive.

1. Recommend that all anorectic *except* fenfluramine be placed in Schedule II of the Comprehensive Drug Abuse Act, fenfluramine to be placed in Schedule IV. (see Tabs E, F and G for draft labeling with respect to Drug Dependence.)

PRO: All CNS stimulant anorectics would be treated consistently and restrictively. Physicians, patients, and addicts would not be led to seek out previously unabused drugs simply because they are not on Schedule II.

Pharmacologic and chemical data would be extensively relied on to *predict* abuse before it occurs. Abuse of these drugs would be prevented, so far as is possible under current law.

FDA and the Bureau of Narcotics and Dangerous Drugs have agreed in general that it is desirable to use predictive data.

Since fenfluramine has a different pharmacologic profile and appears to possess less abuse potential in animal tests, it would be distinguished from amphetamines.

CON: Since predictive data are imperfect, some drugs with little or no abuse potential may be scheduled. In the past, scheduling of non-opiate drugs has often depended upon evidence of actual abuse. Placing all anorectics in Schedule II will be viewed by some as overcrowding this Schedule and rendering the less restrictive Schedules almost meaningless. To act only upon the anorectics is to ignore the abuse potential of sympathomimetic amines in other therapeutic classes, e.g., mephentermine. It is not certain that BNDD will formally concur with our recommendations.

2. Recommend that all anorectics including fenfluramine be placed in Schedule II.

PRO: This would eliminate the competitive advantage which might accrue to fenfluramine if all other anorectics are placed in Schedule II. Past claims that other new drugs, e.g., phenmetrazine, meperidine, do not possess the abuse potential of older congeners have been invalidated with the passage of time.

CON: Fenfluramine appears to possess pharmacologic actions qualitatively distinct from other anorectics, which suggests that its abuse potential is at least quantitatively and probably qualitatively, different from other anorectics. Experts consulted have all been of the opinion that fenfluramine should not be lumped with other anorectics.