does not match up to the safer and readily available over the counter drugs. Combinations of Darvon with aspirin, APAP or APC are not better then using the over-the-counter drugs alone. If the patient requires more pain relief than over-the-counter drugs can provide, the physician should not prescribe Darvon compound or Darvocet N because he has other more effective drug combinations available to him. The only real difference between the Darvon combinations and over-the-counter analgesics is the price. If you use 1978 Redbook average wholesale prices and add on a 30% markup for retail sales, the price for 100 tablets of Darvocet N plus aspirin is $11.50 and for 100 tablets of Darvon N plus APAP is $13.50. If you are a careful shopper you can go to your corner drug store or supermarket and get 100 two tablet doses of APAP for about $2.00 or 100 two tablet doses of aspirin for less than $1.00.

To summarize, I will answer specifically the four questions addressed to me when I was invited to testify before this committee. The first question, from my knowledge and experience what is the relative efficacy of Darvon as compared to other analgesics? In my judgment Darvon is inferior to the commonly marketed aspirin, acetaminophen, or APC combinations. The second question, is it possible to treat patients for pain with analgesics other than Darvon? Absolutely. For patients with mild pain you can do just as good a job, if not better, with aspirin or APAP alone, and you can do it at about one tenth of the price. With regard to the use of Darvon combinations for the treatment of moderate pain, you can achieve significantly superior pain relief using combinations of aspirin with codeine, aspirin with oxycodone, or aspirin with pentazocine or Talwin. For the treatment of severe pain, the use of Darvon either alone or in combination is grossly inadequate treatment and is really inhumane to the patient. The third question, is it possible to maintain good medical practice without the use of Darvon? Yes. I would seriously question whether the use of Darvon is good medical practice at all. And the last question, what is the medical justification for using Darvon? I know of none.

TABLE 1.—MAYO CLINIC EVALUATION OF ANALGESICS IN PURE FORM

Agent	Patients	Percent pain relief
Aspirin, 650 mg	57	62
Acetaminophen (APAP, 650 mg)	57	50
Darvon HCl, 65 mg	57	43
Placebo	57	32

Note: Aspirin superior to Darvon, $p<0.05$. Reference: 22.

TABLE 2.—MAYO CLINIC EVALUATION OF ANALGESIC COMBINATIONS

Regimen	Patients	Percent pain relief
Codeine, 65 mg plus ASA	100	55
Talwin, 25 mg plus ASA	100	54
Darvon N, 100 mg plus ASA	100	41
Aspirin alone, 650 mg (ASA)	100	39
Placebo	100	23

Note: Codeine plus ASA superior to aspirin alone and to Darvon plus ASA, $p<0.05$. Reference: 23.

TABLE 3.—PUBLISHED COMPARISONS OF DARVON[1] WITH PLACEBO

Study result	Number of studies
Strongly favoring Darvon	12
Favoring Darvon	7
No difference	4
Favoring placebo	0
Strongly favoring placebo	0

[1] Darvon at standard doses. Darvon HCl 32.5 to 65 mg; Darvon N 100 mg.

References: 1,4,5,6,7,9,10,11,12,13,15,16,18,23,26,28,31,32,33,34.