We value this information, but we are not a bit surprised to find some other drug present when the person has died, or indeed when they are in the hospital. We do some work on samples obtained from living patients.

As for the medical examiner DAWN data, it is our opinion that it is hopelessly confused in the "drug induced" or "drug related" deaths by naming drugs which may be present but may not be enough to cause death or to be a contributory cause.

This is further complicated by allowing a cause of death determination to be supported by factors other than "Toxicological Laboratory Report" (p. 8, DAWN VI).

This goes all the way down to what somebody has said about the drug.

The data would be meaningful if it was based on the cause of death as certified by the medical examiner where the determination was based on the finding of a toxicologically significant concentration of substance in the body of the deceased.

There indeed, at least the cause of death is a public record and is readily available, even without the Public Information Act, it always has been available to my knowledge.

Table 4.7, page 57 of DAWN VI indicates that there were 308 diazepam-induced deaths and 209 codeine-induced deaths.

A national survey reported that two deaths of the 1,239 "diazepam-related deaths" surveyed "could be substantiated as deaths resulting from the actions of diazepam and diazepam alone."

There were only two of these that could be substantiated.

Thus of 1,239 diazepam-related deaths, only two could be substantiated to diazepam alone.

One of these was in Canada, the other was in the United States. In North Carolina in the past 5 years we have two deaths certified as diazepam deaths and three deaths certified as codeine deaths.

We are talking about in our State of a very small number of deaths. Yet a rather large number in the DAWN data is graphically illustrated in an article where codeine was blamed for "16.6 drug-related deaths per million pills," and as a pharmacist, the last pill I have seen was a digitalis pill, so I use pills in quotes.

Propoxyphene was blamed for 1,090 deaths or "1.6 drug-related deaths per million pills."

We believe that there were far fewer than 420 codeine deaths, which is the figure given.

Using data generated by the same company there were two codeine-containing generic preparations which totaled 1,431,000 prescriptions.

Tylenol with codeine was ranked 7th in prescription frequency and Empirin compound with codeine was ranked 14th with Dalmane being ranked 13th.

What I am trying to get at, I had to use some published tables, I did not have all of the data.

The DAWN data projects 12,795,000 Dalmane prescriptions. Estimating at least 13 million prescriptions for Tylenol with codeine and 10 million for Empirin compound with codeine for a total of about 23 million codeine-containing prescriptions being used in the United States for a year, using an estimate of 36 pills per prescription could give a total of 828 million pills or 0.5 deaths per million pills.