Aspirin, acetaminophen, or codeine are much safer and appear to be sufficiently effective.

Thank you, sir.

Senator NELSON. Thank you very much, Dr. McBay, for your statement.

Given your scientific judgment of marihuana. I trust that when you get back to Chapel Hill you will be very popular with the students.

Anyone have any questions?

Mr. STURGES. Mr. Chairman, just for the record, may we note that Dr. Hudson and Dr. McBay wrote to the Drug Enforcement Administration November 30, 1976, to state that, in their opinion, placing propoxyphene on schedule IV was inadequate, and recommending that the drug be placed on schedule II or, at least, schedule III. If possible, can we include this letter of theirs in the record?

Senator NELSON. Is that still your position today?

Dr. MCBAY. Yes.

Dr. HUDSON. Yes.

[The letter follows:]

OFFICE OF THE CHIEF MEDICAL EXAMINER,
Chapel Hill, N.C., November 30, 1976.

ADMINISTRATOR,
Drug Enforcement Administration, Department of Justice,
Washington, D.C.

Attention: DEA Federal Register Representative.

GENTLEMEN: We object to and protest the placing of dextropropoxyphene in Schedule IV of the Controlled Substances Act.

Our studies and others indicate that dextropropoxyphene is directly responsible for more deaths in the United States than any other prescription item, even the barbiturates collectively. (1–4, 10) It probably takes more lives than any single chemical except alcohol. Our conservative estimate is 1000 propoxyphene deaths; 2000 annually may be much closer to the truth. This is exceptionally ironic since its efficiency as an analgesic has been reported as less than that of aspirin. (5, 11) We grant that most of these deaths are suicides but suggest that in the susceptible the likelihood of attempt increases with availability of means. Classical drug abuse with propoxyphene has long been described in the medical literature. We note also the close similarity in chemical structure that dextropropoxyphene bears to methadone, a habituating narcotic.

Absurdity is heaped upon absurdity with Schedule IV placement of propoxyphene when codeine is in Schedule II. There may be abuse potential for codeine but the evidence is scant. In our combined experience with living patients and with death cases and as consultants to law enforcement agencies, we recall encountering no codeine abusers and no codeine deaths. This was true also before "scheduling" of drugs.

In our opinion abuse of dextropropoxyphene may lead to greater physical and psychological dependence than does codeine. (6–8) It is difficult for us to believe that dextropropoxyphene has a lower potential for abuse than does phenobarbital in Schedule III. We could cite other incongruities.

We have been in direct communication with officials of Eli Lilly & Company, principal marketers of dextropropoxyphene. Their public comments relative to dextropropoxyphene deaths being primarily alcohol and mixed drug problems and to being a "regional phenomenon" are to us specious and self-serving.

Admittedly there has been only relatively recently development of good chemical methods to detect dextropropoxyphene poisoning. This, added to the general lack of adequate death investigation systems in this country has contributed to a late recognition of deaths due to America's most popular analgesic prescription drug. We wonder if reticence to admit a mistake contributes to scheduling the drug no higher than Schedule IV. (9) We also speculate that if this drug had just been created, it would not be licensed by the F.D.A. because of its lack of effectiveness.