low incidence of any sort of adverse effects and a virtually zero incidence of serious adverse effects.

One must also consider the alternatives which the physician has available. When Darvon came on the market in 1957, the significant mild analgesics available as single entites and in combination included aspirin and other salicylates, acetaminophen, phenacetin, and codeine.

Today, over 20 years later, the only addition to this group has been oral pentazocine. When the patient with persistent pain tells his doctor that his current medication is either ineffective or poorly tolerated—a repetitive occurrence for many patients with chronic pain problems—the physician needs alternatives available. Useful alternative medications have simply not been forthcoming.

Number three, physicians in general are very sensitive to the issue of the dependence liability of narcotic drugs. In many situations, this concern has been far in excess of what was warranted by any realistic evaluation of the likelihood of producing iatrogenic narcotic dependence.

This anxiety extended to codeine, which in fact has extremely low abuse liability when used in any medically responsible way.

Propoxyphene was probably originally perceived by physicians as a non-narcotic substitute for codeine and propoxyphene-containing combinations were marketed which corresponded to all of the existing codeine-containing combinations.

Until the beginning of 1977, propoxyphene was an unscheduled drug, which implied that it was safer than codeine and its combinations in terms of dependence liability and also made for more convenient prescribing and dispensing.

Number four, although the most appropriate and, in fact, most popular use of both propoxyphene and codeine is in combination with the antipyretic-analgesics, there are occasional pain problems in which the physician can quite legitimately want to prescribe either propoxyphene or codeine alone. These include situations where there is an allergy or contraindication to the use of aspirin and acetaminophen. It would also include situations in which the practitioner wished to use a mild analgesic with no associated antipyretic effect.

Number five, there is, in fact, good evidence that combinations of narcotics with antipyretic analgesics produce more analgesic than the antipyretic-analgesic given alone, and this increment of analgesic effect may often make the difference between unsatisfactory and satisfactory pain relief for particular patients.

This increment of analgesic is often associated with very little increase in adverse effects and therefore, constitutes a very real benefit for the patient.

To my way of thinking, this constitutes the major acceptable rationale for the use of propoxyphene. It should be noted that this rationale does not apply if the prescribed dose of a combination contains substantially less than the usual full therapeutic dose of the antipyretic-analgesic constituent.

Senator NELSON. With regard to your fourth point, if the patient were allergic to aspirin, of course I assume the doctor then would not want to prescribe the compound of aspirin and propoxyphene.