clinical use—that is, when administered in repeated doses—than would be predicted on the basis of the controlled clinical trials which involve single administrations of test medication.

Senator NELSON. When you say repeated doses, what do you mean by that, over a period of days or weeks?

Dr. BEAVER. Even three or four doses in the course of, say, 12 to 20 hours. The cumulation reaches about 90 percent at its maximum if propoxyphene is given, say, every 6 hours for about 6 doses or so.

Beyond that it does not go up any further.

Senator NELSON. In your testimony, my impression is you are carefully addressing the question of a patient who may not respond to aspirin or acetaminophen and therefore; if I understand your testimony, there may be circumstances in which the doctor then would prescribe something that had a narcotic in it, whether codeine or propoxyphene.

Let me ask you this: As a matter of good medical practice for a patient who the doctor had not evaluated as one whose pain problem was not controlled by the ordinary mild nonprescription analgesics, for that patient what is the drug of choice?

Dr. BEAVER. Oh, my feeling in this matter is very much the same as Dr. Moertel's. I do not know whether he said so yesterday, but he has written about this in a recent paper. I feel the basic mild analgesics of choice are aspirin and acetaminophen. That is where you start and then you start moving on, start adding certain other things to these drugs if they alone are not effective.

Now, the situation you have, though, with a practitioner is that very often the patient, when he arrives at the doctor's office, has already tried out aspirin or APC because they can be purchased over-the-counter. In other words, the patient says, "I have this problem with headache and I have tried aspirin and it does not help" or "I twisted my ankle and it hurts. I have taken some aspirin and it gives me some relief but not enough relief."

For the doctor to turn around and say, "take two aspirin every 4 hours" is perceived by the patient and the doctor as perhaps inappropriate.

You see, all of these reasons I am giving you are not equally defensible reasons for using propoxyphene. What I am trying to do is to get to the issue that repeatedly comes up and is never really grappled with: Why doctors are prescribing $80 million worth of this stuff a year when controlled clinical studies seem to indicate propoxyphene is sort of a mediocre drug.

What I am pointing out here is that there are a lot of considerations that go into the use of analgesics in the actual practice of medicine as it is practiced. They have not been stated and I am trying to define them. We can argue with some of these reasons, and I am not necessarily for all of those different reasons concluding they are good reasons for doing something. I am merely trying to get them on the table so we can consider them.

Suppose propoxyphene were to vanish from the market tomorrow. Puff, and its just gone. I can guarantee one thing that would not happen. The physicians who are now prescribing propoxyphene and its combinations would not tell their patients to go home and take two