

if the off-stated clinical impression that a rather low ceiling exists for the analgesic action of this drug should prove correct, then a mild analgesic or combination thereof which could be demonstrated to have a greater potential (that is, a higher ceiling of analgesic effect) than aspirin would present a real therapeutic advantage.'

In our study, the dose levels of the anti-inflammatory analgesics did not differentiate. Failure to differentiate indicates either a very flat slope to the dose response or a 'ceiling'. When propoxyphene was added, a significant increase in analgesia was observed justifying the use of the combination. However, an increase in adverse effects was also present suggesting that greater analgesia without increased side effects was not observed. Aspirin-containing preparations are unstable when exposed to heat and humidity. These preparations were packaged in paper envelopes and therefore, not stored in ideal containers. However, evidence for pharmaceutical instability was not evidenced by increasing adverse reports over the course of the experiment. Chemical analysis of the products at the end of the study was not done. Data suggesting that analysis should be done had not been compiled or evaluated at that time.

In pharmacological studies such as these, the differences among medications are less manifest than in clinical practice. Although we failed to demonstrate a significant dose response to the medications (contrast 1), we do not imply that the lesser dose is equivalent to the greater dose in therapeutics.

For similar reasons, this study does not answer the question 'Is there a preference between aspirin and phenacetin?' It appears, in our data, that these doses of phenacetin may be less effective than aspirin (contrast 2, hospital II) and produce significantly fewer and/or less severe minor adverse responses. However, since we did not demonstrate a dose response with aspirin or phenacetin, we have not established the ability of this method in this study to measure the effectiveness of these drugs. Therefore, a conclusion that phenacetin is less effective than aspirin is not justified. Furthermore, although the other symptoms following single doses of aspirin were greater than after phenacetin, we have no data, from this test, to establish long-term effects or the occurrence of serious side effects. Therefore, any claim for superiority of one drug over another is not tenable.

We do believe that pharmaceutical combinations which provide additive efficacy, but less than additive adverse effects, are advantageous therapeutic agents. In this regard, the addition of propoxyphene to the