

(b) However, even an occurrence rate of one in 20,000 to one in 100,000 is too great a risk to take in relation to trivial infections or conditions which a less risky agent might better be expected to control.

Given a group of patients representing a wide range of infections, most informed physicians would agree on a subgroup corresponding to (a) in which chloramphenicol should be used. Typhoid fever and severe paratyphoid infections would certainly be included. Many would also name *Hemophilus influenza meningitis*. Life-threatening infections, such as gram-negative septicemia in patients with leukemia, if there is laboratory evidence suggesting the superiority of chloramphenicol, would also be included.

Mr. GORDON. Dr. Best, if I am not mistaken, you are saying here, are you not, that even in these serious cases, chloramphenicol should not be given perfunctorily but only after there is evidence showing that other therapeutic agents are ineffective or are contraindicated?

Dr. BEST. This is the implication of what I have said.

However, I feel that situations will rarely arise in which I would give the drug even before I had the laboratory evidence. If the patient was dying and my hunch was that chloramphenicol would be the best drug, I would give it even before the laboratory reports were returned. If there is not this urgency, then I would certainly say that you should have definite laboratory evidence that it is the superior drug to use.

At the other pole, there would be agreement that corresponding to the trivial conditions of (b) one might name the common cold, viral infections, and many bacterial or rickettsial infections for which other effective agents with lesser toxic potentiality exist.

There would inevitably be a gray zone, in which some physicians would consider the drug indicated; others, not. This would include various acute and chronic infections of lungs, urinary tract, bowel, and elsewhere involving variable organisms, variable laboratory sensitivities, and variable prior therapeutic histories. Since medicine is not an exact science, I do not believe this gray zone can be meaningfully resolved by law or pontification. The individual physician must remain free to exercise his judgment within a general framework of principles such as I have outlined.

This is not to say that such discretion has necessarily always been the rule. Information on why chloramphenicol was originally given was available for 71 percent of the registry cases which I studied. The most frequent reasons together with corresponding percentages of this subgroup are: Lower urinary tract infections (14 percent), the common cold (12 percent), pneumonia (8 percent), kidney infection (6 percent), typhoid fever (4 percent), septicemia (3 percent), chronic bronchitis (3 percent), and ear and sinus infections (3 percent). I might add—not necessarily the next in line, but Dr. Dameshek did mention it—acne. Approximately 2 percent were treated for acne.

Senator NELSON. Is there any conceivable case where you could justify using chloramphenicol for acne?

Dr. BEST. I cannot see it myself. Maybe somebody could defend it but I certainly could not.

In 26 percent of cases there was a serious acute or subacute infection fitting the (a) criteria for use of chloramphenicol, or, at the least, falling into the gray zone. Thirty percent of cases fit the (b) criteria,