

Hospital, and it does seem to be an equal alternative. Therefore using the criteria of the package inserts would be the drug in choice.

I might say parenthetically, in our own study of about 800 of these patients over a period of about 10 years at the contagious diseases hospital in Chicago, tetracycline appropriately used was also equally good in an alternate case series, 400 chloramphenicol patients and 400 tetracycline patients, with less than 2 percent death rate in each group. As a matter of fact, we went one period with 180 consecutive cases treated with tetracycline without a death.

We feel tetracycline is a competitive drug in this area and also less toxic. The vast majority of the pediatric community do not feel this way.

Senator NELSON. The vast majority of the pediatricians do not feel that way? On what do they base their opinion?

Dr. LEPPER. Mainly, I think, the historic—what happened was that hemophilus influenza meningitis in the late forties was being treated with a combination of antiserums, sulfanomides, and streptomycin.

The death rate with these procedures was between 25 and 50 percent. Both tetracycline and chloramphenicol lowered the death rate to less than 5 percent, practically overnight.

This was so dramatic that, depending on which drug you used, you went on the stump for it. It so happens that the leading individual, a very fine person who worked with meningitis all her life, studied chloramphenicol and saturated the pediatric community that this was the drug of choice, and indeed this was very important because people were still using the streptomycin, the sulfanomides and antiserum.

This message had to get across. It has continued to plague us because it has never been really challenged except by our tetracycline data and the Ampicillin data available from the group in California. This is a problem of how do you get communication to change prior teaching.

In many of the infections in which it is potentially effective, such as pneumococcic, streptococcic, and so forth, it has never been shown to be as good as other less toxic agents.

This failure to demonstrate it in part is perhaps because there has been a reluctance to use it by investigators because of the known toxicity. Failure has been observed by us frequently enough to feel that it is actually inferior.

In rheumatic fever prophylaxis the tetracyclines are clearly inferior to penicillin and there is no reason to think that chloramphenicol will not be equally inferior.

One of the major reasons for treating respiratory infections in children is that they may have streptococcal infections and they may therefore get rheumatic fever. Prevention of rheumatic fever is one of the major reasons for using antibiotics, going all the way back to the sulfanomides which did not work well.

It is quite likely from the tetracycline data, that chloramphenicol does not work well in this regard, so if there is any justification for giving antibiotics to children with respiratory diseases fairly indiscriminately, this one specific indication, most important reason for using them, doesn't hold for chloramphenicol.

For an ad like the one Dr. Best referred to, "use certain respiratory infections," undoubtedly if you challenge the basis for this it is these