Senator NELSON. I guess it is that sentence standing alone which bothers me. You are saying it is indicated in any infectious disease in which another antibiotic with less toxic effect is not efficacious, I assume you mean in any disease which is very serious and in which no other antibiotic is effective. Is that what you are saying?

Dr. WESTON. Yes. Any infectious disease which is capable of causing death in which no other antibiotic as—I really would assume we are talking about serious infectious diseases.

Senator NELSON. I knew you were, but standing alone, I thought that the sentence required clarification.

Dr. WESTON. And here again, I think you have to be fair to Chloromycetin and say that some of the drugs that we are using today perhaps have not undergone the therapeutic trial that Chloromyetin has with respect to toxicity. Now, tests were made from 1948 to 1950 with Chloromycetin before we had enough to hold a hearing. Dr. Wintrobe and his associate really met with the council and discussed toxicity of Chloromycetin and some of these agents we are talking about using, especially for hemophilus influenza infections, have barely been on the market much longer than that. So while we are not aware of any toxicity, this does not mean that you can equate the drug at this time with something like Chloromycetin and I would be the first to say that if Ampicillin 5 years from now was showing changes in the body which were toxic, it should be given the same sort of study that Chloromycetin has, but I do not think it has been on the market long enough yet to say beyond a doubt that it is nontoxic.

The use of Chloromycetin should be accompanied by studies of peripheral blood and if necessary the bone marrow at frequent intervals in order that toxicity may be detected as soon as possible. I do not think the physician should be misled into the concept—I question this—into the concept that this is going to detect every fatal bone marrow reaction.

Conversely, the use of Chloromycetin, is positively contraindicated, in minor infections in any location in the body.

In practice, there is no question but that limiting the use of Chloromycetin to hospital practice would result in danger in certain severe fulminating infections and consequently any measure designed to control the use of Chloromycetin should make provision for the emergency dispensing of the drug by physician in such conditions. This may change. In fact, it already appears to be changing as practically the only infection which you can put into that category are these near fatal, early childhood infections of which the most serious is hemophilius influenza and if this triple medication including Ampicillin instead of Chloromycetin proves to be nontoxic over the next couple of months, I would say categorically that you could limit the use of Chloromycetin to hospital practice without endangering any person's life because you can get a patient into a hospital to treat typhoid fever and Salamonella infections or you can treat these with another antibiotic on an outpatient basis. If the risk that is involved in this cannot be sufficiently transferred to the physician by way of communication I certainly would think that admission to the hospital is indicated.

However, the evidence presented indicates that the misuse of the drug continues in spite of numerous warnings to the contrary and