cians across this country and around the world. I want to tell you how they came to us.

When we learned that this committee was planning to hold hearings on indomethacin, we asked a number of investigators who we knew had worked with indomethacin to give us, so we could give to you, their frank appraisal of the drug. Their names and positions and reputations speak for themselves, and also bespeak the fact they would support no drug and no drug company if the facts did not warrant support. We are submitting here every communication we have received, exactly as it came to us. When the committee examines this documentation, it will find it represents the full range of medical and scientific opinion. Some investigators have found indomethacin very useful, some have found it useful in some conditions and not in others; some have found it only marginally useful.

This sample of professional judgment on the part of physicians using indomethacin in their practice reinforces our conviction that when properly used, it is a safe and effective drug that benefits hundreds of thousands of patients. I would like to ask your permission that these letters and telegrams be put in the record.

Senator NELSON. You want it in the record at this point?

Dr. LAWRASON. Yes, sir.

Senator NELSON. They will be put in the record at this point.

(The documents referred to follow:)

RECEIVED FROM DR. F. DUDLEY HART, WESTMINISTER HOSPITAL, ENGLAND

In the light of your extensive experience in the management of diseases for which indomethacin is indicated—

(1) Do you consider that the introduction of indomethacin has contributed to the management of your patients? Yes.

(2) Do you find that indomethacin enables you to obtain results in some of your patients that were difficult to obtain prior to its introduction?

(3) If so, can you define those areas in which the drug has been most helpful?

(a) In acute gout, I would rate it the drug of first choice. Good as are the pyrazoles, we find their action slightly slower, and in this disease a quick result is all-important. Our order of preference is indomethacin first, phenylbutazone and oxyphenbutazone second and colchicine third.

(b) In ankylosing spondylitis, although aspirin is suitable for the mild cases, taken as required, if larger regular anti-inflammatory dosage is necessary, few men doing active work, as are 80% of those attending our clinic, can (or will) take such dosage, and much perfer indomethacin or the pyrazoles. We consider the last two equally effective, but the real but rare danger of blood dyscrasias with the pyrazoles now leads us to try indomethacin first, and only proceed to the pyrazoles if results are unsatisfactory. We try flufenamic acid next, as we find it less effective.

(c) We find indomethacin helpful in half our cases of rheumatoid arthritis, and consider its anti-inflammatory action less than that of the corticosteroids or corticotrophin, but greater than that of the other non-steroidal anti-inflammatory agents. The trial and error method which is necessary in the treatment of rheumatoid arthritis must leave some choice to the patient, who finds large numbers of aspirin tablets tedious to take in many instances, and they will not, and do not, take them. We start with aspirin and only go on to other drugs if therapeutic results are poor to toxic effects troublesome. A number of patients with rheumatoid arthritis prefer indomethacin and do better on it than any other agent. Because of the unwanted endocrine effects, we use corticosteroids only in small dosage in selected patients.

(d) We find indomethacin a useful drug in Reiter's disease.

(e) In osteoarthrosis of cervical spine and hip, we find indomethacin a useful substitute for the pyrazoles, which, though very useful, have the danger of causing blood dyscrasias, though rarely. This is the main reason for preferring indomethacin to the pyrazoles, for in most other respects the drugs are equally effective in the same group of disorders.