in the clinical comparison and, in my opinion, Indocin is definitely superior to Aspirin in the treatment of various forms of rheumatic disease. It, of course, does not control every case but it does help a great many where Aspirin fails to do so.

I am also fully acquainted with the Mainland report, and I think the criteria used are unrealistic and do not give a real evaluation of the drug being studied.

Sincerely yours,

WILLIAM B. RAWLS, M.D.

ARTHRITIS REHABILITATION CENTER,
Washington, D.C., April 23, 1968.

Dr. MAX TISHLER,
Merck Research Laboratories,
Merck & Co., Inc.,
Rahway, N.J.

DEAR DOCTOR TISHLER: I am writing you about our experiences with Indomethacin when used as a therapeutic agent in the management of patients suffering from rheumatoid arthritis. First, let me say that our practice is limited to the diagnosis and treatment of patients with arthritis and rheumatic diseases, that we register over one hundred new cases of rheumatoid arthritis every year and that we have not less than two hundred cases of that condition under close observation at all times. I have checked my Diagnosis File and find that since I first opened an office in 1937, a diagnosis of rheumatoid arthritis has been made in 2,043 patients.

Against the above background, it is my opinion that Indomethacin is an extremely valuable agent in the management of this potentially disabling condition and that it has been an important addition to our medical armamentarium. Thus, we have found patients who did not respond to aspirin, phenylbutazone or oxyphenbutazone, who did respond to Indomethacin. By "respond", I mean that the patients would note less pain and stiffness while the physician would observe lessening of the swelling and increase in the motion of involved joints. Furthermore, patients who have originally shown response to aspirin or one of the other drugs, may later become resistant to that drug and then respond to Indomethacin.

Of course, the reverse is also true and some patients who respond to aspirin and phenylbutazone or oxyphenbutazone will not respond to Indomethacin and some of those who do respond to Indomethacin will later become resistant to it.

I confidently hope that the day is not too far off when we will have a "cure" for rheumatoid arthritis. However, no "cure" is known today, and we must therefore use every therapeutic modality available in our fight against this chronic and too often devastating disease. Any drug which will help retard the condition—even if only for a time—is one to be used as long as it brings about relief. In this context, Indomethacin has earned its place as an agent which should be available to any physician treating rheumatoid arthritis.

Very sincerely,

DARRELL C. CRAIN, M.D.

THE LANKENAU MEDICAL BUILDING,
Philadelphia, Pa., April 24, 1968.

Dr. MAX TISHLER,
Merck Research Laboratories,
Merck & Co., Inc.,
Rahway, N.J.

DEAR DOCTOR TISHLER: I have been recently advised of the question which has been brought up regarding the efficacy of Indocin. I would like to have the privilege of speaking to this.

Indocin has been extremely helpful in my practice in the management of a multiplicity of problems. I have a large pure rheumatologic practice. A rough estimate of my experience with Indocin would include approximately thirty rheumatoid spondolytics, perhaps 200 rheumatoid arthritics and innumerable osteoarthritics and gouts. I am amused by the remarks I recently read regarding the need to do double blind studies with Indocin. There can be absolutely no equivocation as to the efficacy of Indocin in a host of rheumatic disease. After fifteen years of a practice limited to rheumatology one cannot make mistakes