limitation or handicaps. Class III means that the patient has difficulty maintaining self-care and occupation, while class IV refers to patients who are bedridden or confined to a wheelchair.

I would like to stress that I wish we had better measures for drug testing. While we have used this classification, and it is as effective as any we have today, it was devised in 1949. The Therapeutic Criteria Committee of the American Rheumatism Association are continuously devising techniques that might sharpen our therapeutic studies of new drugs even more.

I might add that in this study joint symptoms followed temporary withdrawal of the drug in 24 of the 28 patients——

Senator NELSON. You are talking about your study?

Dr. CALABRO. Yes, this has now appeared in the journal, Arthritis and Rheumatism, in February 1968.

Senator NELSON. Did you ask to have this printed in the record?

Dr. CALABRO. Yes.

Mr. CUTLER. It is attached to Dr. Calabro's letter.

Senator NELSON. It will be printed in the record at the conclusion of Dr. Calabro's statement.

Dr. CALABRO. Return of joint pain was then promptly relieved when indomethacin was again taken by the patients. Actually, we could repeat this withdrawal performance periodically.

Clearly, our report of indomethacin in spondylitis parallels the experience of others, such as Bilka from Minneapolis, Hart of London, and European investigators such as Koss and Pohl, and Rothermich, whom you heard yesterday, that indomethacin is effective in ankylosing spondylitis.

That indomethacin has antirheumatic effects in disorders other than ankylosing spondylitis is also apparent, as judged by numerous reports of its usefulness in the management of the majority of patients with gout—Dr. O'Brien puts it up to 80 percent of gout cases in his publication appearing in early 1968 (Clinical Pharmacology and Therapeutics)—and osteoarthritis of the hip.

I might refer to an additional followup publication, since Mr. Gordon has referred to the Katz, Pearson, and Kennedy article of January–February 1965 (Clinical Pharmacology and Therapeutics), but neglected to mention that at the end of that report it was clearly stated that these therapeutic trials were done with an outmoded indomethacin tablet that was never released. He also neglected to mention that Dr. Pearson, the senior investigator—and I would like to submit this also for the record—has since published on the indomethacin capsule, in May–June 1966, Clinical Pharmacology and Therapeutics, the same journal that Dr. O'Brien has his January–February 1968 publication in Pearson, having now used the capsule, has reported greater success in rheumatoid patients, but most notable was the reduction of adverse side effects, from 37 percent in their initial study to 12 percent in their continuation series, with no serious complications.

Finally, again, Mr. Gordon points to a poll on use of indomethacin in medical practice. We should mention very clearly that this is a poll on the treatment of rheumatoid arthritis. It is true that 8 percent of the pediatricians were using indomethacin. The comment is then made, "Unlike the internists, of whom over 50 percent were using indomethacin, this is in sharp contrast to the 310 pediatricians who relied pri-