**ILLINOIS DEPARTMENT OF PUBLIC HEALTH**

In Re the Matter of:  
Public Hearing to Review:  
Petitions Requesting Addition of Debilitating Conditions to the Medical Cannabis Registry:  
Program.

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**ADVISORY BOARD MEETING**  
Chicago, Illinois  
Monday, May 4, 2015  
9:40 a.m.

Reported by: Jean S. Busse, CSR, RPR  
Notary Public, DuPage County, Illinois

**PRESENT:**  
LESLIE MENDOZA-TEMPLE, Chairperson;  
MICHAEL FINE, Vice Chairman;  
JAMES CHAMPION, Member;  
ERIC CHRISTOFF, Member;  
JACQUELINE LESKOVEC, Member;  
DAVID MCCURDY, Member;  
THERESA MILLER, Member;  
JYOTIN PARIKH, Member;  
NESTOR RAMIREZ, Member;  
ALLISON WEATHERS, Member;

**ALSO PRESENT:**  
CONNY MOODY;  
ROBERT MORGAN;  
ANDREW SCHWARTZ; and  
MALLORY SINNER.

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PROCEEDINGS

CHAIRPERSON MENDOZA-TEMPLE: Good morning, everyone, and thank you so much for coming to this historic meeting on adding conditions and evaluating them for medical cannabis for our patients in Illinois.

This is our first meeting ever; hence, this is going to be a learning process. So I appreciate your flexibility. We've done our best to try and plan everything as well as we could. We have a lot of conditions, a lot of petitions to get through, and we want to be sure we get to all of it today.

We have a few things we're going to start with. All persons should sign in at the registration table; and if you haven't, please do so. These are on our sheet here.

We want to have a respectful meeting. So please don't interrupt the proceedings if it's not your turn. Also, be courteous and civil because this is something we're all wanting to work towards.

The other thing that I wanted to mention -- for an introduction, maybe we should go around first. It would be nice to introduce the Board and tell you who we are. This is a very diverse mix of patients, clinicians, physicians, and bioethicists as well as pharmacists.

So we are going to start with David, and just a brief like two-word thing.

MEMBER MCCURDY: Okay. My name is David McCurdy. I worked in health care for over 30 years as a chaplain and a senior manager and health care ethicist.

Do I need to repeat any of that? Surely not.

Also, I currently teach courses in religious studies at Elmhurst College.

MEMBER RAMIREZ: My name is Nestor Ramirez. I'm a pediatrician and neonatologist by specialty. I work at Illinois Masonic Medical Center.

I apologize to you all if I nod off occasionally because I just came off of a 24-hour shift at the hospital.

MEMBER CHAMPION: My name is Jim Champion. I'm the veterans' rep for the Medical Cannabis Board.

I'm a 100-percent service-connected disabled veteran.

I've done this for 27 years. I'm proud to be here today.

MEMBER LESKOVEC: Jacqueline Leskovec. I'm here as a registered nurse. I work as an information specialist at the National Network of Libraries of Medicine, Greater Midwest Region, located at University of Illinois in Chicago.

MEMBER PARIKH: My name is Jyotin Parikh. I'm a registered pharmacist. I work as a consulting pharmacist. I'm glad to be here on the Board for the first meeting.

CHAIRPERSON MENDOZA-TEMPLE: I'm Leslie Mendoza-Temple. I am a family physician as well as the Chairman of this Board. I also am the Medical Director of the NorthShore University Health Systems Integrative Medicine Program. I'm very excited to be here.

VICE CHAIRMAN FINE: My name is Michael Fine. I am a patient advocate. I lost my arm in a car accident five years ago and suffer from chronic residual limb pain. I'm Vice Chairman of this Board, and I'm delighted to be here.

MEMBER MILLER: My name is Theresa Miller. I am the RN representative here on the Board. I am a nursing instructor. I teach nursing in a baccalaureate program, and I've been a nurse for about 25 years.

MEMBER WEATHERS: I'm Dr. Allison Weathers. I'm a neurologist at Rush University Medical Center.

I'm an academic general neurologist, and I am also the Associate Chief Medical Information Officer at Rush.

MEMBER CHRISTOFF: I'm Dr. Eric Christoff. I'm a general internist and HIV specialist at Northwestern Medicine.

MEMBER MILLER: Good morning. I'm Andrew Schwartz. I'm an Assistant General Counsel for the Illinois Department of Public Health.

MS. MOODY: My name is Conny Moody, and I'm the Acting Deputy Director for the Office of Health Promotion, Illinois Department of Public Health.

MEMBER MORGAN: Good morning. I'm Bob Morgan. I'm the Statewide Project Coordinator for the Illinois Medical Cannabis Pilot Program, at least for two more years.

CHAIRPERSON MENDOZA-TEMPLE: Thank you, everyone, for introduce yourselves.

I would like to make a motion to limit the time frame for presenting technical evidence per petitioner to three minutes.
MEMBER CHRISTOFF: Second the motion.
MEMBER WEATHERS: Second.
CHAIRPERSON MENDOZA-TEMPLE: All in favor?

(The ayes were thereupon heard.)

CHAIRPERSON MENDOZA-TEMPLE: Okay. The second motion I'd like to make is to adjust the order of the agenda to move four of the conditions for discussion to the end of the program because they don't have petitioners scheduled so that if we run out of time, we've been able to hear from all of the petitioners who have been scheduled to speak.

So the proposed order I have is in alphabetical order. So the first set of -- conditions all have petitioners. So there's ten of them. There's anxiety, diabetes, essential thrombocytopenia, IBS, migraine, neuropathy, osteoarthritis, polycystic kidney disease, PTSD, and superior canal dehiscence syndrome.

Then after that we will talk about anorexia nervosa, chronic postop pain, Ehlers-Danlos syndrome, and neuro-Behcet's autoimmune disease.

VICE CHAIRMAN FINE: I second the motion.
CHAIRPERSON MENDOZA-TEMPLE: All in favor?

(The ayes were thereupon heard.)

CHAIRPERSON MENDOZA-TEMPLE: With that new order in mind, you might change your agenda a little bit. We go straight to anxiety. I also wanted to lay down some time frames.

MS. MOODY: We have another motion. The Board has another motion in regard to the voting.

CHAIRPERSON MENDOZA-TEMPLE: Oh, I missed the third motion.

I move to recommend that all votes at the end of each condition, after deliberation on the debilitating conditions, be by ballot box and not by raised hand.

MEMBER MCCURDY: Second.
MEMBER CHRISTOFF: Second.

CHAIRPERSON MENDOZA-TEMPLE: All in favor?

(The ayes were thereupon heard.)

CHAIRPERSON MENDOZA-TEMPLE: So we will start with anxiety.

Actually, for the Board, you may need to reorder your voting slips and just pull out the anorexia, chronic postop pain, Ehlers-Danlos, and neuro-Behcet's. We'll pull out anorexia nervosa, chronic postop pain, Ehlers-Danlos, and neuro-Behcet's.

MS. MOODY: While the Board is reordering their ballot slips, I'm also going to just address the audience in the room.

There may be some conditions for which we need to go into closed session because that was the request of the individual who will be presenting technical evidence.

So at that point in time, the Illinois Department of Public Health Staff is going to clear the room of everyone, except for the person who will be speaking and the Board. The press, the media, and all of the audience members will have to exit the room.

Then once the Board votes to come back into open session, we'll open the doors and have everyone return into the auditorium.

So please be prepared that we may be asking you at a couple junctures today to do that and exit the room, but we'll give you notice when we do so.

CHAIRPERSON MENDOZA-TEMPLE: Has everyone got their papers in order? Okay.

Based on the time, we have our three-minute petitions. Some of the conditions have more petitioners than others; but for the Board, we have about 15 minutes to deliberate on this. Otherwise, we will simply run out of time. We really want to get through all of this, if possible.

If not, then we have to table whatever we don't get to for another time. So we want to have a quality discussion, but we also want to be sure to get as much as we can.

Anything else on a housekeeping basis?

MS. MOODY: I would just say to the Board Members that as we move to the first condition, you will find in your binder the first part of the tab includes the petition information. Then there is an orange piece of paper, and behind that are the Statements to Present Technical Evidence from each of the speakers.

So I think we'll just call the speakers in order; and for the first condition for anxiety, we did have a speaker who canceled, and that is JoJean A. DeGeeter. She will not be here to testify.

So if you wanted to call the speakers in order, speakers may come up to the podium and begin their presentation. Mallory is going to keep an eye on the timing and indicate when the time is up.

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CHAIRPERSON MENDOZA-TEMPLE: I have a Liana Bran.

Is that what you have?

So after the orange page, the condition of anxiety, we have Liana Bran.

MS. MOODY: Mallory, would you please raise your hand?

CHAIRPERSON MENDOZA-TEMPLE: Okay. Please.

MS. MOODY: And then when each speaker arrives at the podium, if you will very slowly, please, speak and then spell your name, first name and last name, for the court reporter. If you would speak slowly, and Jean will give us an indication, if she's able to, if she's got any problems capturing your testimony.

MS. BRAN: Great. My name is Liana Bran. That's L-i-a-n-a, last name B-r-a-n.

So first off, I want to thank the Members of the Medical Cannabis Advisory Board for allowing me to submit information on the proposed addition of debilitating conditions to the Medical Cannabis Registry Program.

Again, my name is Liana Bran. I direct the Substance-Free Workplace Program at a Chicago-based Chamber of Commerce. Through my role I have connected with numerous professionals in substance abuse prevention. Amongst them there is broad consensus that the trend in medical marijuana is troubling.

Today, though, I do not come in this capacity but as that of a concerned citizen. So with regard to the case of anxiety as a debilitating condition, I speak to a report in the New England Journal of Medicine which suggests that while further studies need to be conducted regarding the impact of marijuana use on mental health, evidence links long-term use to increased rates of anxiety, especially among those who initiate use during adolescence.

In a study also published by the British Medical Journal, researchers found that weekly or more marijuana use among teenagers resulted in double the risk of later anxiety with adolescent females being a particularly vulnerable population, demonstrating up to five times the risk of later anxiety with daily use, which at the proposed rates of the medical cannabis that will be made available to individuals, I believe will be likely.

So for me the question is simple. Why would you use any substance to treat an ailment that it has been shown to produce? And that is all I have for this.

CHAIRPERSON MENDOZA-TEMPLE: Thank you.

The second petitioner is Joe Cotton. Is Joe available? Joe Cotton, going once.

Then we have the fourth petitioner, and that is Bruce Doblin, MD, MPH. Is Dr. Doblin here?

DR. DOBLIN: Yes.

CHAIRPERSON MENDOZA-TEMPLE: Thank you.

DR. DOBLIN: I'd also like to thank you for allowing me to speak in front of the panel this morning. I'm a practicing physician --

MS. MOODY: Could you please provide your name and spelling for the court reporter?

DR. DOBLIN: Sure.

MS. MOODY: Thank you.

DR. DOBLIN: It's Bruce Doblin, D-o-b-l-i-n.

As I was saying, I'm a practicing physician, board certified in internal medicine, and for the last 20 years I've provided care to hospice and palliative care patients, to their families, and their loved ones.

Medical cannabis has a 4,000-year-old history of being safe and effective for a number of medical conditions, and I think that's something we're finally becoming aware of.

You may know that there is an oral form of the medication called Marinol, which has one component of marijuana in it, the THC component. In my experience and in the experience of most physicians, it's of minimal effectiveness mainly because smoked marijuana has hundreds of active components called cannabinoids. THC is one of them.

What we're finding is that many of the effects that make medical marijuana so instrumental in reducing suffering and controlling symptoms like anxiety is the combination of those medications, so that the oral pill provides one component, which is the major component within medical marijuana but may be the least interesting one in terms of really providing relief for pain and suffering for many patients.

What I wanted to do is tell you about one patient named Dan, who is obviously not named Dan, who suffers from severe anxiety, a patient in my practice I've seen for over 16 years. When I first saw him,
his ability to work and even to leave the house was limited by severe social anxiety.

Many of the typical medications that we use in the practice of medicine were either ineffective or had side effects that were too extreme for him, and we looked towards a future which would be very limited for Dan until a friend of his introduced him to medical marijuana.

He was reluctant to tell me that he had used it. He came after almost a year of using it and admitted that it was safe and effective. He has started to leave the house. He has started to go back to school to finish school. He was looking forward to a job, which now he has he has kept for the last several years because he found something that was very safe and very effective.

What he didn't find was something that was very legal, and it continues to be his concern that in order to treat his condition, he has to go outside of the law and expose himself to being arrested, limiting the major advances that he's been able to make in his life that have been so profound.

Dan is probably not an unusual story. There are probably hundreds or thousands of people with similar conditions that could be assisted with medical marijuana.

Many of my patients at some point or another have admitted using marijuana for a variety of conditions. It's something that they know that I'm open to because I've been involved with the medical cannabis law here in Illinois for a number of years, but it's something they do in the shadows and they do with some sort of embarrassment and some sort of hesitation.

I think one of the great things about the medical cannabis law here in Illinois is that it allows people to come forward and get the treatment for conditions like anxiety that they would find --

MS. SINNER: Thank you. That's your three minutes.

DR. DOBLIN: Thank you.

CHAIRPERSON MENDOZA-TEMPLE: Thank you, Dr. Doblin.

(Appause.)

CHAIRPERSON MENDOZA-TEMPLE: Just so that the meeting can flow -- I'd like to applaud, too, but let's keep on going. We'll save it until the end.

Also, on another housekeeping note, if you could put your cell phones on vibrate, that would be great.

Joe Cotton, one more chance. If not, we'll open up the discussion to the Advisory Board. We have about 15 minutes.

So if you want to speak, from the Advisory Board we have -- who would like to make some comments about the proposed condition of anxiety?

David?

MEMBER MCCURDY: This is not about the merits. It's really more of a procedural matter that I think I ought to raise at the beginning.

That is in reviewing the petition for anxiety disorder along with, actually, a number of the other petitions, there is some language in sections that represent to be an individual's personal experience in which the "I" language in some sections is all identical. I'm sure other people may have noticed this.

But at any rate, it seems to me that this is something that we should in some way consider as a phenomenon that may cast a shadow on some of the statements of personal experience, and maybe we'll as a Board want to give that some thought.

I don't have a specific recommendation. One thing would be, so to speak, throw them out, but I don't know that that -- that seems precipitous, and it just seems like there needs to be some thought about that.

CHAIRPERSON MENDOZA-TEMPLE: And maybe I can put a background to that.

The petitions that we received as a Board are a combination of anecdotal personal testimonies as well as scientific evidence and summary papers about what cannabis might be used for whatever condition.

So as a Board, we are weighing all of these things in whole, which is challenging because if you're just one way about things, we have to really deliberate on this particular condition itself.

I just want the group to know that's the mix of evidence that we've gotten. Yes, there are plenty of the personal stories as well that we must consider.

MEMBER CHAMPION: I was just going to say that I did notice that, too, that some of them were almost like written from a template, but I don't think
the people who were writing them should be punished because they wrote from a template.

This was just giving them ideas like “Live the life that I want to live.” I read that on 14 different people’s applications. That was just something that went along.

MEMBER WEATHERS: I noticed that as well. I assumed that there was, like you said, some template that was found online, an advocacy group that was supporting it.

I was more concerned that, for the most part, the same two physicians seemed to be writing support notes, which made me concerned about was there a true occupational relationship.

That being said, going back to Jim’s point, I still didn’t necessarily want to hold that against them. This was the advice that they were given, but I think that as a group, maybe separate from our purpose here today, we need to determine how to handle that.

Will we accept those letters from a provider given our concerns?

MEMBER CHAMPION: I also want to remind the Board that veterans do not need a doctor-patient.

They cannot have one. So please don’t punish the veterans. They do not have a duty. They don’t have to under our law.

MEMBER CHRISTOFF: I’d just like to say that in my practice of general internal medicine, anxiety is one of the psychiatric disorders that requires a broad range of treatments in individuals in order for them to be successful, including basics like improving their sleep and getting enough exercise.

I think that -- moving beyond how this might have been presented here, it is my belief that this should be added as a practicing physician because for years I have talked to patients who have used this medicine in this way to manage anxiety, whether it’s to the level of panic disorder and disrupting daily life or whether it is more occasional than that.

I’ve seen the range of this in my patients and heard this for years. So I am wholeheartedly in support of this petition.

MEMBER WEATHERS: Thank you.

MEMBER CHAMPION: Thank you.

Just to add, to comment on Ms. Bran’s, the first petitioner, evidence that we heard, I think she raises certainly a valid point, and that’s something that we need to be cognizant of and concerned about.

However, that being said, a number of the currently prescribed medications for anxiety, which is the whole class of benzodiazepines, are known to have a risk of having paradoxical effects, especially in older patients.

So we certainly don’t rule them out. They’re still kind of the gold standard for how we manage a lot of these conditions.

So I think, you know, that certainly they can speak to the fact that we’re not making individual patient recommendations here today, obviously, and that all of this needs to be taken in kind of consultation with your patients as well; but it’s been a discussion of risks versus benefits and possible adverse outcomes as you would for any medication that you prescribe for a patient.

CHAIRPERSON MENDOZA-TEMPLE: Michael?

VICE CHAIRMAN FINE: While I have no doubt that anxiety is a serious condition, my only issue is not with regard to the specific merits of an individual that submitted a petition. It is with regard to the specificity of anxiety.

There are many types of anxiety, and classifying general anxiety as a condition to receive medical cannabis opens a door to me that is a little troublesome.

If it’s severe anxiety, such as PTSD or some other type of chronic disorder, I’d be much more apt to be in favor of it; but I’m just concerned that -- I don’t want to open the door to someone creating a condition with a doctor in order to get medical cannabis.

It’s something that’s a little difficult to prove, and I’m not doubting the veracity of anyone’s intentions; but that’s my concern with the condition.

CHAIRPERSON MENDOZA-TEMPLE: As a clinician, I see everybody who has anxiety. I think that for the purposes of the title "anxiety" as a condition, I would like to see more of a definition of what kind of anxiety. Mild anxiety? Moderate?

I’m definitely in favor of moderate to severe anxiety or treatment-resistant anxiety that has been documented to have treatment fail the patient --
patients don't fail treatment; treatment fails

patients -- for six months or some other predetermined amount of time.

One of my concerns is that I have a patient coming to see me for the first time saying, "I have anxiety. Can I get cannabis?". I'm going to say, "Well, what else have you done?"

The Pilot Act gives me as a clinician guidance that says, "Well, you know what? Let's be sure we're trying these other approaches."

There is more than the use of medications. There's mind-body approaches, et cetera, but I'd like to see more definition and not just passing anxiety as it is. It is too broad of a category, in my opinion.

We are going to vote on this, and it may pass; but if it doesn't pass, petitioners have an opportunity to reapply under a more sophisticated heading other than just plain anxiety.

So there are certain conditions on this list as well that are very general that I may want to throw that guidance out to. You can reapply, by the way.

This isn't the end of it all.

David?

MEMBER MCCURDY: I guess this might be a question for our Staff in terms of what the law and the rule actually would permit us to do here.

Is what we're able to do limited to an identified condition, say, with an ICD code or would it be possible to impose conditions such as, for example, what Leslie has tried to specify here, in addition to a specific diagnosis?

MR. SCHWARTZ: At this point, Reverend, the way the law and the rules are written is that the recommendation of the Board is on the petition that's proposed.

So at this point the recommendation would be on anxiety as it's included in the petition, not -- in law we call them "lesser and included offenses," but that's not what we're going to call them here. We're not going to some other form of condition which may be included in a broader title. It will be a recommendation on the petition as it is presented to the Board.

CHAIRPERSON MENDOZA-TEMPLE: For instance, severe fibromyalgia is on -- I believe it's written as "severe fibromyalgia," not just "fibromyalgia."

So I would like to see more qualifications because I believe this will help our clinicians feel more comfortable and feel more guided as to whether they feel a patient would be eligible for certification.

MEMBER PARIKH: I'm a practicing pharmacist for the last 38 years, and anxiety is a very broad thing.

I have seen patients coming in without any kind of purpose, and I ask them, "What happened?"

They said, "Well, I was anxious in the doctor's office. I had anxiety, and my blood pressure was high."

So all those medicines can apply once we approve cannabis for anxiety (inaudible). So we have to define anxiety for the time being.

CHAIRPERSON MENDOZA-TEMPLE: And that would be the job for future petitions in case it doesn't pass.

Other comments?

VICE CHAIRMAN FINE: Motion to vote.

CHAIRPERSON MENDOZA-TEMPLE: Any other comments?

MEMBER RAMIREZ: Second.

CHAIRPERSON MENDOZA-TEMPLE: So we will vote. The votes will be tabulated, and we will announce the results.

Diabetes is next. Diabetes is the next condition. So if the petitioner wants to start getting ready to come down.

The nays have it. Eight voted nay, two voted yea for the condition of anxiety. Thank you for coming to provide your testimony.

Our next condition is diabetes. So for the next topic of diabetes, the petitioner, Joe Cotton -- has he arrived yet? -- has also requested time at the podium.

But if he's not here, we have to close the session because we do have a request for a closed portion of the hearing. So I move that -- I know there's language.

MR. SCHWARTZ: You can use that language or you cannot. It was just exemplary.

CHAIRPERSON MENDOZA-TEMPLE: I move that we close the proceedings to listen to this portion of the hearing, as requested by the petitioner.

VICE CHAIRMAN FINE: Second.

MEMBER MCCURDY: Second.

CHAIRPERSON MENDOZA-TEMPLE: All in favor?
The ayes were thereupon heard.

Whereupon at 10:13 a.m., the Board adjourned into executive session, after which the following proceedings were had in public session commencing at 10:21 a.m.)

CHAIRPERSON MENDOZA-TEMPLE: If we can get ourselves settled in. We are reconvening our meeting. Thank you for bearing with us. We're going to do it two more times. You have to get used to it. We are going to reconvene. If we could have everyone in the aisles please take their seats. Please turn your phones on vibrate. I appreciate that.

The next condition up is diabetes. We have a petitioner, Mr. Joshua Levy. If you could please come up to the podium.

Is Mr. Levy present?

MEMBER WEATHERS: Were people told specific times?

MS. MOODY: No.

CHAIRPERSON MENDOZA-TEMPLE: We're on the topic of diabetes.

One more time for Joshua Levy.

If you have not signed in on the registration list, please do so when you have an opportunity.

Mr. Levy is not here.

MEMBER WEATHERS: I think we're going to run and check the list just to make sure.

CHAIRPERSON MENDOZA-TEMPLE: So Mr. Levy has not signed in. We'll proceed with the deliberations by the Board on the topic of diabetes.

Comments from the Board? Dr. Weathers?

MEMBER WEATHERS: I had significant concerns about this application. One, in speaking to our concerns, I mirror our concerns for the first petition that this was very, very generic. I do not think there's sufficient evidence at all that medical marijuana has a true kind of antiglycemic property. I'm actually concerned that this would be dangerous to put out there that this would be used as a substitute for insulin or for diabetes medication.

That being said, I think when we get to neuropathy, there are certainly some very specific diabetes-related conditions where it may be indicated; but for diabetes as a whole, I do not feel there was sufficient evidence provided.

CHAIRPERSON MENDOZA-TEMPLE: Dr. Christoff?

MEMBER CHRISTOFF: As a general internist, I think across-the-board use of marijuana tends to contribute to appetite, therefore, weight gain. So from my perspective, I'm not understanding the application, and perhaps it's because it's too broad. As you were saying, the neuropathy component has another petitioner coming up later today.

I think one study was provided, which I did not get a chance to look over; but until this petition was presented, I hadn't actually thought of diabetes as being something we would treat with marijuana.

CHAIRPERSON MENDOZA-TEMPLE: Jim?

MEMBER CHAMPION: I was just going to say something similar.

My question was that do all people who have diabetes suffer from neuropathic pain? While I think diabetes is a terrible disease, I think that this applicant would be better served if they filed for medical cannabis under neuropathy.

CHAIRPERSON MENDOZA-TEMPLE: Which will be discussed today. I read the article that accompanied the packet, and I didn't feel it was substantial enough evidence to merit this as an eligible condition as titled.

MEMBER RAMIREZ: Why not?

CHAIRPERSON MENDOZA-TEMPLE: It had a pretty small study, as many of the cannabis studies are.

MEMBER RAMIREZ: Just qualitative and descriptive of five or six people?

CHAIRPERSON MENDOZA-TEMPLE: It was a smaller study. It was a study that measured one parameter of diabetes when it was measured, but we know diabetes is a complex disease measured by many aspects.

To use that as just the reasoning that we should use it for diabetes, like one molecule is affected so we should use it, I didn't think that was enough at all. I also looked for other evidence just for diabetes in my own literature, and I didn't find any.

So I am concerned also about the appetite stimulation and making blood sugars worse.

Other comments from the Board?

VICE CHAIRMAN FINE: Motion to vote.
Member Christoff: Second.
Chairperson Mendoza-Temple: Ayes?
(The ayes were thereupon heard.)
Chairperson Mendoza-Temple: The next topic on the agenda is essential thrombocythemia with JAK 2 mutation. We have one petitioner. If the Board would kindly turn to that tab.
Mr. Schwartz: Just give us a minute for the tally.
Chairperson Mendoza-Temple: Okay. Just so the petitioner is ready, we have one open petition -- Jessica Harshbarger.
Is she present?
Ms. Harshbarger: Yes.
Chairperson Mendoza-Temple: Okay. Good. We'll start when we finish this vote announcement.
Mr. Schwartz: Take a seat in the front row just for a minute.
Ms. Harshbarger: Okay.
Chairperson Mendoza-Temple: Sorry. I just wanted you to be ready.
The motion failed, ten to zero, nay, for the condition of diabetes.
So the next topic is essential thrombocythemia with JAK 2 mutation. We have a petitioner, Jessica Harshbarger. If you would kindly step to the podium.
Ms. Harshbarger: My name is Jessica Harshbarger. I have essential --
Ms. Moody: If you could spell your name for the reporter.
Ms. Harshbarger: Sure. I'm sorry.
Jessica, J-e-s-s-i-c-a, Harshbarger, H-a-r-sh-b-a-r-g-e-r.
So I was recently diagnosed about 2 years ago with essential thrombocythemia with JAK 2 mutation, which basically means that my body is producing too many platelets. My platelet levels are generally around 800, 900.
I have daily headaches. I have migraines. I have migraine with aura. I've also had a couple incidents where I've lost consciousness.
I'm a single mom. I have two boys. I'm trying to stay working and stay healthy as much as I can right now.
My only option that my doctor has given me is to take something called hydroxyurea. Hydroxyurea is a chemotherapy pill, which will cause me to have nausea, loss of appetite, a broken-down immune system.
Chairperson Mendoza-Temple: Thank you for your presentation.
Deliberation from the Board? David?
Member McCurdy: Not being a medical person, I did notice in the petition materials that according to them, many patients are asymptomatic. If that would be true, then some distinction would have to be made between those who were and those who weren't in terms of eligibility.
Chairperson Mendoza-Temple: Jim?
Member Champion: I just wanted to add that this is one of those conditions where I believe medical cannabis would be beneficial not only to counteract the side effects of the chemotherapy drug, but it would also help with the migraine headaches and the other symptoms of this disease.
So it seems like a prime condition for medical cannabis. It would serve more than one purpose.
Chairperson Mendoza-Temple: Dr. Weathers?
Member Weathers: Just a couple of concerns in reading through the petition.
I think the incidence of migraine is so high in the general population, as Dr. McCurdy pointed out. Essential thrombocythemia is usually asymptomatic, so I don't know that we can make a direct correlation. It may be that the petitioner is suffering from severe migraines on top of it. Also, I think it sounds as if hydroxyurea has not yet been tried, and I know we're talking not about a specific case. Generally, although it is in fact belonging to a class, it is generally much better tolerated than some of the other chemotherapies. This is my concern with the diabetes petition, I think there's no significant evidence, other than a few of those major trials, that medical marijuana would lower platelet counts. Again, I'm concerned about things coming out there that it's not actually a treatment for the condition that's being petitioned.

Chairperson Mendosa-Temple: Michael?

Vice Chairman Fine: Not being one of the medical professionals onboard, I would put it in the hands of the medical professionals that want to determine whether this patient is in pain for prescribing medical cannabis. I have the utmost respect and sympathy for the petitioner. I really firmly believe that anything pain related, severely, is worthy of passage into the conditions. Thank you.

Chairperson Mendosa-Temple: So in my literature review -- I did a separate one from this -- I couldn't find any other data for the actual condition of essential thrombocythemia. Migraines, yes. The spin-offs from that disease, yes, can have some symptoms. It's generally something -- it's not felt to have patients with this, and they do try hydroxyurea. No one likes it, but for the most part, no complaints.

As a clinician, looking at the evidence base for that particular disease population was more from the laboratory level of things, and that's where it gets tricky. We are going to see human trials. Let's just face it. We're not at that phase yet with cannabis research. But I think for this particular condition, I would rather see this particular petitioner look at the migraine category, something else as a condition to shoot for because essential thrombocythemia itself implies to me that we're treating the bone marrow and we're trying to reduce the platelets. There's not enough evidence in the literature that I find for this particular condition. Theresa?

Member Miller: Thank you, Leslie.

Also, I did a separate literature review of this condition, and I did not find any current literature out there to support the use of medical cannabis with relation to essential thrombocythemia. There was literature related to migraines, again, as you mentioned spin-offs of this disease process, but I didn't see anything. The evidence that was affiliated with the petition was not current evidence. It dated back to 2003, 2005, and 2006, and it was more related to leukemia and not to thrombocythemia. So that was a whole separate disease process.

So again, perhaps the petitioner could look at something more related to the migraine, which seems to be what the complaint was in the petition. Thank you.

Chairperson Mendosa-Temple: And those were issues amongst the petitioner's issues as well.

Member Weathers: The other category is -- and I'm trying to remember the specific ICD-9 code. There's a B code for treatment of chemotherapy. That would be something for a future petition to consider given the known associated side effects with chemotherapy usage with that in terms of if a specific request was around the nausea and possible other side effects from the hydroxyurea. So that would be something I think, as I said, for future petitions.

Chairperson Mendosa-Temple: The treatment that's already approved is for cancer, which is a broad category.

Member Weathers: Yes, yes. This is a more generic.

Chairperson Mendosa-Temple: Other comments from the Board regarding essential thrombocythemia with JAK 2 mutation?

Member McCurdy: Call for the vote.

Member Miller: Second.

Vice Chairman Fine: Second.

Chairperson Mendosa-Temple: The next condition on the agenda is irritable bowel syndrome.
We have two petitioners, including a closed session. So this will be another opportunity to use the restroom.

MR. SCHWARTZ: We have to call for a closed session.

CHAIRPERSON MENDOZA-TEMPLE: We're going to wait for the vote first so everyone is teed up and ready.

MEMBER WEATHERS: There's two. One is closed and one open.

Should we do the open first?

CHAIRPERSON MENDOZA-TEMPLE: With the next condition of IBS we will have one petitioner present at the podium. Then we will close the session for the other petition.

So if the Board would turn to IBS.

VICE CHAIRMAN FINE: While the votes are being tabulated, the next petitioner, Mr. Joe Cotton, if you would please come down and sit down. Wave and let me know if you're here.

Did Joe Cotton sign in?

MS. SINNER: The name again?

VICE CHAIRMAN FINE: Joe Cotton.

MS. SINNER: No.

VICE CHAIRMAN FINE: No sign-in? Thank you.

CHAIRPERSON MENDOZA-TEMPLE: For the condition of essential thrombocythemia with JAK 2 mutation, the nos have it eight to two. The motion has failed.

The next condition is for irritable bowel syndrome, and I'll make one last call for Joe Cotton. Otherwise, we have to close.

MEMBER WEATHERS: All right. I make a motion to enter a closed session.

Subsection 2a of the Open Meeting Act, 5 ILCS 120/2(c)(4), allows for "Evidence or testimony presented in open hearing, or in closed hearing where specifically authorized by law to a quasi-adjudicative body, as defined in this Act, provided that the body prepares and makes available for public inspection a written decision setting forth its determinative reasoning."

"B. 77 Illinois Administrative Code 946.30(j)(4) provides, "A petitioner may request to close a portion of the hearing to protect the disclosure of confidential information."

CHAIRPERSON MENDOZA-TEMPLE: This petition is only three minutes, so don't get too comfortable.
actual pain that I feel.
I think this is a perfect situation for cannabis as a narcotic alternative.
CHAIRPERSON MENDOZA-TEMPLE: Just for the group to know, there's a difference between irritable bowel syndrome, which is a functional problem with the gut, versus inflammatory bowel diseases, which ulcerative colitis is on the eligible list for cannabis here in Illinois.
I also know there are moderate, mild, and severe instances of this. So I just wanted to call that to your attention that maybe some guidance on that would be helpful as well.
I can differentiate this from anxiety because this has a pretty debilitating effect on the body that is brutal. You can see it through the symptoms that come out on the other end. So to me, I feel more comfortable with this as a condition, but part of me is also thinking we need -- I'd like to define it a little bit further with it being severe, but we can say that about a lot of conditions. That's my opinion.
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VICE CHAIRMAN FINE: Again, hopefully, the medical professional involved in the relationship would differentiate between something moderate to something severe.
While I think in the future petitions, you know, as we all move along as a learning curve, will specify, you know, the severity, especially the condition -- it could be mild, medium, questionable situated to warrant medicinal cannabis -- I put my trust in the medical professionals to be able to ferret that out as to what their patient is suffering from based on the term of their established medical relationship.
CHAIRPERSON MENDOZA-TEMPLE: I would say just from a consistency standpoint, though, and the way we do the anxiety, it's also going to have definition.
IBS is a much narrower definition. It's got constipation and diarrhea. It causes dysfunction, but we can't find a reason on the colonoscopy why. Also, this is a condition that's not supposed to wake someone up from sleep, which is a red flag that tells us that it's probably an ulcerative or irritable bowel -- or inflammatory bowel disease or potential cancer.
So IBS to me is also in that spectrum of anxiety-related diseases, but it that has, obviously, really tough digestive consequences; but for the sake of being consistent, if we did that with anxiety, I'm thinking why it would be different with IBS if it does have a spectrum.
Now, I also agree the physician should be the one deciding, "Yeah, this person has a very severe case." Then I would write the physician certification letter and leave it to the clinician to make that decision, but then we could say that about anything.
MEMBER WEATHERS: Just to simply counter that, I think, as you've alluded to, that each concern is unique. It would be hard for us as a panel to determine what constitutes moderate to severe.
Moderate, given the nature of digestive disorders, can still have a significant impact on the quality of life. I'm not, frankly, quite as concerned with this one.
Also, there's very limited FDA-approved medications. Those that are out there have significant side effects. Given the relative safety profile and limited adverse reactions, this is helpful even for a moderate case, and I think it could be warranted in this one.
MEMBER MILLER: I wanted to point out, too, that the difference here, in my opinion, with regards to irritable bowel and anxiety, as we talk about that consistency with the definition, is that there isn't any current literature on the effectiveness of cannabis with generalized anxiety.
There are a few studies from 2011 and some current studies on the effect of irritable bowel syndrome as well as fibromyalgia. So I'm more comfortable with that because in reviewing the literature, there is some evidence out there to support that where there isn't any literature to support generalized anxiety.
There are cognitive-based therapies that are out there and medications which can have some harmful side effects, but there's a lot of success with cognitive-based therapy.
CHAIRPERSON MENDOZA-TEMPLE: Any other comments? David?
MEMBER MCCURDY: Call for the vote.
MEMBER WEATHERS: Second.
(The ayes were thereupon heard.)

CHAIRPERSON MENDOZA-TEMPLE: While the votes are being tallied, the next condition on the agenda is migraine, for which we have five petitioners, including a closed session. That's the last closed session.

We'll see the petitioners first, and then for the closed session we'll do the same thing.

CHAIRPERSON MENDOZA-TEMPLE: Motion passed, ten to zero.

(Applause.)

CHAIRPERSON MENDOZA-TEMPLE: We're moving on to the next topic, which is migraine. We have four petitioners for the open session and one for the closed.

MR. SCHWARTZ: Madam Chair, just to clarify, I've reviewed the sign-in log as well as other Staff has reviewed the sign-in log. The presenter -- A VOICE: I can't hear.

MR. SCHWARTZ: Hold on. It does not appear that the presenter of technical evidence that requested a closed session is here.

Is there any objection? I don't want to call the name. Hold on. I thought I heard "I'm here."

A VOICE: I said, "I can't hear."

MR. SCHWARTZ: That's much different than "I'm here."

It doesn't appear that the presenter of technical evidence for the closed session signed in. The sign-in log has been reviewed by myself and other Staff. So there won't be a need for a closed session.

CHAIRPERSON MENDOZA-TEMPLE: We'll have four petitioners in open session. You don't have to leave the room.

So our first petitioner is Dela Annani-Akollor. Sorry if I mispronounced that.

Is that petitioner here? Dela Annani-Akollor?

Did they sign in? Did this petitioner sign in?

MR. SCHWARTZ: I'm going to go check.

CHAIRPERSON MENDOZA-TEMPLE: No?

So this petitioner hasn't signed in, is not present. We'll move to the second one, which is Dr. Bruce Doblin.

DR. DOBLIN: My name is Bruce Doblin, D-o-b-l-i-n. I'm a practicing physician and a hospice physician here in the Chicago area.

Three minutes goes very quickly, so I'll just make a few points. One is I'm speaking on behalf of the use of medical cannabis for migraines.

I'm conscious of the panel's concern about not opening up broad categories of use. Migraines by definition are very different than headaches. They are more debilitating, they are more symptomatic, and they are more profound. So the diagnosis of migraine already puts a patient in a different kind of category than the usual headache.

The law in Illinois has been referenced very wisely with the prescribing physician in a meaningful relationship with the patient. So I think we're talking about a condition that's being monitored overall.

It seems to me that there are many impressive things that medicine does today, but what they don't do very well is they don't experience patients' pain. They don't experience many of the symptoms that we're talking about treating with medical cannabis.

We can't take a temperature of somebody's migraine disability, but we can know that many patients don't respond well to typical medications. We often use one after another after another in a vain attempt to find something that's helpful.

It would be my suggestion we just include medical marijuana as one of those things. I am not even saying necessarily the first thing but one of those things that is possible given the fact that going back to 1999, the Institute of Medicine, in reviewing all the literature at the time, clearly indicated that there are therapeutic ways in which medical marijuana can help in the treatment of pain. I would put migraines in that category very clearly.

Thank you.

CHAIRPERSON MENDOZA-TEMPLE: Thank you.

Our next petitioner is Jessica Harshbarger.

Then after that testimony will be Dr. Greg Kuhlman.

If you could come down to the front as well. Dr. Greg Kuhlman.

Thank you, Ms. Harshbarger.

MS. HARSHBARGER: So I'm speaking again on behalf of medical cannabis for migraines and,
hopefully, migraines with aura.

As we all know, medical cannabis has a lot of benefits for people with pain. Of course, when you're experiencing a lot of pain from a migraine, it can be as simple as not being able to handle light but as severe as being trapped in a dark room for hours and hours trying recuperate.

So obviously, anything that can take the edge off that pain is going to be beneficial, especially with the least possible side effects. So I definitely feel that medical cannabis could benefit me for my migraines, help keep me a little more functional.

So, you know, I would like to have the opportunity to try that. I'm certainly not somebody who is just looking to try to smoke cannabis. I would like to be able to ingest it, the oils and things, so for the medical benefit purely.

So that's really all I have to say.

Is he on the sign-in sheet?

So we'll open the discussion to the Board.

Comments from the Board on migraine?

VICE CHAIRMAN FINE: A perfect case of an alternative. I think this is a textbook example of what cannabis would be, a wonderful alternative to the drugs that are often prescribed for the pain associated with migraines.

MEMBER CHRISTOFF: I second that use regarding narcotic use of migraines, which is often a very slippery slope.

I think this is also a candidate condition that has a range of responses to traditional both preventive and abortive therapy, and there is apparently a lot of published evidence on this topic as well that we were provided.

MEMBER WEATHERS: So just to speak to this, opioids, that whole class of drugs, are actually not recommended for the chronic treatment of migraine.

There is a physician statement out from the American Academy of Neurology against their use.

They can lead to significant medication overuse, headache -- what we call rebound headache, and other issues.

So I agree that although I feel more research and several more studies need to be done, cannabis can potentially act as an alternative abortive therapy.

MEMBER MILLER: I would agree.

When I read the literature, I also know that opiates as a drug class are not used to treat migraine headaches. It's actually contraindicated in that because of the same reasons that Allison spoke of.

There is some recent literature out there, but it does all go back to the use of narcotics; and there does need to be more research out there for this diagnosis I feel.

I also agree that anytime you can see an alternative for that particular pain, that that would be helpful.

CHAIRPERSON MENDOZA-TEMPLE: Other comments?

MEMBER LESKOVEC: I think having to limit our discussion to migraine specifically as a symptom and diagnosis that could be consistent with pain control is definitely much more direct than the other conditions that we talked about before, which is rather broad.
days -- (Inaudible)

It's sticky, and it's a hard distinction. I think it goes back to the point that Michael raised that, unfortunately, by nature what we've been tasked to do, we're choosing ICD-9 codes in addition, and then it's up to the individual patient provider to have that discussion and say, "I'm not recommending this as a treatment until I know that you have failed current established abortive therapy, just work our way down to the triptans class. You're not responding to other therapies."

I think I just worry we get into practice of it.

CHAIRPERSON MENDOZA-TEMPLE: I'm very open to suggestion as well about putting a little more definition in the title of the condition. As a clinician, how can that also help our doctors, who are definitely the gatekeepers of all of this, and give some guidance on this?

MEMBER CHRISTOFF: To my knowledge, there's not a distinction in the Neurology Society's definition of migraine as to severity.

CHAIRPERSON MENDOZA-TEMPLE: Maybe "treatment resistant" might be a better term.

MEMBER CHRISTOFF: Well, I'm not a neurologist, so I'm not going to pretend I know the specifics here.

I'm not aware that with migraine, as distinguished from cluster, from rebound, from muscle tension headache, and the other ways these are defined, I'm not aware that they are defined as mild, moderate, and severe.

So I think this is one where provider discretion, having a relationship with the patient, given that conventional abortives and preventives have failed, means that it is not necessary for us to distinguish that it has to be a particular category.

I think that's overstepping on our part here.

If we believe that this is a disorder, once it's failed conventional therapy, that is eligible for cannabis in the State, then we should approve this petition.

MEMBER CHAMPION: I was just going to say that this is a condition that may be mimicked by some.

I've seen the firsthand effect. My wife suffers from terrible migraines. I think extreme cases should be approved. I also feel that approval of this condition will cover many other conditions that cause migraines.

Research for cannabis as being beneficial for these patients is crucial.

CHAIRPERSON MENDOZA-TEMPLE: There's also a condition that's rare, superior canal dehiscence, which we'll talk about at the end, which is featured with migraines, which might be helpful for the Board as well.

MEMBER PARIKH: I think mild, moderate, severe, that's subjective on who is treating the condition. (Inaudible) Once we approve this condition then there is no saying that it's mild, moderate, or severe. If it's approved, it's approved.

So if we have a concern about it, then we should put some sort of restriction that they have tried traditional medications and nothing has helped before they approve. I don't know if we can do that or not.

MEMBER LESKOVEC: I don't think that we should consider cannabis as an alternative. I think that it should be made available (Inaudible) to help alleviate the pain of the patient.

"treatment resistant" might be a better term.

MEMBER CHRISTOFF: Well, I'm not a neurologist, so I'm not going to pretend I know the specifics here.

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MEMBER CHAMPION: I was just going to say that this is a condition that may be mimicked by some.

I've seen the firsthand effect. My wife suffers from terrible migraines. I think extreme
probably beat the lunch rush. It's about 11:15 now.
I know it's early for some, but that may be the most
efficient way after the vote is presented if we go
into a short lunch recess.

CHAIRPERSON MENDOZA-TEMPLE: After the votes
are tallied and announced, we'll go into our lunch
recess and reconvene at --

MR. SCHWARTZ: 11:45.
CHAIRPERSON MENDOZA-TEMPLE: It's now 11:15.

Let's take a minute still to tally.
We can't bring food in here. We'll meet
back here at 11:45.
The motion for migraines has passed eight to
two.

(Application.)
CHAIRPERSON MENDOZA-TEMPLE: We need to vote
on the recess.
MEMBER MCCURDY: I move.
VICE CHAIRMAN FINE: Second.
(The ayes were thereupon heard.)
(Recess taken at 11:17 a.m.)

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MEMBER WEATHERS: So do we include autonomic?

MEMBER CHRISTOFF: Is there a request regarding autonomic neuropathy as well? Because that's yet another disorder entirely.

MEMBER WEATHERS: Diabetes can include autonomic. I mean, if you looking at Page 205 in one of the petitions, they really -- I mean, a lot of them reference all the autonomic manifestations of peripheral as well.

MR. SCHWARTZ: So what we attempted to do -- as you said, the Department attempted to organize these by the category of neuropathy, but it's at the Board's discretion if they want to vote to hear the petitions individually.

The first one is listed as peripheral neuropathy, which I believe was not the one that Dr. Weathers was talking about with all the significant citations. That was the second one, and then the final petition was for diabetic neuropathy.

So you could hear them all separately, and then I guess we could hold three different votes.

MEMBER RAMIREZ: If we don't have any testimony on any of the three, can we postpone it and table it to a future meeting?

MR. SCHWARTZ: That's also at your discretion.

MEMBER RAMIREZ: She could table this issue.

MR. SCHWARTZ: I wouldn't recommend that because there's a certain time frame in which the Department has to decide on petitions that were received.

Since a secondary hearing date hasn't been established, it's in the best interest of the Department as well as the people that the discussions and the deliberations are held today.

MEMBER WEATHERS: Just for my two cents about that, Nestor, I think we have to be careful because the petitions were set forth, it sounds like, by patients versus the three people that were going to speak were all physician advocates.

I think it's a big category we'd have to tackle or hear later. I'd rather -- I think we just need to have a conversation.

CHAIRMAN FINE: I motion to separate the categories of neuropathy based on the conditions that were listed in the petitions.

MEMBER CHRISTOFF: Second.

MEMBER MCCURDY: It was seconded. Now we can discuss the issue.

So the question is: How are you going to divide them?

VICE CHAIRMAN FINE: By the petitions as they are listed. So we can start with diabetic neuropathy. Is that No. 1?

MR. SCHWARTZ: That's No. 3. MEMBER WEATHERS: It's the easiest. We can start with that.

MEMBER MCCURDY: Aren't there four?

MR. SCHWARTZ: I have it as 3, Dr. McCurdy.

So I have peripheral neuropathy, and the second one begins -- I'm just reading under "Proposed Medical Conditions." The first line is ICD-9. That's Code 72, peripheral neuropathy, and then that one continues for quite some time.

MEMBER LESKOVEC: Question: If we're going to address them separately, then we will be voting separately?

MR. SCHWARTZ: Yes.

VICE CHAIRMAN FINE: Let's modify our ballot. We can write the categories on our ballot as to the conditions and then talk about them.

MEMBER CHRISTOFF: I think we need to come to a better consensus about the peripheral neuropathy, which I think means a distal sensory neuropathy secondary to a disorder or a medication, such as long-standing HIV infection or medications used to treat HIV caused by distal sensory neuropathy. I think that's what is intended.

MEMBER WEATHERS: If we're talking about peripheral polyneuropathy, I think it could be sensory-motor. Diabetic is sensory-motor.

What we're trying to separate out is that we're not talking about -- (Inaudible) I'd like to distinguish those.

MEMBER MCCURDY: May I also -- to get back to the question of how many we have --

CHAIRPERSON MENDOZA-TEMPLE: There are four.

MEMBER MCCURDY: Yes. I see the 356.8 or whatever, also. So we have three peripheral and one diabetic.

MS. MOODY: That is correct.
background for the group here, neuropathy is a big, harry condition. It's featured with numbness and tingling in various body parts.

What we're working on is differentiating there's different causes of neuropathy, and it's just such a big category that the Board has moved to separate it into diabetic neuropathy, if I'm saying this right, and then peripheral neuropathy. Then we're going to vote on those two.

MS. MOODY: On two conditions, peripheral and diabetic.

MR. SCHWARTZ: Peripheral polyneuropathy.

VICE CHAIRMAN FINE: Shall we write "Number 1" on this thing, peripheral polyneuropathy, and then put the checkboxes there next to it?

One is peripheral-- do you want to spell it because I can't do that.

MS. MOODY: Would you like to spell that out?

CHAIRPERSON MENDOZA-TEMPLE: Peripheral, p-e-r-i-p-h-e-r-a-l, and polyneuropathy.

MEMBER RAMIREZ: I have a question. Are we including the various categories of the classification, which include hypoesthesia and hyperesthesis? They're are types of neuropathy.

MEMBER WEATHERS: I think all of those fall under 70(e)2.0. Those are all symptoms. They're not specific diagnoses.

VICE CHAIRMAN FINE: So 1 is peripheral polyneuropathy.

CHAIRPERSON MENDOZA-TEMPLE: Number 2 will be diabetic neuropathy. We're voting on two conditions.

Then just if all the Board members could mark their ballots a yea or nay.

VICE CHAIRMAN FINE: So are there two or four?

CHAIRPERSON MENDOZA-TEMPLE: Two conditions, but we've got four petitioners that none of them --

MS. MOODY: There were three for peripheral and one for diabetic, yes.

CHAIRPERSON MENDOZA-TEMPLE: We have three peripheral petitions and one diabetic neuropathy petition. We called it, and no one is here.

On another editorial note, if people are taking the time to petition these conditions and have us evaluate these, please show up.

Did Dr. Doblin come in?

A VOICE: Dr. Doblin had to leave.

CHAIRPERSON MENDOZA-TEMPLE: Okay. We understand there are circumstances that don't allow for this. So we will start with peripheral neuropathy.

Comments from the Board?

MEMBER CHAMPION: I was going say that he having MS, I'm very familiar with this type of pain.

I'm actually shocked that neuropathy itself was not included on the original bill.

On Page 78 of "Medical Marijuana as Medicine," what we were given to read, it states that narcotics are not effective in treating neuropathic pain. I found that to be untrue myself.

The feeling that your legs or feet or whatever are frozen in a block of ice or feel like they're on fire is just not a very pleasant feeling at all.

I took gabapentin for many years. I had seizures on gabapentin from taking me off too abruptly. I had water gain. I got up to 240 pounds from the medicines they gave me to help with my peripheral pain. When I started taking cannabis, I no longer needed gabapentin. The weight fell off me like nothing.

Like I said, I can say firsthand that I know neuropathy is very painful, and I'm shocked it wasn't on the original bill; but it's something I feel strongly on, and I urge you guys to vote.

VICE CHAIRMAN FINE: I agree with Jim wholeheartedly. For the most part, the condition that I suffer from, chronic residual limb pain, is a form of neuropathy.

I, too, was on gabapentin. I'm on Lyrica.

I still feel my arm isn't attached. It's encased in a block of ice and being squeezed all the time. Sometimes I file literally pins and needles, almost like a frostbite feeling into my hand, and it changes with varying degrees of pressure and temperature and so forth.

So again, even though hand and limb pain is one of the covered conditions, it is a specific type of this neuropathy. I again wholeheartedly encourage you guys to vote.

CHAIRPERSON MENDOZA-TEMPLE: I think, as a clinician who has treated a lot of patients with neuropathy from various sources, I can say even with the integrative therapies I've tried with acupuncture...
and massage, they are all helpful to a point. But I think that this is, as a clinician, one of the toughest conditions that I have had to treat with a very long course of improvement that is so-so. I feel that with the literature review that was provided, that is ample evidence for me, scientifically as well as clinically, to promote this to be approved.

**MEMBER MCCURDY:** I guess I would pretty much echo, as a layman. There was an article from the Journal of Pain in 2013 that I thought was quite good sort of supporting it. The other thing was the fact that the physician at the San Francisco Hospital, the University of California, the San Francisco doctor was willing to write a letter in support of this to the Department. That was about severe pain, not just neuropathy, but the literature, including the articles he coauthored, seemed to be persuasive on this point, also, I think.

**CHAIRPERSON MENDOZA-TEMPLE:** Other comments from the Board on peripheral neuropathy?

**VICE CHAIRMAN FINE:** Call the vote.

**MEMBER SCHWARTZ:** You might as well keep moving on to diabetic.

**CHAIRPERSON MENDOZA-TEMPLE:** We will vote on our discussion after both conditions, peripheral neuropathy and diabetic neuropathy. We'll talk about -- have comments on diabetic neuropathy.

**MEMBER WEATHERS:** For diabetic, just to clarify, I think that can include the manifestations of diabetic nerve disease, polyneuropathy, diabetic myopathy (Inaudible) severe diabetic autonomic neuropathy, which can lead to some of the GI conditions that we discussed. So specifically for that one, I think we should include all the related diabetic neuropathic conditions.

**CHAIRPERSON MENDOZA-TEMPLE:** I think clinicians in general -- again, we had a discussion about diabetes, that it can promote appetite as well. From a clinical standpoint, I want to make sure I warn my patients of watching their blood sugars. That's on a side note.

**MEMBER CHRISTOFF:** Practically speaking, we've had diabetes out of control for a lot of patients who have neuropathy as a disorder. The train has left the station a long time ago with respect to sugar control and their nerves. So this is palliative care in that sense for an issue that I think doesn't always manifest in diabetics necessarily universally related to the degree of sugar control that they have.

**MEMBER WEATHERS:** For the most part, yes.

**CHAIRPERSON MENDOZA-TEMPLE:** Other comments from the Board on diabetic neuropathy?

**MR. TAYLOR:** Good afternoon, Ladies and Gentlemen. My name is Jared Taylor, J-a-r-e-d T-a-y-l-o-r.

According to the Mayo Clinic, "Osteoarthritis is the most common form of arthritis, affecting millions of people worldwide. It occurs when the protective cartilage on the ends of your bones wears down over time. "Although osteoarthritis can damage any joint in your body, the disorder most commonly affects joints in your hands, knees, hips, and spine. Osteoarthritis often gradually worsens, and no cure exists."

**CHAIRPERSON MENDOZA-TEMPLE:** Okay. Our next topic is osteoarthritis. We have a petitioner before us.

Please proceed.

**MR. TAYLOR:** I'm here today to voice my support to add osteoarthritis as a qualifying condition to the Illinois Medical Cannabis Pilot Program. According to the Mayo Clinic, "Osteoarthritis is the most common form of arthritis, affecting millions of people worldwide. It occurs when the protective cartilage on the ends of your bones wears down over time. "Although osteoarthritis can damage any joint in your body, the disorder most commonly affects joints in your hands, knees, hips, and spine. Osteoarthritis often gradually worsens, and no cure exists."
Signs and symptoms of osteoarthritis include pain, tenderness, stiffness, loss of flexibility, grating sensation, and bone spurs. A prominent medication that is used to treat osteoarthritis is acetaminophen, known by the brand name of Tylenol, which can relieve pain but does not reduce inflammation. Taking more than the recommended dosage of acetaminophen can cause liver damage. As well, nonsteroidal anti-inflammatory drugs, NSAIDs, may reduce inflammation and relieve pain. NSAIDs include medications such as Advil, Motrin IB, and Naproxin. NSAIDs can cause stomach upset, ringing in your ears, cardiovascular problems, bleeding problems, and liver and kidney damage. As well, NSAIDs should not be used by individuals over 65 years of age. Other ways to manage arthritis include physical therapy, occupational therapy, attending a chronic pain class, cortisone shots, and lubrication injections. I was officially diagnosed with osteoarthritis earlier this year but have experienced many of this disease's symptoms for the past few years. Specifically, my osteoarthritis is in the facet joints of my lower spine. This condition makes it painful and difficult for me to sit. Even in the brief time I have been here today, I'm already in pain from sitting. In order to cope with the daily pain that my condition causes, I've gone through physical therapy, take NSAIDs and acetaminophen on an almost daily basis, and perform stretches almost every morning and every evening. Today I'm introducing into the record a medical journal article titled "Cannabionoid CB2 Receptors Regulate Central Sensitization and Pain Responses Associated with Osteoarthritis of the Knee Joint." This study was conducted in 2013 by the University of Nottingham. The basic premise of the article is that when cannabionoid receptors are activated through the use of cannabis, the CB2 receptors in our brain inhibit pain sensitization and chronic osteoarthritis pain. Therefore, I urge the Illinois Department of Public Health to add osteoarthritis as a qualifying condition to the Illinois Medical Cannabis Pilot Program.
helps me with the pain.

MEMBER MILLER: I just have some concerns.

A lot of the evidence that was included in
the petition are not recognized as valid evidence or
scientific evidence. They are .com websites, and
those aren't usually recognized as having

evidence-based literature research behind it,
especially in support of medical treatment. It's not
usually what we base medical treatment on is
the .coms.

With that being said, there is a study that
was done -- and I don't have the date in front of me.
It was 2011 or 2013 -- regarding end-stage
osteoarthritis.

I know as a nurse I've not ever seen a
diagnosis of end-stage osteoarthritis before, but it
was clearly labeled in this article as being helpful
for end-stage.

I know plenty of patients who have
osteoarthritis. Yes, it is painful. I have
lupus/rheumatoid arthritis. It's painful. It's
painful. I live with it every day. They don't know
what it is. It's either lupus or rheumatoid
arthritis. Nobody seems able to agree. That's
neither here nor there.

I think we need to make sure that we're not
opening this up. I see this as a generalized
diagnosis, a generalized category. I want to express
some caution.

MEMBER CHRISTOFF: Perhaps this is one where
we could clarify the diagnostic situation and say
that -- I hadn't heard end-stage as a description.

You know, I guess what's the definition of that?
To me it's when the patient has toxicity
from acetaminophen or NSAIDs and/or once they are
taking Tramadol or narcotics to control their pain and
they also aren't eligible for a joint replacement or
they're too young to have one. So that's what it
would mean to me.

So here again, the issue about
provider-patient relationship and provider discretion,
you know, I think we can trust providers --
physicians, I should be saying, since we're the only
ones who can certify -- to know that their patient
doesn't need medical cannabis because they had a
little bit of osteoarthritis seen incidentally on
their lumbar spine film and they're 25 years old and
it is not believed to be a cause of any chronic pain
requiring narcotic.

I think maybe we don't have to be that
specific; but if it is necessary for some members of
the Board to feel okay voting as to this that we
qualify it, then I think we should do that because I
think we know what this means and who this doesn't
apply to.

MEMBER LESKOVEC: I think it's important
that the way they have the system set up today to
evaluate these conditions and such is left to the
layperson to describe, and then we talk about general
terms such as osteoarthritis.

We can consider those things that were
mentioned, which are that this is end-stage.

Has it been ameliorated by other types of
treatment previous?

So I think that this is, unfortunately, one
of the diagnoses that does not really allow us to
differentiate.

If we are going to be evaluating these
petitions based on the petitions, I think this should
more be a consideration of patient education that's
necessary for the patient coming forth being able to
know about the disorder that should be treated.

CHAIRPERSON MENDOZA-TEMPLE: So this is
another one of those conditions that is to me very
broad. I as a clinician would like to see in
particular this one defined.

I know we've talked about principles of
defining severity or not, but this is so wide open
that I think, at least from a clinician and patient
guidance standpoint, that we need to know how bad it
is, how treatment resistant has it been for our
petitioner here, just to give a little guidance versus
the plain label of osteoarthritis.

I would like to see -- because people can
petition over and over again, I'd like to see a more
sophisticated, somehow qualified description of
osteoarthritis.

MEMBER WEATHERS: I think we're back to --
do we ask, though, does the petition process lend
itself to that qualification?

If we're asking people to just submit a
ICD-9 code, I don't know that we'll ever get that
level of specificity.

Are we allowed as a Board in our
recommendation back the IDPH to add those qualifiers
on our vote for today?
Do we say that we're approving this petition -- whether we add trackable or severe, treatment resistant?

I just think to extend this out another year, by the time we go back and petition, the petition didn't call for that, let alone specificity.

We clarified neuropathy.

MS. MOODY: I think that's a good point, but I think on neuropathy there were clearly two separate petitions that were specifically one specific -- out of the four petitions that were submitted for neuropathy, there were three for peripheral and one for diabetic. So that's not necessarily a clarification of the condition for which the petition was submitted.

In this case, the petitions were specific to osteoarthritis.

VICE CHAIRMAN FINE: While I understand everybody's -- the medical professionals' concerns and I certainly agree that there needs to be some level or element of severity to whatever condition that we're talking about here, I again put my trust in that medical professional to determine that it is at a point where cannabis -- again, keep in mind I feel that cannabis doesn't need to be an alternative when all other medications fail.

It could be an alternative that could help, you know, with a regime of other treatments, including narcotics or acupuncture or other holistic means to treat a condition.

So I don’t think it needs to be the only thing that could help after everything else has failed. It could be something in the arsenal that a patient would be able to use and access, depending on the level and variance of degree of pain.

That's why with regard to this condition, I'm going to defer to the medical professional as well as the patient in determining if it could be helpful.

MEMBER CHRISTOFF: I agree with your comment.

I think we are overthinking this one in particular. So the distinction from the anxiety example this morning, this is more clear because it has objective evidence, for starters, on what the disorder is, whereas anxiety is less clearly defined.

It has many different diagnostic descriptions and underpinnings. This is discrete in terms of the objective evidence.

So moving from there to your point, just considering conventional therapies is not necessarily how we would want to proceed with this either. My assumption is if patients and doctors are talking about this as an option, it's because other more conventional approaches have been explored and were found not to be ideal. So I don’t think we should spend a lot of time worrying about opening the floodgates or something like that.

Yes, it's a common disorder; but speaking for myself, the vast majority of patients that I have in my practice with osteoarthritis of some type, probably 80 percent of them don't have it to a degree where they need chronic pain management in any context.

So while the numbers of people who have this disorder are high, the ones that need this therapy as part of their care regimen is not large. So I think we as clinicians can define who would need this. It would be part of the discussion, part of the doctor-patient relationship that is built into this law in the first place.

To not approve it means that we are removing a significant cause of debilitation and time away from work and time out of life; and then taking this option off the table I think just condemns people to their current state of affairs, which is not suitable for any kind of engagement in life.

CHAIRPERSON MENDOZA-TEMPLE: I see some guidance that we could use from IDPH.

This forum has been extremely helpful for me to at least have everyone understand what are our thought processes in approving or not approving conditions and also just as an educational tool for all of us.

So I wonder if there's a way we can get an emphasis that the statute is for clinicians to decide because that's where all the decision-making goes when it comes to certifying or not certifying.

So I'm just glad that we're having this discussion. Now it comes to the second part where I keep being a stickler about I'd like to see a little more description. That's my opinion.

There are opportunities to reapply for petitions if for some reason they don’t pass, are too controversial. They can always be repackaged into something. So you're getting that feedback here.
public is getting that feedback.

Thank you.

MEMBER LESKOVEC: I'd like to say that I think we sometimes lose sight of the fact that the physician-patient relationship is one that is actually going to determine what the treatment modality is.

I think if this were made available to clinicians and patients who decide this is really useful in the treatment of chronic pain and some level of debilitation that's caused by osteoarthritis, that it would be best if we could allow that decision to be made.

CHAIRPERSON MENDOZA-Temple: We are running out of time, so Jim is going to be the last one.

MEMBER MCCURDY: Really, this is not a new point but to say I am persuaded by Dr. Christoff's last set of comments, I think, about the reality that you have a spectrum of possibilities, and in most cases the physician and the patient would agree you don't want to do something complicated if you don't have to.

That really does narrow the field to decision-making when the symptoms are more difficult.

I think that makes sense.

MEMBER PARISH: I think when we are relating this patient-doctor relationship, specifically I think it boils down to communication.

Everything is related to the doctor-patient relationship, and the Board has no authority to decide which conditions are there. If it's going to be like that, then we might as well approve one condition for severe pain.

Osteoarthritis is a very vast condition.

(Inaudible) If we approve it, the patient can deceive the doctor and say, "This isn't helping" without even trying.

MEMBER CHRISTOFF: I must make one more comment because I'm an HIV treater, as I mentioned at the beginning.

Probably 80 to 85 percent of my HIV patients don't need medical cannabis. It won't get certified by me even if they ask for it, but somehow that was included on the list.

In the original legislation, if we look for corollary examples of a disease state where you can have well-managed all the way to in decline, not doing well, not able to leave the house, you know, and also not knowing how long someone has suffered that way, back to the certifying physician's discretion along with shared decisions with the patient, this is the critical element.

I don't see that as a problem for us to add disorders to this list, like this one, osteoarthritis, that are of a chronic nature and for which conventional treatments do not necessarily afford relief enough so that people can get on with their lives.

But I can give the opposite example, too, of things that were included in the legislation that are equally broad.

Again, it's not the role of this Board, I think, to be so specific. These petitions were submitted for this diagnosis in the general sense, but it is up to the certifying physician and the patient to make the decision that this makes sense to the patient to use cannabis.

MEMBER MILLER: I don't mean -- I agree that physicians do have that authority, and it is very important, that physician-patient relationship, but I've got to go back to the evidence because that was what we were also charged with, making sure that these are supportive by medical evidence.

There is no medical evidence to support this, osteoarthritis. The only thing I found, current evidence, is end-stage osteoarthritis. The evidence support that was attached to the petition is not scientific evidence.

MEMBER CHRISTOFF: There were two packets of info. I'm not sure you saw both. Some were from peer-reviewed journals.

MEMBER MILLER: I didn't see that.

MEMBER CHRISTOFF: The one had a media account, and the other one had a couple of peer-reviewed articles.

MEMBER MILLER: The ones I saw that I read were not peer reviewed.

MEMBER WEATHERS: I know what you're talking about. There were scientific articles attached.

CHAIRPERSON MENDOZA-Temple: Unless we have burning comments that must be made, I think we should call the vote.

VICE CHAIRMAN FINE: Call for the vote.

MEMBER MILLER: Second.

VICE CHAIRMAN FINE: Second.
CHAIRPERSON MENDOZA-TEMPLE: While they're tallying this, I think just this whole discussion is helping us understand further as clinicians, also, to spread the word about the benefits of medical cannabis but also for our physician colleagues who are reluctant to even go there.

I hope that this activity and the news and the spin-off that comes from that will help increase the comfort level of those physician groups who have these patients but yet won't write the letter, regardless. I think that is a waste of an opportunity to help patients do better, to feel better, have a quality of life.

So I think it needs to be said that we do have what we would call a bottleneck. Physicians are the ones who certify, and, hopefully, through education and advocacy we'll at least show physicians what is useful, what is not, what are the benefits, what are the risks, truly, rather than relying on preconceived notions or lack of comfort level.

So the motion for osteoarthritis has passed with a vote of seven yeah and nay three.

(Applause.)

MR. SCHWARTZ: Doctor, before we continue on, the next one is polycystic kidney disease. We received a late request for this to be called into closed session for a presentation of technical evidence.

CHAIRPERSON MENDOZA-TEMPLE: Okay. So I need to close the session for our petitioner to present their technical evidence.

MR. SCHWARTZ: Hold on. Before everyone starts closing stuff, can you just wait one second so we can read something? Then you can all start closing stuff.

Because Allison tried to read it.

So we really need to put this on the record that Subsection 2(a) of the Open -- do I read that?

Oh, here.

5 ILCS 120/2(c)(4) allows for, "Evidence or testimony presented in open hearing, or in closed hearing where specifically authorized by law, to a quasi-adjudicated body, as defined in this Act, provided that the body prepares and makes available for public inspection a written decision setting forth its determinative reasoning."

Then "77 Ill. Admin. Code 946.30(j)(4)

provides, "A petitioner may request to close a portion of the hearing to protect the disclosure of confidential information."

MR. SCHWARTZ: Now you can all close your stuff.

(Whereupon at 12:40 p.m., the Board adjourned into executive session, after which the following proceedings were had in public session commencing at 12:49 p.m.)

CHAIRPERSON MENDOZA-TEMPLE: Please take your seats. We have finished our closed session, and we are looking for comments to the Board for the condition of polycystic disease.

MEMBER WEATHERS: I have more of a question.

I don't know if any of us here are going to be able to answer it.

I guess if it was -- does the national listing -- even though it's State approved, does being on medical cannabis in any way affect your ability to be listed on the transplant list?

Because of that whole State versus Federal thing and the way the transplant list works, I wanted to know if any of us know about whether being on medical cannabis affects your ability to be listed on the transplant list. I don't think so but I just wanted to --

MEMBER CHRISSOFF: I've often wondered how the legislators came up with the list that we got. However that process occurred, this would be, I think, a compelling diagnosis that should have been considered, but I just think it's not a common diagnosis.

I'm thinking about my entire practice. I've been in practice for 18 years; and I've seen one or two people with this disorder, and neither of them had it to the degree that they were making cysts and thinking about transplants or things like that in the short time I knew them.

Beyond the concerns you are expressing about the substances and ability to be transplantable, again, this is a provider-physician relationship sort of thing.

There was a letter of support for this petitioner from her nephrologist suggesting that it was either not considered or it's not an issue, but I endorse that we should put this on the list of disorders that qualify.

MEMBER WEATHERS: So that's interesting.
I give full credit to Theresa, who just found this. There's an act that's been introduced in California where medical cannabis has been legal for quite some time that's out there to protect medical cannabis patients from discrimination in the organ transplant process. The bill will prohibit a hospital, physician, or any participant in the organ transplant process from using the patient's use of medical cannabis as the sole reason in denying his or her eligibility as an organ recipient, except when the cannabis use is clinically significant as to that decision. This is a proposed act in California.

CHAIRPERSON MENDOZA-TEMPLE: I think that with poorly functioning kidneys, you have even less choices in terms of your pain management medication. That pool shrinks dramatically because we're worried about hurting the kidneys even more. So I think given the relatively good safety on cannabis, I would support this petition, even though it's rare and I have not had any patients in my practice.

Any more comments from the Board?

VICE CHAIRMAN FINE: Motion to vote.

MEMBER MILLER: Second.

CHAIRPERSON MENDOZA-TEMPLE: The next condition on the list is posttraumatic stress disorder. We have six petitioners. Our first petitioner will be Liana Bran. If you could get ready to present while we make this announcement on the vote.

The motion for polycystic kidney disease has passed ten to zero.

(Applause)

CHAIRPERSON MENDOZA-TEMPLE: Liana, please. L-i-a-n-a B-r-a-n. Good afternoon. Thank you again for allowing me to share my comments.

With regard to the addition of posttraumatic stress disorder, no scientific evidence currently exists to support the efficacy for long-term consequences of using marijuana to treat the disorder. For this reason, the American Psychiatric Association officially does not endorse marijuana use for PTSD. A recent review led by the Vermont Department of Health further confirms that marijuana use among PTSD patients in fact results in poor treatment outcomes with the worst outcomes produced at higher doses of marijuana.

Evidence-based therapy zens that are proven effective in the treatment of PTSD patients are compromised by the introduction of medical marijuana. According to the US Department of Veteran Affairs, individuals diagnosed with PTSD also demonstrated greater risk of abusing marijuana and, additionally, have more difficulty in recovering from marijuana addiction.

Development of a substance abuse disorder only complicates the recovery process, adding a new mental health issue that requires attention. Higher marijuana potency and its ability to produce episodes of paranoia and psychosis is a significant risk for individuals diagnosed with PTSD as well, given that patients already suffer from unrealistic perceptions as a consequence of their trauma. The possibility of marijuana to encourage these perceptions presents a real risk of harm to PTSD patients and those with whom they come in contact. Though medical marijuana may provide short-term relief of symptoms associated with PTSD, the long-term effects are unclear; and based on the available scientific evidence, it is likely to worsen rather than better the outcomes for these individuals.

I believe the citizens of Illinois and certainly the veterans who served our country deserve better. They need improved access to tried and tested treatments that currently exist as well as a commitment from our legislative leaders to invest in newer therapies, which may include something eventually derived from marijuana, that are subjected to a level of medical standard that can demonstrate that they are safe and effective.

Thank you.

CHAIRPERSON MENDOZA-TEMPLE: Thank you for your testimony.

If you could kindly refrain in the audience, please, and give the petitioners and the Board members the respect they deserve when they have the floor. Our next speaker and petitioner is Dr. Bruce Doblin. He's not here still. We do have a petitioner. The next one is Joel Erickson.
MR. ERICKSON: Hi, my name is Joel Erickson, J-o-e-l E-r-i-c-k-s-o-n.
Good afternoon. I'm an 80-percent disabled Air Force veteran with service-connected PTSD due to a TBI with a postconcussive syndrome, and I am testifying in favor of adding PTSD as a qualifying condition.
I have tried prescription treatments for my symptoms. I spent a week in the hospital dealing with suicidal ideations I did not have prior to taking Zoloft and that I have not had since I stopped taking it. I continue to refuse to take it each time it is offered, but other SSRIs I have had significant adverse side effects to.
Let me be clear. PTSD affects civilians as well as members of the military, but for veterans who can benefit from cannabis and who rely on the VA for their health care, the Federal interference that keeps doctors from having open and honest conversations with their patients continues.
This past Thursday, the U.S. House of Representatives came within three votes of acknowledging that the doctor-patient relationship is sacred, and I'm thankful that the MCPP delivers on Illinois' promise of state sovereignty and national union when it comes to taking care of its veterans when Federal policies fail, especially when conservative estimates are that 22 veterans take their lives each day.
Giving vets the ability to legally choose cannabis instead of pills for relief is commendable. I hope other states take Illinois' example into consideration when crafting their medical cannabis programs.
If I could ask you for a moment to imagine a Venn diagram. Over this circle is this TBI with postconcussive syndrome; over this circle is PTSD. There is a frequent but not yet understood connection between the two. It's not uncommon for some overlap in terms of symptoms.
In my case, as far as the VA is concerned, there's almost complete overlap between the two, meaning it's difficult to tell the difference between the two based on symptoms. So it's possible to have PTSD without a TBI.
This is important because PTSD is not a condition that only afflicts military members. It also affects civilians who have never stepped foot into combat, but their struggles are a result of the most personal kind of terrorism, like rape, domestic violence, and other forms of abuse, and the outcomes in terms of symptoms are the same.
Please consider the study in the packet I've given you entitled "PTSD Symptom Reports of Patients Evaluated for the New Mexico Cannabis Program," which states that patients reported over a 75 percent reduction in 3 areas of PTSD symptoms, which were reexperiencing avoidance and arousal while using cannabis.
The symptoms covered by these three categories include anxiety, difficulty obtaining restorative sleep due to nightmares, persistent avoidance of reminders of trauma, and an exaggerated startle response.
A 75 percent reduction in all these areas isn't a 75 percent increase in quality of life, but it would go a long way in helping treat the invisible wounds of PTSD and reducing the number of Illinois veterans who take their own lives.
Thank you.

MEMBER CHRISTOFF: And thank you for providing the articles, Joel. We appreciate that.
CHAIRPERSON MENDOZA-TEMPLE: We have another petitioner, Daniel Jabs.
MR. JABS: My name is Dan Jabs. The last name is J-a-b-s, Jabs. I'd like to thank you all for giving me the opportunity to speak here on behalf of myself, on behalf of the rest of the veterans that I'm trying to represent here.
I'm currently a veteran peer support specialist, and what that is is basically a connection between a veteran and their service provider, whether it be their primary care provider or mental health.
The information that our doctors receive is not the same information that I receive from our patients. The reason is because everything that happens in the VA is written down. Our patients are not able to discuss with their provider what they're going through or what they're using as a substance in order to treat their symptoms.
Real quick, my military experience, I joined the Service back in '99 as a military police officer. I was a reservist. In 2001 I helped my unit in Egypt.
In 2005 I was a patrol leader in Iraq. I spent about
a year on the ground there. My unit went through a difficult time, very unique experiences, ambush, being attacked by small-arms fire, IEDs. Multiple team members of mine have traumatic brain injuries from those results. Of course, they are not at this point able to access cannabis. Some of the symptoms that we deal with when we come back are depression, anxiety, nightmares, restlessness, hypervigilance. All of these conditions, every single one of them, can be managed with cannabis. Okay?

The VA’s current position is generally once you go in and actually get some help, they spend the first year utilizing you as Guinea pig testing you on five, ten different medications to find out what works.

So basically they’re using a sledgehammer to get to one little problem; right?

The negative side effects of these medications can be deadly. I think we’re all familiar with some of the side effects that are possible; but the fact that you can die from this, that’s not something that happens with cannabis. There have been no known related deaths with cannabis.

Ms. Sinner: Thank you. That’s your three minutes.

Mr. Jab: Thank you.

Chairperson Mendoza-Temple: Thank you for your testimony.

Next we have Ms. Kathryn Ross. Please spell your name for the reporter.

Ms. Ross: Hello, Ladies and Gentlemen. My name is Kathryn Ross, K-a-t-h-r-y-n R-o-s-s.

Ladies and Gentlemen, I’m here today to voice my support for adding posttraumatic stress disorder to the Illinois Medical Cannabis Pilot Program.

I was into abusive -- mentally, physically, and sexually -- relationships when I was in my late teens. Because of these relationships, I was unable to engage in any normal intimate relationships with any partners for many years.

In 2011 I was diagnosed with PTSD officially. Prior to and since that time, I have personally been placed on numerous medications to attempt to treat some of these symptoms of PTSD with little to no success.

I will not elaborate on the benefits of medical cannabis for IBS or vascular conditions that I also suffer from other than to say that the effects of those conditions on my life combined with the PTSD have not enabled me to be able to enjoy a normal adolescence or college experience.

However, when I was in college is when I tried medical cannabis. Because of medical cannabis I was able to finish college and engage in the postgraduate studies that I eventually graduated from and pursue the career that I have today.

I feel that without medical cannabis, I would have been unable to achieve these things.

However, as of today, opiate medications are the best prescription legal alternative that most of my physicians have been able to find to treat these symptoms.

Specifically, there have been no medications other than forms of medical cannabis which have been consistently and reliably found to work to enable me to have normal intimate relations with my partners, specifically due to the PTSD.

As someone who has been prescribed opiates for multiple years to try and treat some of these same symptoms that cannabis has been able to assist me with, I urge you to please add posttraumatic stress disorder to the list of qualifying conditions.

Thank you.

Chairperson Mendoza-Temple: Thank you.

Stephen Trapp. Is Stephen Trapp present? Is Stephen Trapp present?

Is he on the list? I think that’s everyone;
Thank you, all of the petitioners who came up and had the bravery to share your story. I know that was not easy.

We will open up the comments session for PTSD.

MEMBER CHAMPION: While PTSD is something that I worry can be mimicked, I think that if the Federal Government can give a person a medical discharge for PTSD, I definitely feel that they should be showing compassion for our programming, especially given all of the evidence in support of cannabis as a treatment for PTSD, which has a success rate of 75 percent.

Veterans’ suicide rate due to PTSD is as high as 8,000 per year. PTSD affects over 30 percent of all Vietnam, Iraq, and Afghanistan veterans. Cannabis can help clear the mind, even if it is only temporary, which is a great relief to many. PTSD in all forms should be approved, but we especially owe it to our veterans who gave their all for us.

I highly urge a yes vote. I spent a lot of time at Hines VA Hospital. I talk to PTSD vets all the time, some of the greatest people in the world. They’re just looking for a little bit of relief. They can’t find it. So please consider your vote.

CHAIRPERSON MENDOZA-TEMPLE: Thank you, Jim. Comments? Dr. Christoff?

MEMBER CHRISTOFF: This one is very straightforward in my mind. It’s a little different than the chronic conditions that are already on the list and that we’ve considered today.

The risk of not correctly and appropriately arresting PTSD, which is the same thing as saying we should take an option off the list, is death from suicide.

So I would strongly endorse this proposal.

VICE CHAIRMAN FINE: Jim’s discussion in and of itself warrants passage or acceptance of this as a condition.

On a personal level, it’s not just veterans who definitely deserve the utmost respect and this medication. For three months after my accident -- I was hit head-on by a truck while driving a convertible at work. It took my arm off in the accident. For three months I woke up every night with nightmares and sought treatment through a pain and drama therapist, who helped me tremendously. Fortunately, I’m no longer having those nightmares, but those three months were just as difficult as the physical pain that I feel now from the pain syndrome.

It’s absolutely a real-deal thing. The stakes are way too high not to pass this.

CHAIRPERSON MENDOZA-TEMPLE: Any other comments? Reverend?

MEMBER MCCURDY: I took seriously -- I do take seriously the comments -- the first set of comments from Ms. Bran that we heard earlier, in addition to the other ones, in terms of what is the medical evidence that we have and is there a downside that we need to pay attention to, particularly for some populations.

At the same time, it did seem to me in the literature that we received that at least one of the Israeli studies and the study of veterans in New Mexico seemed to show that there’s something to be said in terms of an evidence base on the side of supporting this.

So I think I’m inclined to go in that direction myself.

MEMBER WEATHERS: I’m just adding on. Overall, I think we all certainly recognize the risk in adolescence for long-term neurocognitive impact. I think it began as (Inaudible) especially those who suffered severe traumatic events, who suffer from PTSD (Inaudible) but that each situation would need to be carefully considered.

CHAIRPERSON MENDOZA-TEMPLE: Just a point of clarification, when a condition is recommended by the Board and sent to the IDPH, who makes the ultimate decision, these conditions are also being approved for pediatrics if the caregiver, the parent -- you know, we follow all the rules, you have two physicians who sign a certification letter.

So everything that we’re talking about also applies to children, just as a point of clarification.

It’s important.

Any other comments?

MEMBER MILLER: I move to vote.

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA-TEMPLE: While that is being tallied, our next condition is
superior canal dehiscence syndrome. We have a petitioner.

Glen Hoffman, if you want to start making your way down to the front.

CHAIRPERSON MENDOZA-TEMPLE: Jim Champion will make the announcement.

MEMBER CHAMPION: I'm very, very proud to say that PTSD passed by a vote of ten to zero.

(Applause)

CHAIRPERSON MENDOZA-TEMPLE: So we have our next condition on the list, which is superior canal dehiscence syndrome. We have our petitioner.

MR. HOFFMAN: Hi. My name is Glen Hoffman, G-l-e-n H-o-f-f-m-a-n.

One of the problems with my condition is my own voice creates nausea. So it's very hard for me to speak loudly.

This is a condition that I'm not sure that many of you have ever heard of before you saw this petition, but it is very rare. I had a craniotomy in 2011. At that time there were approximately 300 confirmed cases in the world.

I would ask the Board to please not hold the rarity against the lack of direct evidence or studies. You will never find a study of marijuana on superior canal dehiscence syndrome because there just aren't enough of us in the world to perform an accurate study.

For those of you who aren't familiar with what this is, in laymen's terms it's a condition where a hole forms in your temporal bone, which is supposed to be one of the most dense bones in the body to protect the brain from sounds.

The hole forms, whereas then the sound of my voice, the sounds around me enter right here, go directly into my brain and are picked up by my optic nerve. As I'm talking to you, you're all jumping around. It's basically like being in a state of constant seasickness.

Traditional anti-nausea medications just don't seem to work. What happens is that my optic nerve and my vestibular system are giving me conflicting information as to my balance and basic positioning.

MEMBER WEATHERS: I'm sorry. Can we pause here for one second?

I'm sorry. Because it's hard for him to speak loudly, we'd really appreciate it if the rest of the room would try to be as quiet as possible right now so we can do our best to hear him. Thank you all very much.

MR. HOFFMAN: This is one situation in my life that is very hard for me to take with all the noise, people talking. The noise makes me dizzy. Honestly, there's no escape from it.

One of the strange things of this condition is being able to hear your own eyeballs move in your head. As I'm moving, I hear a "swish, swish, swish."

I hear my own heartbeat going through.

I always thought it was odd that people would be jogging and trying to check their pulse when you could just hear it for me.

I also have trouble eating due to the nausea, so marijuana does help me. I'm embarrassed to say that the only thing that helps me makes me a criminal basically, for somebody who has never had a traffic ticket or been arrested.

The other thing is the nausea, to help with the food. I've basically treated it as a prescription. I smoke one bowl before each meal, one before bed.

I also use it as a sleep aid where when I go into an REM state, when I'm in my sleep, the sound of my eyeballs wakes me up at night. I don't sleep very well without marijuana.

I'm not really a pill person. I've tried the anti-nausea things. I've had a craniotomy performed. What they do with that is they attempt to fill that whole, and --

MS. SINNER: Thank you. That's three minutes.

MR. HOFFMAN: -- there's varying successes and a very high failure rate.

MR. SCHWARTZ: Excuse me, Mr. Hoffman.

MR. HOFFMAN: Yes.

MR. SCHWARTZ: If I could interrupt you for one moment.

Allison, I know you had some issues here. I don't know about the rest of the Board. If you all want to take a motion to extend his time slightly so he can reiterate some points that may not have been
VICE CHAIRMAN FINE: Motion to extend the time.

MEMBER CHRISTOFF: Second.

MEMBER MILLER: Second.

MR. HOFFMAN: Thank you. I appreciate that. Again, this is very hard to convey. It took me about 20 years to get a proper diagnosis for this. When I first started having problems, I went to a doctor. At the time she had told me, "Well, you seem depressed." I said, "Well, I don't feel very happy about this." She put me on antidepressants for about five years, and that wasn't helping any. So later I went back to her; and as the symptoms progressed, I told her that the sound of my own voice in my head was just booming. Her question to me was, "What is the voice telling you?" At that time I knew, okay, we're not on the same page. This is not a psychiatric problem. So I left that. I ended up having to do all the research on my own, and I did actually find via Wikipedia that if you can hear your own eyeballs in your head, there's only one thing it can be, which is superior canal dehiscence syndrome.

At that time I went to my new doctor. He seemed interested, sent me on to a specialist. As I was talking to her, she sat on the other side of the desk. I told her my symptoms. I told her, "This is exactly what I have." She sat and looked at me and said, "You don't have that. It's too rare. Wait another few years." So I waited another few years.

I finally found online a paper written by a doctor who really seemed to know something about this, who happened to be in Chicago, and I made an appointment. I underwent a battery of tests, and sure enough, it was superior canal dehiscence syndrome.

This is nothing that's objective. It's very -- the testing is very -- what's the word I'm looking for? -- very thorough. You go through hearing tests, vestibular tests, tests for nystagmus, which is the movement of the eye. If everything indicates, then a high-resolution CT scan does confirm the hole in the temporal bone.

When I finally found a surgeon who was willing to do the surgery, he had warned me of the side effects, which include facial palsy, loss of hearing, possible stroke. At that time I got frustrated. I asked him, "How soon can you do it?" After the recovery, there's no way I would ever do that again. I literally had to relearn up, down. During my recovery I was tumbling, tumbling. I would really just hold on to the side of my bed, and I was not able to verbalize what was wrong. They ended up sedating me and sending me back for an emergency CT scan.

CHAIRPERSON MENDOZA-TEMPLE: Mr. Hoffman, at this time we probably will need to go to our discussion.

MR. HOFFMAN: That's fine.

CHAIRPERSON MENDOZA-TEMPLE: The time extension was helpful?

MR. HOFFMAN: Yes.

Due to the rarity, if anyone has any questions, by all means, I'll be happy to answer them.

CHAIRPERSON MENDOZA-TEMPLE: Thank you for your testimony.

We will open it up to discussion from the Board.

MEMBER WEATHERS: So I'll start by saying I think a lot of what we struggle with today is this incredibly specific -- it's a very specific diagnosis. It's rare, but essentially in my practice we suspect it a lot, we report it a lot because it is something that we would be treat. A high-resolution CT shows it or doesn't. This isn't open for interpretation. It's not like somebody can come in and say they're dizzy. We do have a specific diagnosis.

VICE CHAIRMAN FINE: To all of you medical professionals on the Board, is there something associated with this condition, because it's so rare, that it would be basically forwarded to a different condition? And are migraines something frequently associated with this condition or no?

Again, I have no doubts of the veracity of this. I can't imagine what it's like to go through life like this. I thank you so much for having the courage to come up and discuss it with us.

But is it more effective from a standpoint of just, you know, applying it under migraines or applying it under something else is my question for all of you.
MEMBER WEATHERS: I think we need to take this specific one as the petition before us. I think certainly by approving this, we're helping a limited number of people; but I don't think it's within our realm -- it would be under generalized vertigo. So we would have to expand it out to vestibular neuritis, Raniers, BPPV, which has physical therapy treatments.

So again, I almost like this one because of the specificity of it. I think you're right. As you said, it's a very limited number of people, but people can certainly put it out there that we would entertain petitions for some of the more -- some of the other vertiginous conditions that impact a wide number of people.

MEMBER LESKOVEC: Thank you.

I think what we're seeing here is a challenge that we have between identifying the symptoms and diseases or disorders.

If we limit this to migraine, I think we're losing out on the larger aspects of this particular syndrome, and it's not only -- as we've seen from the testimony, it's not only migraine symptoms but also others that would be very limited if we were not to acknowledge this as one of the diagnoses.

MEMBER CHAMPION: I just want to ask one question: Are migraines and vertigo -- do all people with SCDS suffer from migraines and vertigo?

MEMBER WEATHERS: No, they don't all suffer from migraines. Vertigo, though, is one of the classic symptoms of it.

I'm more used to it being vertiginous. Being vertiginous all the time can make people feel head strain and eye strain. It's not a true diagnosis.

VICE CHAIRMAN FINE: Vertigo is not a condition?

MEMBER WEATHERS: Vertigo is a symptom.

MEMBER MCCURDY: It would seem to me that in terms of whether or not the cannabis is effective, the comments about nausea alone would be enough to convince me on that point, let alone the other things.

CHAIRPERSON MENDOZA-TEMPLE: I think as a condition, I also did an independent search for SCDS, cannabis, found nothing.

So we also have to keep in mind that from an evidence-based perspective, we don't have anything, but the corollary symptoms are the key here and the fact that the treatment options are really pretty dismal.

So while I was on the fence about this particular condition because it's so -- to me, I've never seen anyone with it. It's so rare. But that all aside, I think that I'm on the same page with David.

VICE CHAIRMAN FINE: Again, the value of your personal testimony swayed me. If you go through the troubling of filing a petition, specifically come and talk to us, please, because it helps tremendously getting really firsthand experience from anyone that's going through this.

Thank you very much, again, for your courage.

CHAIRPERSON MENDOZA-TEMPLE: Any other comments?

MEMBER WEATHERS: Motion to vote.

VICE CHAIRMAN FINE: Second.

MEMBER MILLER: Second.

CHAIRPERSON MENDOZA-TEMPLE: While the votes are being tallied, our next condition, since we moved some of these to the end, will be anorexia nervosa.

We have no petitioners.

MR. SCHWARTZ: Madam Chair, I was actually going to recommend -- it appears that there are no more presenters for any of the remaining petitions.

So if you wanted to take a ten-minute recess, let people stretch their legs, and then try to power through, I believe, the remaining four in one block.

CHAIRPERSON MENDOZA-TEMPLE: We can do that.

It's 1:30. So we'll wait for the vote.

So the motion for superior canal dehiscence syndrome has passed ten to zero.

(Applause)

MEMBER WEATHERS: I make a motion that we break for ten minutes.

MEMBER MILLER: Second.

CHAIRPERSON MENDOZA-TEMPLE: Please be back here by 1:40.

(A recess was taken from 1:29 p.m. to 1:47 p.m.)

CHAIRPERSON MENDOZA-TEMPLE: If everyone will commence their seats, we'll do the last four petitions.
What we have left is anorexia nervosa, chronic postoperative pain, Ehlers-Danlos syndrome, and neuro-Behcet's autoimmune disease. Then we, fortunately, should have time for public comment. So I move we open reopen the proceedings again. We will start with anorexia nervosa, for which we have no petitioners or presenters. So let's take comments from the Board.

VICE CHAIRMAN FINE: Second.

MEMBER WEATHERS: This one kind of makes sense to me.

VICE CHAIRMAN FINE: So after reviewing the data and just to share the appetite stimulant aspect of the potential, you know, side effects to cannabis, I'm all for this one. It makes perfect sense to me.

MEMBER MCCURDY: Perhaps not having seen all the studies, I guess what was here, though, I didn't see much in the research side of evidence for medical benefit for this condition. So I'd like to be persuaded about that.

MEMBER CHAMPION: I just wanted to say that under anorexia, I know firsthand how it helps with the --

THE REPORTER: I'm sorry. I can't hear this. Please go a little slower, and speak into the microphone.

MEMBER CHAMPION: (Inaudible) Cannabis is a highly effective appetite stimulant. Anorexia affects both men and women. Only 40 percent ever fully recover from anorexia. It has a high mortality rate. 10 percent die within the first ten years of being diagnosed, but we can't help these people in stimulating their appetite. I don't know if we can help.

CHAIRPERSON MENDOZA-TEMPLE: I think we have to differentiate between anorexia and nervosa, which is the condition before us, which is --

MEMBER CHAMPION: I just read the definition to you officially from here.

This is anorexia nervosa, which is characterized by anhedonia, which means lack of interest in anything, whereby patients experience little pleasure or reward in many aspects of their lives regarding -- let me start over from that.

Okay. Anorexia nervosa is a psychiatric disorder with a complex etiology resulting in extraordinarily high rates of mortality, 12.8 percent and suicide 6 percent.

It is characterized by an onset during adolescence, predominantly in females, with food restriction, food-related anxiety, dramatic weight loss, increased physical activity, hypothermia, which is feeling cold, and abnormal endocrine function, which means a loss of menstrual period.

Importantly, in terms of the present study that was given by the petitioner, there's anhedonia or reduced pleasure.

So this is different. This is a condition that -- maybe Dr. Weathers had some comments. I want to define that for the group.

MEMBER WEATHERS: One of my only reservations, not to influence necessarily how people vote but, I believe, to discuss it as a group, is that this is a disorder that by nature primarily impacts adolescents.

That's the one group that we've raised concerns about today in terms of the known serious adverse effects of cannabis in the long-term, especially the long-term psychological neurocognitive impact.

I find some evidence, albeit small.

MEMBER MILLER: I will concur with that, Leslie. I did a literature search as well and came up with a small study.

It was from 2012 that talked about the efficacy of THC in anorexia patients, and they found it's successful with increasing the weight in kilograms when it was combined with a high-fat diet. They were very specific about that in their conclusions.
My concern is there is a body image, self-esteem, self-worth usually attached to anorexia, the mental health disorder of anorexia nervosa. Again, it usually effects adolescents. I'm not sure in reading the literature that they would combine that therapy with a high-fat diet. I think it just seemed to contradict. That's what I found.

MEMBER CHRISTOFF: This is a disorder that I have no personal experience with by and large because I guess I didn't treat many teenagers over the years.

It is a good example of one where there's typically -- if it's going to be done correctly, there would be a multidisciplinary team that is taking care of a patient like this. So there would a psychiatrist and a psychologist and a primary care doctor.

So the diagnosis of this is serious enough that I don't think generalist physicians would be tackling it alone, although I guess there's a lot of places where there's not a team to call on necessarily.

So in that sense, I think there would have to be some shared decision-making, not just with one doctor and one patient, to certify a patient like this because I think there would have to be some agreement amongst the broader care team before this would seem like a reasonable thing to do or a safe thing to do.

Regarding the teenager thing with this, parents have to consent and agree to be sponsors for their children; right? Children can't -- whoever is the responsible adult in this child's life has to, first and foremost, give consent to engage in the treatment.

But in the sense that it is a serious disorder that can lead to a relatively high rate of suicidality and risk of death, then the parents, in my opinion, go for the best of all the options being available.

CHAIRPERSON MENDOZA-TEMPLE: I think this is another situation with anorexia nervosa, for those who walked in late, that it's a treatment decision that should be with the treating clinician.

In the case of an adolescent, so anyone under 18, who presents with this and, say, the parents or the physician feel that cannabis would be helpful in the treatment of anorexia nervosa for the purpose of appetite stimulation and weight gain to possibly save their life or their quality of life, then I think, because the rules are so strict for certifying kids under 18 for cannabis, it would require a parent -- just one parent?

MS. MOODY: A caregiver.

MEMBER WEATHERS: -- or a caregiver, and you need two physicians to sign the certification letter.

So this isn't something that could be done super easily. It's hard enough as it is. So I think that allowing that option will be useful.

CHAIRPERSON MENDOZA-TEMPLE: Another situation with anorexia nervosa, for those who walked in late, that it's a treatment decision that should be with the treating clinician.

As a pain in the location of the surgery that persists for many months or even years beyond the usual course.
of an acute injury and is different of that suffered preoperatively. Persistent pain can be due to long-lasting nociception caused by processes such as inflammation, chronic infection, or tumor. The most important causes are neuropathic pain states due to nerve compression, entrapment, or other damage.

Acute postoperative pain, which is not what we're discussing today, is defined as pain lasting more than three to six months after surgery. Chronic postoperative pain develops when the pain continues to linger longer than six months. It has been estimated that acute postop pain will develop chronic postop pain in 10 to 15 percent of individuals after common operations. Since the pain can be severe in up to 10 percent of these patients, chronic postop pain represents a major clinical problem affecting at least 450,000 people each year.

Comments from the Board?

MEMBER MCCURDY: When I read the petition, at least according to the notes I have on it, I just didn't get a sense that the benefits and the research base that was cited really goes to chronic postoperative pain. I see some evidence for relief of acute postoperative pain and some, you know, personal claims about what may have benefited this person, but I don't see a lot of evidence, actually, with regard to the chronic postoperative pain. Maybe others found other things.

MEMBER MILLER: I looked for the evidence as well. It's all pointed more towards acute. I didn't see any recent evidence that pointed towards chronic postoperative pain. Did anybody else find anything?

CHAIRPERSON MENDOZA-TEMPLE: So the research article that we were provided with in the petition, there is a human trial in here. Patients 18 to 75 were recruited, so this was an acute pain trial. So we're talking about chronic postsurgical pain, folks who just cannot seem to get over the pain. They haven't healed. It's ongoing.

MEMBER WEATHERS: I agree with the other comments that noted that as well. That being said, I felt like this is another one -- we talked about a lot of different chronic pain conditions today, and there are a lot that are already approved, but this didn't seem to fall under that umbrella. Also, concerns have already been raised about if this could be a viable alternative for longstanding narcotic use and all the risks and adverse effects that go along with it.

Understanding that the scientific supports it, as much as I would like to see it, I think from just my clinical understanding, this one didn't seem to make sense to me.

MEMBER CHAMPION: When I did some research on this, not only did it seem close to neuropathy, but it also stated that 60 percent of amputees suffer from chronic postoperative pain. With that being said, amputees are already covered under our program. It seems appropriate that this might be, too.

CHAIRPERSON MENDOZA-TEMPLE: One of the larger questions I'd like to pose -- and this is not on this list of conditions -- but chronic treatment-resistant pain. That is a larger umbrella for all of these conditions that might be proposed in the future because postop pain is just one source of it.

I've seen a pattern here. Opioids are being used. We're seeing side effects or treatment resistance or failure of the stuff to work. I'm wondering if -- and this is my personal opinion -- chronic treatment of resistant pain with some caveats with it might be something to consider in a future petition.

But for the chronic postsurgical pain, other comments from the Board?

MEMBER MCCURDY: Call the question.

CHAIRPERSON MENDOZA-TEMPLE: Motion to vote?

VICE CHAIRMAN FINE: Second.

CHAIRPERSON MENDOZA-TEMPLE: While the votes are being tallied, we'll be evaluating Ehlers-Danlos syndrome. Chronic postoperative pain has passed with a vote of seven to three. (Applause.)

CHAIRPERSON MENDOZA-TEMPLE: On to the next with Ehlers-Danlos syndrome. Maybe it would help if I just read the diagnosis, what it is, for the group. We're on Ehlers-Danlos Syndrome. It's a little bit out of order in our notebooks.
So there are six categorized types of Ehlers-Danlos syndrome, and we're not talking about all the subtypes of this. We're talking about the syndrome as a whole. But individuals with this syndrome have a genetic disconnect in their connective tissues. These are the tissues that provide support to many body parts, like the skin, muscles, tendons, ligaments, blood vessels, organs, gums, eyes, etcetera. It provides the structural strength in most human tissue, including the heart and blood vessels, eyes and skin, cartilage and bone, as mentioned. When muscles, ligaments, tendons, and large organs are built with defective collagen, their is systemic weakness and instability evident throughout the body. The problem results from one's body being built out of a protein that behaves unreliably and can be widespread and show up in places that seem unrelated until the underlying connection to EDS is recognized. This disease is characterized by joint hypermobility, loose and unstable joints prone to frequent dislocation and subluxation, hyperextensible joints in multiple areas of body that I won't read and early onset of osteoarthritis. Osteoarthritis, a degenerative joint disease, occurs at a younger age than in the general population possibly because of chronic joint instability resulting in increased mechanical stress. Osteoporosis, which is bone marrow density, in individuals with EDS may be reduced in some individuals. Back and neck pain are the most common reports among these patients. I won't go on any further, unless you'd like me to.

Comments on Ehlers-Danlos syndrome?

Motion to vote?

MEMBER WEATHERS: Motion to vote.

MEMBER MILLER: Second.

CHAIRPERSON MENDOZA-TEMPLE: We've made amazing progress at this meeting. I'm really pleased with how our inaugural petition has gone. I'm just thrilled with the passion that has been brought to this room but also the thoughtfulness that we've brought to certifying or not certifying conditions. I hope that the feedback that we've given to the public regarding conditions was helpful in terms of making the next round of petitions, which will be occurring in the fall -- and I believe, Conny, is it June 1 we start accepting --

MS. MOODY: July 1.

CHAIRPERSON MENDOZA-TEMPLE: That's right. July 1 we'll be accepting new petitions.

For those of you who weren't in the room when I said this, I think it's really important that the petitioners who signed up really show up for these. It's very valuable to hear the testimonies. We really want to hear those.

Provide full-text articles and not just links -- website links that we have to copy and paste it. We've got so much material to cover. We've got that all under our fingertips.

We'll announce the vote.

For the condition of Ehlers-Danlos syndrome, the condition has passed -- the motion passes yeah, nine votes to one.

(Applause)

CHAIRPERSON MENDOZA-TEMPLE: This is the last condition on the list, and it's 2:11. Amazing.

Do we have any other announcements?

MS. MOODY: We have one more. We have neuro-Behcet's.

MEMBER WEATHERS: Just for the Board, Neuro-Behcet's combines the neuropathology cirrhosis with superimposed supraoral genital ulcerations.

CHAIRPERSON MENDOZA-TEMPLE: I remember in medical school -- I remember these were "Can't see, can't pee, can't climb a tree." That's how you remembered what symptoms were involved. We have to learn so many different diseases.

MEMBER WEATHERS: Just to add on -- and I'll give credit to Eric -- it doesn't respond to the normal immune modulations. It requires immunosuppression, which comes with its own side effects.

CHAIRPERSON MENDOZA-TEMPLE: I have a question for you, Dr. Weathers.

Do you see a lot of patients with this, since we have no testimony?

MEMBER WEATHERS: It's pretty rare. It sort of descends from Turkish patients. It can be in other patient populations as well, but we certainly do have a few patients. It certainly pales kind of in incidence compared to multiple sclerosis and neuromyelitis, which are much more common autoimmune
disorders.

CHAIRPERSON MENDOZA-TEMPLE: Dr. Christoff, have you seen this?

MEMBER CHRISTOFF: I have not seen a case of this.

CHAIRPERSON MENDOZA-TEMPLE: Other comments from the Board? Questions? Parikh?

VICE CHAIRMAN FINE: Motion to vote.

MEMBER PARIKH: Second.

MEMBER MILLER: Second.

CHAIRPERSON MENDOZA-TEMPLE: The condition of neuro-Behçet's autoimmune disease passed with a yeah vote, ten to zero.

MEMBER MILLER: We've made miraculous, wonderful time. I really appreciate everyone's cooperation in keeping the flow going very smoothly. We're ahead of schedule.

So I invite our public comment session to begin, and we have two individuals signed up. We previously moved on the Board to limit the discussion to three minutes at the podium, which is the same amount of time that petitioners received. Even though we have more time, it's only fair to keep their time the same. So three minutes.

Two people signed up. We have Ben -- sorry, I can't read your last name -- Rediger.

MR. REDIGER: Thank you. My name is Ben Rediger, R-e-d-i-g-e-r. I'm a CEO off CBD Education Services and CBD Education Charities.

I would like to thank all of you for taking the time out of your day to do this. I know the patients in the industry appreciate this effort. On my end, my responsibility is to provide education not only to the community but to medical professionals as well. If you all did not know, there are now online continuing medical education courses to explain to the medical industry how the endocannabinoid system works in the human body. I would take more of your time today; but I know that since Sue Sisley is here, she would do well with it. So I'm going to yield the rest of my time to her.

Thank you.

MS. SISLEY: Hi. My name is Sue Sisley. I'm a physician from Arizona.

THE REPORTER: Could you spell your name, please?

MS. SISLEY: Oh, sure. The last name is S-i-s-l-e-y. I'm an M.D. I practice internal medicine and psychiatry in Scottsdale. I'm the principal investigator on a randomized control trial looking at whole-plant marijuana for PTSD in military veterans.

Sadly, this study has been stonewalled by the Government for over five years now. We've had FDA approval since 2011. We've endured all the Federal Government obstacles, except the NIDA monopoly.

The National Institute on Drug Abuse is the only legal supply of marijuana in the country for any Federally regulated marijuana research. So this is a big problem, and that's why our study continues to be delayed waiting over a year now for a marijuana study drug from the Federal Government.

But in the meantime, this Committee has made some really excellent decisions. I wanted to applaud you for having the sensibility, the compassion, the courage to embrace these diagnoses that may not have a randomized control trial behind each one of them but certainly have a mountain of anecdotal evidence suggesting that marijuana could be an effective treatment intervention for them.

So I just want to really acknowledge the incredible amount of work. You've read and pored over hundreds of pages of documents in order to get to this point. You've listened to all this compelling testimony, but you've already made some wonderful decisions.

The diagnosis that I was particularly interested in advocating for you've already passed, PTSD. As you'll see here, many of us are wearing this dog tag today. Our military veterans created this awareness campaign. Instead of a ribbon, they developed the number 22 engraved on a dog tag to signify the number of military veterans who kill themselves each day in this country presumably due to untreated or undertreated PTSD.

So I'm grateful that you all have made the decisions that have happened today. I hope that the Governor's Office has the wisdom and the sensibility to uphold the decisions.

I look forward to being a resource for your Committee or for your administration to call on us. In Arizona we've had a medical marijuana law for over four years now. We've added PTSD back in January of
It's been a real gift to all the PTSD sufferers, not just our military veterans but folks with trauma of all causes. They have been able to access -- they have been able to safely access lab-tested marijuana in a legal framework, and that's been crucial.

So thank you all very much, and please call on us in Arizona. We can help guide you as you continue your rulemaking process. We can share our experiences, help you avoid pitfalls, and also help optimize your programming.

Thank you.

Chairperson Mendoza-Temple: Thank you, Dr. Sisley.

So we're closing public comment. In the future, we will have individuals sign up on the sheet so it remains a streamlined process.

I thought it would be useful to go through the list of conditions that were approved and which were not approved.

Do we need a yeah or nay?

Chairperson Mendoza-Temple: Thank you, Dr. Sisley.

Reiterate, for those who haven't been here the whole day, anxiety did not pass. Diabetes did not pass. Essential thrombocythemia with JAK 2 mutation did not pass. Irritable bowel syndrome passed. Migraine passed. Neuropathy, which we broke into peripheral neuropathy, passed, and diabetic neuropathy passed. Both categories were passed. Osteoarthritis passed. Polycystic kidney disease passed. Posttraumatic stress disorder passed. Superior canal dehiscence syndrome passed. Anorexia nervosa passed. Chronic postoperative pain passed. Ehlers-Danlos syndrome passed. Neuro-Behcet's autoimmune disease passed, for a total of three failed and eleven passed.

Chairperson Mendoza-Temple: Thank you very much.

Just as a reminder, July 1 we'll be accepting a new set of petitions.

Chairperson Mendoza-Temple: What is the timetable on the decisions of the Director?

Chairperson Mendoza-Temple: So just to reiterate, for those who haven't been here the whole day, anxiety did not pass. Diabetes did not pass. Essential thrombocythemia with JAK 2 mutation did not pass. Irritable bowel syndrome passed. Migraine passed. Neuropathy, which we broke into peripheral neuropathy, passed, and diabetic neuropathy passed. Both categories were passed. Osteoarthritis passed. Polycystic kidney disease passed. Posttraumatic stress disorder passed. Superior canal dehiscence syndrome passed. Anorexia nervosa passed. Chronic postoperative pain passed. Ehlers-Danlos syndrome passed. Neuro-Behcet's autoimmune disease passed, for a total of three failed and eleven passed.

Chairperson Mendoza-Temple: Thank you very much.

Chairperson Mendoza-Temple: So just to reiterate, for those who haven't been here the whole day, anxiety did not pass. Diabetes did not pass. Essential thrombocythemia with JAK 2 mutation did not pass. Irritable bowel syndrome passed. Migraine passed. Neuropathy, which we broke into peripheral neuropathy, passed, and diabetic neuropathy passed. Both categories were passed. Osteoarthritis passed. Polycystic kidney disease passed. Posttraumatic stress disorder passed. Superior canal dehiscence syndrome passed. Anorexia nervosa passed. Chronic postoperative pain passed. Ehlers-Danlos syndrome passed. Neuro-Behcet's autoimmune disease passed, for a total of three failed and eleven passed.

Chairperson Mendoza-Temple: Thank you very much.

Just as a reminder, July 1 we'll be accepting a new set of petitions.

Chairperson Mendoza-Temple: What is the timetable on the decisions of the Director?
MR. SCHWARTZ: Correct.
MS. MOODY: Now, our administrative rules require the Department to provide notice 30 days in advance of the open petition period.
So I recommend that everyone watch the Department's website and also the MCPP.Illinois.gov website, which is the statewide Medical Cannabis Program website, because we will post notice in advance and indicate that within 30 days the open petition period will be opened so that everyone has notice about that process.

CHAIRPERSON MENDOZA-TEMPLE: Another note on the petitioner presentations, I think that clarifying the deadlines, I don't know if you want to --
MR. SCHWARTZ: We'll definitely look at that after. We'll review our internal processes after this meeting to try and make sure that it is as effective and as streamlined as possible, Madam Chair.

VICE CHAIRMAN FINE: Motion to adjourn.
MEMBER RAMIREZ: I think before we adjourn, we should give a round of applause for Robert Morgan's work for the program and all his work.

(Applause.)
CHAIRPERSON MENDOZA-TEMPLE: And also an incredible amount of work by our IDPH Staff as well, Conny, Andrew, Mallory. I know I'm missing someone, I'm sure, but a ton of work has gone into it.
By the way, these are all volunteers on this Board. So that's how passionate we are about this.

(Applause.)
MEMBER MCCURDY: I just wondered, is there some opportunity that we should look -- and this could involve another meeting or some such, and that may not be what people want -- but to look at our own process and see how did all of this -- did all of this serve us well today or are there things that we would want to suggest be tinkered with in the petition forms or any of that sort of thing. I guess that would be a question.

You all will be reviewing, but is this something that should involve the Board as well?

MS. MOODY: Well, I think the answer to that is definitely yes. I think we've learned a lot from this process today.

Obviously, as Leslie said as we started the day, this is all very new to us. We were learning as we went along. I'm very pleased by how well we learned and how quickly we learned, but I think there might be recommendations that the Board has, that the Staff has that could make this a process that is new and improved.

We will seek and opportunity to obtain that kind of input from the Board and perhaps even more informally through a meeting because we had discussed at our first Board meeting the possibility of having a summer Board meeting prior to the next petition hearing to discuss the rules that we have passed already for the Board, the process, any recommendations that the Board would like to make to the Department.

CHAIRPERSON MENDOZA-TEMPLE: Mike?
VICE CHAIRMAN FINE: Sure. Motion.
MEMBER CHRISTOFF: Maybe there is a case to make here, like we should be doing this meeting in other places, but I think most of us live in this region. I don't know that for a fact, but those of us that don't are probably not necessarily a lot closer to Springfield.
MEMBER RAMIREZ: But Springfield is the capitol of our state. We're all working for the people of Illinois.
People downstate might have to present their case and have to travel here.
MEMBER CHRISTOFF: That's true, but it will be expensive to move all of us there as well.
MR. SCHWARTZ: I think we all appreciate this debate. I think it definitely is meritorious and should be continued at possibly the summer meeting.
MEMBER RAMIREZ: Thank you.

MR. SCHWARTZ: Motion to adjourn.
MEMBER MCCURDY: Second.
CHAIRPERSON MENDOZA-TEMPLE: All in favor of closing the meeting?
(The ayes were thereupon heard.)

PROCEEDINGS CONCLUDED AT 2:30 P.M.

STATE OF ILLINOIS )
 ) SS.
COUNTY OF DU PAGE )

I, Jean S. Busse, Certified Shorthand Reporter No. 84-1860, Registered Professional Reporter, a Notary Public in and for the County of DuPage, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this 11th day of May, 2015.

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