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Dear Dr. Sapienza,

I was provided a copy of your March 4, 2003 response to Dr. Lyle Craker, and am afraid that it is both inaccurate and misrepresentative of the actual situation.

I have, indeed, held a Schedule I Drug License since 1996, and possessed 100 g of NIDA marijuana under that permit since 1997. Unfortunately, the material was of such poor quality, we did not deem it to be representative of true medical cannabis, and have not yet ascertained an appropriate set of biochemical experiments for which to utilize it. I can provide comparative photographs should you require graphic representation.

It is similarly disingenuous to claim that you are not persuaded by my arguments. The only reason that I have not completed my FDA-approved clinical study of cannabis in migraine is that NIDA refused to supply the material. This is precisely the reason that the University of Massachusetts facility is necessary; all FDA-worthy studies should have access to clinical cannabis without superfluous, expensive and redundant PHS oversight.

Finally, for the sake of accuracy, I am in the process of taking over the Compassionate Use IND of Irvin Rosenfeld, precisely because NIDA has not responded to his continual requests for higher potency material, and he desires a physician who will support his efforts.

For the record, I admire Dr. ElSohly and his colleagues at the University of Mississippi, and harbor no personal animus. I have never said that NIDA is incapable of producing a quality product, but merely that their efforts do not result in material that is representative of domestic, Canadian or European clinical cannabis. Despite protestations to the contrary, NIDA continues to supply seeded material that is poorly cured, and relatively impotent. Techniques of seedless cultivation as ganja have been known from India for 2500 years. This deficiency is now widely acknowledged. I would refer you to the Canadian Senate Report on cannabis:

http://www.parl.gc.ca/Common/Committee_SenRecentReps.asp?Language=E&Parl=37&Ses=1

in which the committee criticized NIDA cannabis and encouraged additional research through the Canadian Compassion Clubs with organic seedless high-potency strains of cannabis. Considering that millions of dollars may be required to complete Phase III clinical trials, no sponsor of cannabis research is likely to accept a situation in which they have no say or control over the product that they hope to be marketing in the future.

In closing, it is grossly evident that NIDA is profoundly conflicted in serving as purveyor of cannabis for medical studies, and there is no better reason that the University of Massachusetts facility should advance with the project.

Sincerely,

Ethan Russo, MD