June E. Riedlinger, R.Ph.
8514 Parkview Avenue
Brookfield, IL 60513

Administrator
Drug Enforcement Administration
1405 I Street, N.W.
Washington, D.C. 20537

Attn: DEA Federal Register Representative

Dear Mr. Mullen or Designate:

This letter responds to your proposal, appearing in 21 CFR Part 1308 of the Federal Register, to place 3,4-methylenedioxy-methamphetamine (MDMA) into Schedule I. Please acknowledge receipt of my comments when you enter them into the record.

I am a Registered Pharmacist (R.Ph.) with several years of professional experience working in hospital pharmacies. My current employer, the Foster G. McGaw Hospital, is part of the Loyola University Medical Center in Maywood, Illinois -- a medical environment both practical and academic. The perspective I bring to the issue at hand is therefore based on clinical experience and knowledge of current drug theories and research, enhanced by my recent attendance at a "state-of-the-art" symposium on treatment of depression using psychoactive drugs.

In regard to your finding, reported in 21 CFR Part 1308, that MDMA has high potential for abuse, I would remind you that potential for abuse has not compelled the DEA to place certain other substances in Schedule I. Every day, for example, a significant number of emergency room admissions can be traced to abuses of alcohol, including alcohol toxicity and motor vehicle accidents. (Waller, reporting in AAA Foundation, 1983, notes that roughly half of all fatal motor vehicle accidents involve alcohol.) The carnage wrought by nicotine from cigarettes is also well-known and documented; this includes undeniably higher mortality rates for smokers due to heart disease, lung cancer and other respiratory illnesses. Alcohol and nicotine, however, are legally available everywhere with few restrictions. Yet both have been listed as having no recognized therapeutic value by Spiegel and Aebi (1983). The same reference classifies antidepressant and psychostimulatibg drugs as having recognized therapeutic value.

MDMA belongs squarely in the latter category. There are clear indications from early research that its therapeutic value is substantial. From my perspective, MDMA is a promising drug for the treatment of depression and for pain control. The following reasons apply.

(1) MDMA is an antidepressant. In a government report on phenethylamines (Department of Health and Human Services, 1984), MDMA, like other biologically-active therapeutic drugs, was found to have a positive isomer activity that induces the release of serotonin in the brain. According to Coppen (1967), some and possibly all forms of depression are caused by deficiencies of serotonin, a neurotransmitter, in parts of the brain. Subsequent research by van Praag and de Haan (1979) and by van Praag (1982) support this theory. It is possibly relevant, therefore, that when Greer (1983) tested MDMA on 29 human subjects he found the drug to be especially effective as a psychotherapeutic tool for treating interpersonal problems related to depression and low self-esteem. Greer concluded: "The study demonstrates a potential use for MDMA as a safe and effective adjunct to psychotherapy, especially for both the prevention and treatment of interpersonal problems and substance use disorders." He could have added that MDMA performs this function efficiently: It works in an hour or two instead of days or weeks, and is effective when administered infrequently, in weekly or monthly dosing intervals, thus reducing the potential for troublesome side effects. This compares to the multiple daily dosing required for all of the currently legal drugs prescribed for treating depression (e.g., tricyclic antidepressants, MAO-inhibitors and lithium), which often take several days to produce antidepressant effects and which frequently cause lasting troublesome side effects.

(2) MDMA is an analgesic. The second major benefit that research seems to indicate for MDMA applies to pain control. Your own Schedule I control recommendation (Drug Control Section, 1984) acknowledges the analgesic qualities of MDMA. Braun, Shulgin and Braun (cited in the same report) have determined that MDMA has even greater analgesic effect than MDA, and according to them is both potent and non-sedating. As a hospital professional with years of exposure to patients with excrutiating pain, I can tell you that new analgesics with properties like those of MDMA are desperately needed. Sedation, for example, is a troublesome negative side effect with all of the strong analgesics that are currently available for medical use. These analgesics almost always have a morphine-analog chemical structure to which many patients are strongly allergic. No such danger of cross-sensitivity exists with MDMA.

The foregoing directly refutes your contention, in 21 CFR Part 1308, that MDMA "has no currently accepted medical use in treatment in the United States." I urge you, for that reason, not to place the drug into Schedule I. We need it "in the field," to alleviate real-life anguish and pain.

Sincerely,

June E. Riedlinger

June E. Riedlinger, R.Ph.

REFERENCES

Coppen, A. 1967. Biochemistry of affective disorders. Brit. J. Psychiat. Vol. 113:1237-1264.

Department of Health and Human Services. 1984. Phenathylamines. A special report prepared for the World Health Organization by Sheu, Y., NIDA, 5600 Fishers Lane, Rockville, Maryland 20857.

Drug Control Section, Office of Diversion Control. 1984. Schedule I control recommendation under the CSA for 3,4-methylenedioxymethamphetamine (MDMA). A publication of the Drug Enforcement Administration.

Greer, G. 1983. MDMA: a new psychotropic compound and its effects in humans. Report available from Greer, G., 333 Rosario Hill, Santa Fe, New Mexico 87501.

Spiegel, R. & Aebi, H.-J. 1983. Psychopharmacology. New York: John Wiley & Sons.

van Praag, H.M. 1982. Neurotransmitters and CNS disease. Depression. Lancet. 1982ii:1259-1264.

van Praag, H.M. & de Haan, S. 1979. Central serotonin metabolism and frequency of depression. Psychiatry Research. Vol. 1:219-224.

Waller, P.F. 1983. Spitting in the ocean: realistic expectations of the impact of driver alcohol education and rehabilitation programs on the problem of drunk driving. Report from a colloquium on DWI (driving while intoxicated). Published in DWI Reeducation and Rehabilitation Programs -- Successful Results and the Future. Falls Church, Virginia: AAA Foundation for Traffic Safety.