SECTION VII

APPENDICES
APPENDIX 1

SUBMISSIONS SINCE INTERIM REPORT
The following individuals and organisations made written submissions to the Committee after the tabling of the Interim Report.

Submission No.
64. The Hon. M.J. Ahern, Premier of Queensland, Brisbane, QLD
65. Queensland Gymnastics Owners Association, Brisbane, QLD
66. Australian Athletic Union, Moonee Ponds, VIC
67. Dr R. Shawhan, Department of Social and Preventive Medicine, University of Queensland, Herston, QLD
68. Queensland Rugby Football League Ltd., Milton, QLD
69. Mr L. Azar, Carrindale, QLD
70. Mr S. Shortis, Chatswood, NSW
71. Mr S. Zammataro, Mirianni, QLD
72. Mr C. Dunko, Trinder Park East Home, Woodridge, QLD
73. National Basketball League, South Yarra, VIC
74. Victorian Football League, Melbourne, VIC
75. The Hon. K. Greiner, Premier of NSW, Sydney, NSW
76. Ms D.L. Jones, Combined Regional Bodybuilding Association, Newcastle West, NSW
77. Mr J.G.H. Reifs, Carlton, VIC
78. Ms Debbie Flintoff-King, Moorooduc, VIC
79. Mr Robert Wilks, Australian Powerlifting Inc., South Yarra, VIC
80. Mr G. Ellison, Kallaroo, ACT
81. Mr S. Haynes, Australian Sports Drug Agency, Curtin, ACT
82. Mr G. Jones, Australian Drug Free Powerlifting Federation, Queanbeyan, NSW
83. Mr K. Cernicic and Ms J. Dobson, PO Box 3, Ruaiadawes Bay, NSW
84. Mr J. Czapla and Mr S. Ha, 5 Casino Avenue, Greystanes, NSW
85. Mr R. Rigby, PO Gordon, VIC
APPENDIX 2

SCHEDULE OF PUBLIC HEARINGS
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<th>Date of Hearing</th>
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<td>11 September 1989 (Brisbane)</td>
<td>Mr N.B. Jones</td>
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<td>12 September 1989 (Brisbane)</td>
<td>Mr K.A. Wilson, Mr P. Kabeko</td>
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<td>Department of Social and Preventive Medicine, The Medical School, University of Queensland</td>
<td>Dr M. Shwehan, Senior Lecturer, Mr R. Henderson, Student Researcher</td>
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<td>Brisbane Broncos Rugby League Club</td>
<td>Mr B.A. Kelly, Student Researcher</td>
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<td>Queensland Powersports Association</td>
<td>Mr D.D. Toci, Coaching Co-ordinator</td>
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<td></td>
<td>Mr W.A. Scarffe, Dr B.T. Ross, Mr L.A. Azar, Dr F. Minc</td>
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<td>14 September 1969 (Brisbane)</td>
<td>Australian Sports Drug Agency&lt;br&gt;Mr W.J. Lewis&lt;br&gt;Mr G.L. Olling&lt;br&gt;Dr E.T. Hobbs&lt;br&gt;Queensland Rugby Football League</td>
<td>Mr S. Haynes, Chief Executive</td>
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<td>15 September 1981 (Brisbane)</td>
<td>Mr G.S. Jensen&lt;br&gt;Mr F.J. McCarthy&lt;br&gt;Mr H. Jardine&lt;br&gt;Australian Sports Drug Agency</td>
<td>Mr S. Haynes, Chief Executive</td>
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<td>25 October 1989 (Canberra)</td>
<td>NSW Rugby League Inc.</td>
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<td>Australian Soccer Federation&lt;br&gt;Dr A.R. Cottigan, Director, Medical Commission&lt;br&gt;National Basketball League</td>
<td>Mr I. Brizziuto, Chairman&lt;br&gt;Mr W.A. Palmer, Junior, General Manager</td>
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<td>13 November 1989 (Sydney)</td>
<td>Australian Drug Free Powerlifting Federation&lt;br&gt;Chief Inspector&lt;br&gt;L.G. Topping&lt;br&gt;Mr J.C. Brant</td>
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<td>Australian Weightlifting Federation</td>
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<td>Federal Government of Canada</td>
<td>Mr L.M. Maskowsky, Assistant Deputy Minister, Ministry of Fitness and Amateur Sport</td>
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APPENDIX 3

SCHEDULE OF COMMITTEE CONTACT WITH PERSONS ADVERSELY MENTIONED IN THE SECOND DRUG IN SPOR T REPORT
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<td>Mr Christopher Stewart</td>
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Mr. Nick Voroklatov
Mr. Bruce Walsh
Mr. Scott Boyd
Mr. Charlie Coleiro
Mr. Mauro Jardine
Mr. Rosita Zodalle
Mr. Terry Lendini
Mr. Peter Martin
Mr. Ray Rigby
Mr. Wayne Scarfe
Mr. Vito Stenn
Mr. Dino Toci
Mr. Larry Widdow
Mr. Glenn Waterfall

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* pro forma letter
APPENDIX 4

PARLIAMENTARY PRIVILEGE
PROCEDURES TO BE OBSERVED BY SENATE COMMITTEES FOR THE PROTECTION OF WITNESSES

That, in their dealings with witnesses, all committees of the Senate shall observe the following procedures:

1. A witness shall be invited to attend a committee meeting to give evidence. A witness shall be summoned to appear (whether or not the witness was previously invited to appear) only where the committee has made a decision that the circumstances warrant the issue of a summons.

2. Where a committee desires that a witness produce documents relevant to the committee's inquiry, the witness shall be invited to do so, and an order that documents be produced shall be made (whether or not an invitation to produce documents has previously been made) only where the committee has made a decision that the circumstances warrant such an order.

3. A witness shall be given reasonable notice of a meeting at which the witness is to appear, and shall be supplied with a copy of the committee's order of reference, a statement of the matters expected to be dealt with during the witness's appearance, and a copy of these procedures. Where appropriate, a witness shall be supplied with a transcript of relevant evidence already taken.

4. A witness shall be given opportunity to make a submission in writing before appearing to give oral evidence.

5. Where appropriate, reasonable opportunity shall be given for a witness to raise any matters of concern to the witness relating to the witness's submission or the evidence the witness is to give before the witness appears at a meeting.

6. A witness shall be given reasonable access to any documents that the witness has produced to a committee.

7. A witness shall be offered, before giving evidence, the opportunity to make application, before or during the hearing of the witness's evidence, for any or all of the witness's evidence to be heard in private session, and shall be invited to give reasons for any such application. If the application is not granted, the witness shall be notified of reasons for that decision.

8. Before giving any evidence in private session a witness shall be informed whether it is the intention of the committee to publish or present to the Senate all or part...
of that evidence, that it is within the power of the committee to do so, and that the demane has the authority to order the production and publication of undisclosed evidence.

(9) A chairman of a committee shall take care to ensure that all questions put to witnesses are relevant to the committee's inquiry and that the information sought by those questions is necessary for the purpose of that inquiry. Where a member of a committee requests discussion of a ruling of the chairman on this matter, the committee shall deliberate in private session and determine whether any question which is the subject of the ruling is to be permitted.

(10) Where a witness objects to answering any question put to the witness on any ground, including the ground that the question is not relevant or that the answer may incriminate the witness, the witness shall be invited to state the ground upon which objection to answering the question is taken. Unless the committee determines immediately that the question should not be pressed, the committee shall then consider in private session whether it will insist upon an answer to the question, having regard to the relevance of the question to the committee's inquiry and the importance to the inquiry of the information sought by the question. If the committee determines that it requires an answer to the question, the witness shall be informed of that determination and the reasons for the determination, and shall be required to answer the question only in private session unless the committee determines that it is essential to the committee's inquiry that the question be answered in public session. Where a witness declines to answer a question to which a committee has required an answer, the committee shall report the facts to the Senate.

(11) Where a committee has reason to believe that evidence about to be given may reflect adversely on a person, the committee shall give consideration to hearing that evidence in private session.

(12) Where a witness gives evidence reflecting adversely on a person and the committee is not satisfied that that evidence is relevant to the committee's inquiry, the committee shall give consideration to expunging that evidence from the transcript of evidence, and to forbidding the publication of that evidence.

(13) Where evidence is given which reflects adversely on a person and action of the kind referred to in paragraph (12) is not taken in respect of the evidence, the committee shall provide reasonable opportunity for that person to have access to that evidence and to respond to that
evidence by written submission and appearance before the committee.

(14) A witness may make application to be accompanied by counsel and to consult counsel in the course of a meeting at which the witness appears. In considering such an application, a committee shall have regard to the need for the witness to be accompanied by counsel to ensure the proper protection of the witness. If an application is not granted, the witness shall be notified of reasons for that decision.

(15) A witness accompanied by counsel shall be given reasonable opportunity to consult counsel during a meeting at which the witness appears.

(16) An officer of a department of the Commonwealth or of a State shall not be asked to give opinions on matters of policy, and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a Minister.

(17) Reasonable opportunity shall be afforded to witnesses to make corrections of errors of transcription in the transcript of their evidence and to put before a committee additional material supplementary to their evidence.

(18) Where a committee has any reason to believe that any person may be given before the committee, or has been subjected to or threatened with any penalty or injury in respect of any evidence given, the committee shall take all reasonable steps to ascertain the facts of the matter. Where the committee considers that the facts disclose that a person may have been improperly influenced or subjected to or threatened with penalty or injury in respect of evidence which may be or has been given before the committee, the committee shall report the facts and its conclusions to the Senate.

Resolutions of the Senate - 25 February 1988

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APPENDIX 5

IN CAMERA EVIDENCE
A Senate Committee may agree to take evidence in camera. This means that the evidence will be taken in private, with the public and press excluded. In agreeing to take evidence in camera the Committee will inform a witness whether it is the intention of the Committee to publish or present to the Senate all or part of the evidence. For example, where a matter is either before a court of law or pending legal proceedings (sub judice), the Committee might wish to hear evidence in camera in order to avoid influencing or prejudicing the outcome of court proceedings. In these circumstances the Committee may indicate that it will authorise the publication of the in camera evidence once the legal proceedings have been completed.

When receiving in camera evidence for other than sub judice reasons it will generally be the intention of the Committee that the evidence will not be published. However, it should be noted that the Committee is unable to give a binding assurance that evidence taken in camera will not be disclosed. This is because disclosure can be authorised by three mechanisms:

- a resolution of the Committee concerned can result in the publication or the presentation to the Senate of evidence taken in camera;
- the production and publication of undisclosed evidence can be authorised by the Senate;
- an individual member of the Committee preparing a dissenting report may, without reference to the Committee or the witness, disclose in camera evidence which the member claims is clearly relevant to the matter on which the Senator dissents and which forms a necessary part of the reasoning of the dissent.

Clearly, the first of these mechanisms is under the control of the Committee and is unlikely to be applied if the Committee has indicated it does not intend to disclose in camera evidence. However, the membership of the Committee may change or the Committee may decide at some later stage that the reasons for confidentiality may no longer exist. In this case the Committee would normally notify the witness and seek his or her up-to-date preference about the matter. The other two mechanisms through which disclosure can be authorised are outside the direct control of the Committee. However, it should be noted their use has been rare.

In giving in camera evidence it should be noted that the resolutions adopted by the Senate on 25 February 1988 concerning procedures to be observed by Senate committees for the protection of witnesses state that;
(where evidence is given which reflects adversely on a person ... the committee shall provide reasonable opportunity for that person to have access to that evidence and to respond to that evidence by written submission and appearance before the committee. (paragraph 13)

When a Committee has taken evidence in camera involving allegations made against an individual, the committee will normally try to raise these allegations with the individual concerned in such a way that the identity of the witness making the allegations is not disclosed. This would be done during the course of an in camera hearing.

Distribution of the Hansard transcript of in camera evidence is limited to the witness, the Committee members, the Committee secretariat and to demand. Extra security, such as double enveloping is used in the distribution of such evidence.

Unauthorized disclosure of in camera evidence is both a contempt of the Senate and a criminal offence. The Parliamentary Privileges Act 1987 sets out the penalties for unauthorized disclosure of in camera evidence as:

- in the case of a natural person, $5 000 or imprisonment for 6 months;
- in the case of a corporation $25 000

It should be noted that disclosure can be authorised only by the three methods described. Disclosure cannot be authorised by the witness providing the evidence. If a witness later changes his or her mind about the need for secrecy, the Committee should be advised as in this case, the Committee might wish to consider the possibility of disclosure.

If a witness wishes to keep confidential the fact that he or she has appeared to give evidence before the Committee, as well as the evidence given, this should be made clear to the Committee secretary as soon as possible.

Note:
Where there is an absolute need to ensure confidentiality a Committee may agree to hold private discussions with a prospective witness rather than take formal evidence.
APPENDIX 6

INTERNATIONAL OLYMPIC COMMITTEE LIST OF DOPING CLASSES AND METHODS 1989
I. DOPING CLASSES
   A. Stimulants
   B. Narcotics
   C. Anabolic Steroids
   D. Beta-blockers
   E. Diuretics

II. DOPING METHODS
   A. Blood doping
   B. Pharmacological, chemical and physical manipulation

III. CLASSES OF DRUGS SUBJECT TO CERTAIN RESTRICTIONS
   A. Alcohol
   B. Local anaesthetics
   C. Corticosteroids

NOTE:
The doping definition of the IOC Medical Commission is based on the banning of pharmacological classes of agents.

The definition has the advantage that also new drugs, some of which may be especially designed for doping purposes, are banned.

The following list represents examples of the different dope classes to illustrate the doping definition. Unless indicated all substances belonging to the banned classes may not be used for medical treatment, even if they are not listed as examples. If substances of the banned classes are detected in the laboratory the IOC Medical Commission will act. It should be noted that the presence of the drug in the urine constitutes an offence, irrespective of the route of administration.

EXAMPLES AND EXPLANATIONS
I. DOPING CLASSES
   A. Stimulants e.g.
      amfepronol
      amphetamine
      amfetaminil
      benzphetamine
      benzphetamine
      caffeine
      catherine
      chlorphenetermine
clobenzexorx
clopreneine
cocaine
copropanol (component of 'Micron')
crotrothalamide (component of 'Micron')
dimethastamine
ephedrine
etadidine
ethamivan
etilmethastamine
fencamfemine
fenoldrone
fenproporex
furfenorex
menfenoxex
methamphetamine
methoxyphenamine
methylphenidate
moxonone
nikebumide
pencoline
pentetrazol
phenmetrazine
phentermine
phenylpropanolamine
pipradol
prolinane
propylhexedrine
pycrovalerone
strychnine and related compounds

For caffeine the definition of a positive depends upon the following: if the concentration in urine exceeds 12 μg/ml.

Stimulants comprise various types of drug which increase alertness, reduce fatigue and may increase competitiveness and hostility. Their use can also produce loss of judgement, which may lead to accidents to others in some sports. Amphetamine and related compounds have the most notorious reputation in producing problems in sport. Some deaths of sportsmen have resulted even when normal doses have been used under conditions of maximum physical activity. There is no medical justification for the use of 'amphetaminees' in sport.

One group of stimulants is the sympathomimetic amines of which ephedrine is an example. In high doses, this type of compound produces mental stimulation and increased blood flow. Adverse effects include elevated blood pressure and headache, increased and irregular heart beat, anxiety and tremor. In lower doses, they e.g. ephedrine, pseudoephedrine, phenylpropanolamine, norpseudoephedrine, are often present in cold and hay fever.
preparations which can be purchased in pharmacies and sometimes from other retail outlets without the need of a medical prescription.

Thus no produce for use in colds, flu or hay fever purchased by a competitor or given to him should be used without first checking with a doctor or pharmacist that the product does not contain a drug of the banned stimulant class.

-β2 agonists

The choice of medication in the treatment of asthma and respiratory ailments has posed many problems. Some years ago, ephedrine and related substances were administered quite frequently. However, these substances are prohibited because they are classed in the category of 'sympathomimetic amines' and therefore considered as stimulants.

The use of only the following β2 agonists is permitted in the aerosol form:

bitolterol
ociprenaline
ritterol
setubutosal
terbutaline

B. Narcotic analgesics e.g.

alnaprodine
aligeridine
buprenorphine
codeine
dextromoramide
dextropropoxyphen
diamorphone (heroin)
dihydrocodeine
dipipanone
ethinylscamino
ethylmorphine
levorphanol
methadone
morphine
nalbuphine
pentazocine
methadone
phentazocine
trimeperidine and related compounds

The drugs belonging to this class, which are represented by morphine and its chemical and pharmacological analogs, act fairly specifically as analgesics for the management of moderate to severe pain. This description, however, by no means implies that their clinical effect is limited to the relief of trivial
disabilities. Most of these drugs have major side effects, including dose-related respiratory depression, and carry a high risk of physical and psychological dependence. There exists evidence indicating that narcotic analgesics have been and are abused in sports, and therefore the IBC Medical Commission has issued and maintained a ban on their use during the Olympic Games. The ban is also justified by international restrictions affecting the movement of these compounds and is in line with the regulations and recommendations of the World Health Organisation regarding narcotics.

Furthermore, it is felt that the treatment of slight to moderate pain can be effective using drugs - other than the narcotics - which have analgesic, anti-inflammatory and antipyretic actions. Such alternatives, which have been successfully used for the treatment of sports injuries, include Antranilic acid derivatives (such as Methamisic acid, Flacetamine, Diletamine, etc.), Phenylpropanoic acid derivatives (such as Diclofenac, Ibuprofen, Ketoprofen, Naproxen, etc.) and compounds such as Indomethacin and Sulindac. The Medical Commission also reminds athletes and team doctors that Aspirin and its newer derivatives (such as Diflunisal) are not banned but cautions against some pharmaceutical preparations where aspirin is often associated to a banned drug such as Codeine. The same precautions hold for cough and cold preparations which often contain drugs of the banned classes.

NOTE: DEXTROMETHORPHAN IS NOT BANNED AND MAY BE USED AS AN ANTI-TISSUE. DIPHENOXYLATE IS ALSO PERMITTED.

C. Anabolic steroids e.g.

bolasterone
broadone
ciclohecol
dehydrochlormethyltestosterone
fluoxymesterone
mesterolone
metandrenone
metylene
methyltestosterone
nanolone
norethandrelone
oxandrolone
oxymesterone
oxymetholone
stanozolol
testostereone** and related compounds

** Testosterone: the definition of a positive depends upon the following - the administration of testosterone or use of any other manipulation having the result of increasing the ratio in urine of testosterone/epitestosterone to above 6.
It is well known that the administration to males of Human Chorionic Gonadotrophin (HCG) and other compounds with related activity leads to an increased rate of production of androgenic steroids. The use of these substances is therefore banned.

This class of drugs includes chemicals which are related in structure and activity to the male hormone testosterone, which is also included in this banned class. They have been misused in sport, not only to attempt to increase muscle bulk, strength and power when used with increased food intake, but also in lower doses and normal food intake to attempt to improve competitiveness.

Their use in teenagers who have not fully developed can result in stunting growth by affecting growth at the ends of the long bones. Their use can produce psychological changes, liver damage and adversely affect the cardiovascular system. In males, their use can reduce testicular size and sperm production; in females, their use can produce masculinization, acne, development of male pattern hair growth and suppression of ovarian function and menstruation.

D. Beta-blockers e.g.

- acebutolol
- alprenolol
- atenolol
- labetalol
- metoprolol
- nadolol
- oxprenolol
- propranolol
- sotalol and related compounds

The IOC Medical Commission has reviewed the therapeutic indications for the use of beta-blocking drugs and noted that there is now a wide range of effective alternative preparations available in order to control hypertension, cardiac, arrhythmias, angina pectoris and migraine. Due to the continued misuse of beta-blockers in some sports where physical activity is of no or little importance, the IOC Medical Commission reserves the right to test those sports which it deems appropriate. These are unlikely to include endurance events which necessitate prolonged periods of high cardiac output and large stores of metabolic substrates in which beta-blockers would severely decrease performance capacity.

E. Diuretics e.g.

- acetazolamide
- amiloride
bendrofluamide
benzthiadiazide
bumetanide
caronemone
chlorothiazide
clofibrin
ethylthiazide
clofibrin
furosemide
hydrochlorothiazide
merzalyl
spironolactone
triamterene and related compounds

Diuretics have important therapeutic indications for the elimination of fluids from the tissues in certain pathological conditions. However, strict medical control is required.

Diuretics are sometimes misused by competitors for two main reasons: namely, to reduce weight quickly in sports where weight categories are involved and to reduce the concentration of drugs in urine by producing a more rapid excretion of urine to attempt to minimize detection of drug misuse. Rapid reduction of weight in sport cannot be justified medically. Health risks are involved in such misuse because of serious side-effects which might occur.

Furthermore, deliberate attempts to reduce weight artificially in order to compete in lower weight classes or to dilute urine constitute clear manipulations which are unacceptable on ethical grounds. Therefore, the IOC Medical Commission has decided to include diuretics on its list of banned classes of drugs.

P.B. For sports involving weight classes, the IOC Medical Commission reserves the right to obtain urine samples from the competitor at the time of the weigh-in.

II. METHODOLOGY

B. Blood doping

Blood transfusion is the intravenous administration of red blood cells or related blood products that contain red blood cells. Such products can be obtained from blood drawn from the same (autologous) or from a different (non-autologous) individual. The most common indications for red blood transfusion in conventional medical practice are acute blood loss and severe anaemia.

Blood doping is the administration of blood or related blood products to an athlete other than for legitimate medical treatment. This procedure may be preceded by withdrawal of blood from the athlete who continues to train in this blood depleted state.
These procedures contravene the ethics of medicine and of sport. There are also risks involved in the transfusion of blood and related blood products. These include the development of allergic reactions (rash, fever etc.) and acute haemolytic reaction with kidney damage if incorrectly typed blood is used as well as delayed transfusion reaction resulting in fever and jaundice, transmission of infectious diseases (viral hepatitis and AIDS), overload of the circulation and metabolic shock.

Therefore the practice of blood doping in sport is banned by the IOC Medical Commission.

B. Pharmacological, chemical and physical manipulation

The IOC Medical Commission bans the use of substances and methods which alter the integrity and validity of urine samples used in doping controls. Examples of banned methods are catheterisation, urine substitution and/or tampering, inhibition of renal excretion, e.g. by probenecid and related compounds.

III. Classes of drugs subject to certain restrictions

A. Alcohol

Alcohol is not prohibited. However breath or blood alcohol levels may be determined at the request of an International Federation.

5. Local anaesthetics

Injectable local anaesthetics are permitted under the following conditions:

a) that procaine, xylocaine, etc. are used but not cocaine;

b) only local or intra-articular injections may be administered;

c) only when medically justified (i.e. the details including diagnosis; dose and route of administration must be submitted immediately in writing to the IOC Medical Commission).

C. Corticosteroids

The naturally occurring and synthetic corticosteroids are mainly used as anti-inflammatory drugs which also relieve pain. They influence circulating concentrations of natural corticosteroids in the body. They produce euphoria and side-effects such that their medical use, except when used topically, require medical control.

Since 1975, the IOC Medical Commission has attempted to restrict their use during the Olympic Games by requiring a declaration by the team doctors, because it was known that corticosteroids were being used non-therapeutically by the oral, intramuscular and even the intravenous route in some sports. However, the problem was not solved by these restrictions and therefore stronger
measures designed not to interfere with the appropriate medical use of these compounds became necessary.

The use of corticosteroids is banned except for topical use (ocular, opthalmological and dermatological), inhalational therapy (asthma, allergic rhinitis) and local or intra-articular injections.

ANY TEAM DOCTOR WISHING TO ADMINISTER CORTICOSTEROIDS INTRA-ARTICULARLY OR LOCALLY TO A COMPETITOR MUST GIVE WRITTEN NOTIFICATION TO THE IOC MEDICAL COMMISSION.
APPENDIX 7

JOURNAL ARTICLE ON THROMBOGENIC EFFECTS OF ANABOLIC STEROIDS
APPENDIX 8

JOURNAL ARTICLE ON ANABOLIC STEROID DEPENDENCE
Anabolic Androgenic Steroid Dependence
Kirk J. Brown, M.D., Frederic C. Blow, Ph.D., Thomas P. Berenson, M.D., and Craig Furling, M.D.

CASE REPORT
A 25 year old man, a heavy weight lifter, came to his psychiatric emergency room because of heightened irritability and increased anger, which he attributed to the use of anabolic androgenic steroids. He reported progressively becoming more aggressive in his work, with increased duress and sleep disturbances. Despite prior psychological or psychiatric evaluation, he now presented with a marked increase in aggressiveness and irritability. At the time of his psychiatric evaluation, he was taking anabolic androgenic steroids to increase his performance in the gym. His irritability and anger had become so severe that his employer had refused to allow him to work in the gym. The patient had a history of schizophrenia, but he was not taking any medication for his symptoms.

The patient had been using steroids for approximately 3 months and had been taking them daily. He had been noticed by coworkers for becoming more aggressive and irritable. The patient had been referred to a psychiatrist for evaluation and treatment.

The psychiatrist conducted a thorough psychiatric evaluation and administered a battery of psychological tests. The patient was found to be experiencing significant cognitive and memory impairments. The patient was also found to be experiencing significant mood disturbances, including irritability, aggression, and irritability. The patient was referred to a neurologist for further evaluation.

The patient was diagnosed with anabolic androgenic steroid dependence and was referred to a drug and alcohol rehabilitation center. The patient was started on a tapering dose of a mood stabilizer and a cognitive behavioral therapy program. The patient was also referred to a physical therapist for a program to improve strength and flexibility.

The patient was encouraged to continue his medication regimen and to participate in the physical therapy program. The patient was also encouraged to avoid future use of anabolic androgenic steroids.

The patient was discharged from the hospital after 2 weeks of treatment. The patient was scheduled for follow-up appointments with the psychiatrist and the physical therapist. The patient was also provided with a referral to a support group for individuals with anabolic androgenic steroid dependence.

The patient was contacted 6 months after discharge. The patient reported that he had continued to follow the treatment plan and was doing well. The patient was also reported to be continued on the medication regimen and participating in the physical therapy program. The patient was encouraged to continue his progress and to avoid future use of anabolic androgenic steroids.
was positionally detected, with some opacity. His affect was appropriate, pleasant, and not labile. Irregularities were not noted, and the patient was pleasant and cooperative with the examiner. Mild interpersonal interaction was present. The patient's thought processes were normal and associated with no delusions or hallucinations. He was not paranoid. His speech was normal, clear, and well articulated. He was concerned about significant weight changes; although he did not report any affective lability, neither did he report suicidal or homicidal ideation. His thought content was non-cataleptic, non-random, non-perplexing, and non-fluent.

The results of the physical examination were unremarkable. The patient had no apparent deficit in attention, memory, or other cognitive functions. The neurological examination revealed no specific abnormalities. The patient's ability to perform serial 7s and to repeat the word "bicycle" was normal. The patient was oriented to person, place, and time. He exhibited a normal gait and had no apparent weakness or sensory deficit in any extremity. The patient's funduscopic examination was normal. The remainder of the examination was unremarkable.

DISCUSSION

Anxiety and depression are prevalent in psychiatric practice, and are often perceived as being indicative of psychopathological disorders. The presence of anxiety and depression in the elderly population is of particular interest, as these disorders are often overlooked in this age group. The diagnosis and treatment of anxiety and depression in the elderly require careful consideration, as these conditions may be exacerbated by co-morbid medical conditions and medication side effects.

According to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), a diagnosis of anxiety or depression must meet specific criteria for a diagnosis of a psychiatric disorder. These criteria include symptoms that are present for a significant amount of time, interfere with the patient's daily functioning, and are not attributable to a medical condition or substance use.

The course and outcome of these disorders vary widely. In the elderly population, anxiety and depression may co-occur, leading to a complex and often challenging clinical picture. Effective management of these conditions requires a comprehensive evaluation, individualized treatment plan, and close monitoring of the patient's response to treatment.

REFERENCES


J Clin Psychiatry 50:1, January 1989

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APPENDIX 5

POST-MORTEM REPORT ON BODYBUILDER
Standing Committee on Environment, Recreation and the Arts
Australian Senate
Parliament House
CANBERRA A.C.T. 2600

Attention: Mr P C Grundy

Dear Sir/Madam,

Death of Maurice FERRANTI
Your Ref: letter#8/11/89

Please find enclosed a copy of the postmortem report relating to the abovenamed deceased.

Yours faithfully,

[Signature]

 Clerk of the Local Court. 36

enc.
Medical report upon the examination of the dead body of:

Name: Maurice FERRANTI  
PM Number: 83/1912

I Johan Duflou a legally qualified medical practitioner, carrying on my profession as the Division of Forensic Medicine, in the State of New South Wales, do hereby certify as follows:

At 8.00 in the forenoon, on the 26th day of October, 1989 at Sydney in the said State, I made an internal examination of the dead body of a male identified to me by Dr. Mullinger of Division of Forensic Medicine in the State aforesaid, as that of Maurice FERRANTI aged about 23 years.

I opened the three cavities of the body.

upon such examination I found:

The body was that of a very well-built, heavily muscled adult male whose appearances were consistent with the stated age.

There was minimal subcutaneous body fat.

Body weight 79 kg  
Body length 1.75 m.

The body was cold to touch and there was some dorsal post-mortem lividity.

Early decompositional change was evident in the form of softening of organs and green discoloration of the anterior abdominal wall.

External examination of the body:

1. There was an endotracheal tube in situ.

2. There were three E.C.G. dots on the anterior trunk.

3. Intravenous cannulae were in situ in the right antecubital fossa as well as on the anterior surface of the left lower arm.

4. No ante- or peri-mortem injury was identified on the surface of the body.

Head and neck:

The scalp and skull were normal.

Specifically there were no skull fractures.

The meninges were similarly normal and there was no extradural or subarachnoid hemorrhage.

The brain weighed 1680 g and was placed in formalin of later detailed examination once tied.

The eyes, ears, nose and mouth were normal.

The neck was similarly of normal appearances and there were no cervical spine fractures.

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Cardio-vascular system:  
The pericardium was healthy.  
The heart weighed 360 g and showed mild biventricular dilatation.  
The atria and valves of the heart were within normal limits.  
The free wall thickness of the right ventricle was 3 mm and that of the left ventricle was 15 mm.  
There were areas of alternating pallor and congestion of the myocardium of the left ventricle.  
There were no mural thrombi, nor were there areas of old fibrosis within the myocardium.  
The coronary arteries were involved by very early atherosclerotic disease, but there was no obvious narrowing of their lumina.  
The aorta, proximal carotid arteries, renal arteries and iliac arteries all showed moderately advanced fatty streaking of the intima.  
The venous system was normal.  
There were no pulmonary emboli.  

Respiratory system:  
The pharynx, larynx and trachea contained grey charcoal-like material.  
The bronchi contained blood-stained fluid.  
The left weighed 740 g and the right lung weighed 860 g.  
Both lungs were markedly congested throughout.  
No focal pulmonary lesions were identified.  
The chest wall and diaphragm were normal.  
There were no rib fractures.  

Gastro-intestinal system:  
The tongue, oesophagus, and stomach mucosa were coated by charcoal-like material.  
The stomach contained approximately 300 ml black fluid.  
The duodenum was normal.  
The remainder of the bowel on external examination appeared normal and was not opened further.  

Hepato-biliary system:  
The liver weighed 2450 g and was markedly congested and fatty.  
No focal hepatic lesions were identified macroscopically.  
 bile from a normal gallbladder could be expressed with ease through the extrahepatic biliary system into the duodenal cavity.  
The pancreas was autolytic.  

Hematopoietic system:  
The spleen weighed 200 g and was uniformly congested.  
There was no lymphadenopathy.  

Genito-urinary system:  
The left kidney weighed 180 g and the right kidney weighed 150 g.  
The capsules of both kidneys stripped with ease to reveal normal renal parenchyma throughout.  
Both ureters were patent throughout their lengths, ending in a normal urinary bladder containing approximately 50 ml cloudy urine.  
The prostate gland was of normal appearances.

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The right testis weighed 15 g and the left testis weighed 12 g. Both testes were markedly atrophic.

**Embryonic system:**

The pituitary gland and thyroid gland appeared normal.
The left adrenal weighed 9 g and the right adrenal weighed 8 g.
The adrenals were of normal macroscopic appearances.

Histology being performed. (Brain)

Blood was sent for the estimation of alcohol, and blood, liver, stomach and contents, urine and bile for chemical analysis.

The body was identified to Dr. Hollinger by Const. D. Zuepp of No. 14 division.

**Microscopic Examination:**

**Heart:**
Sections of right and left ventricles, interventricular septum and cardiac conduction system showed no abnormalities apart from occasional atrial subendocardial contraction bands.

**Lungs:**
Showed fairly extensive intra-alveolar hemorrhage and oedema in all sections. Bronchial basement membranes are thickened.

**Liver:**
Shows centrifugal congestion only.

**Spleen:**
No abnormality detected.

**Pancreas:**
There is advanced autolysis.

**Kidneys:**
No abnormality detected.

**Adrenals:**
Numerous eosinophilic intracytoplasmic inclusion bodies are noted in the zona glomerulosa of the adrenal cortex, highly suggestive of "Adalactone bodies". There is cortical lipid depletion.
Pituitary:
Shows no histological abnormalities.

Thyroid:
Normal.

Testes:
There is some fibrosis of the seminiferous tubules and partial spermatocytic arrest is identified.

Skeletal Muscles:
Sections stained with H & E and frozen fat stains show no histologic abnormalities.

MACROSCOPIC REPORT OF THE BRAIN:
The leptomeninges are thin and transparent. The vessels at the base of the brain have a normal architectural pattern with no atheroma. The external surface of the cerebrum, cerebellum and brain stem appears normal.

The cerebrum is sectioned in the coronal plane in 1 cm slices. No abnormalities are seen on the cut surfaces of the cerebral cortex, white matter, basal ganglia, hippocampus or diencephalon.

The cerebellum is sectioned in the sagittal and parasagittal planes. No abnormalities are seen on the cut surfaces of the cerebral cortex, white matter or dentate nuclei.

The brain stem is sectioned in the transverse plane in 0.5 cm slices. No abnormalities are seen on the cut surfaces of the midbrain, pons or medulla.

MACROSCOPIC DIAGNOSIS
Normal brain.

MACROSCOPIC REPORT OF THE BRAIN:
Normal.

In my opinion death had taken place about 5 days previously and the cause of death was:

1. DIRECT CAUSE:
   Disease or condition directly leading to death:
   (a) CARDIAC ARREST (due to)
ANTecedent CAUSES:

1. Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last:

2. Other significant conditions contributing to the death but not relating to the disease or condition causing it:

TO THE STATE CORONER,

(Signature)...................................

SYDNEY

(Date) 23rd January, 1990.
CLIENT:  (0305)  Department of Health
Division of Forensic Medicine
42-50 Parramatta Road
GLEBE NSW 2037

SAMPLE DESCRIPTION: URINE SAMPLE T000767 FERRANT

LABORATORY REPORT NUMBER: 498/46777
Client Reference Number:

DATE: 28-JUL-99

A REASONABLE REASONABLE SAMPLE WAS GIVEN TO ME FOR THE ANALYSIS OF ANDROGENIC ANABOLIC STEROIDS AND METABOLIC ANABOLIC STEROIDS. THE SAMPLE WAS THAT OF MR. FERRANT, AND WAS RECEIVED ON THE CODE T000767.

The pH was measured at 7.5 and the specific gravity was 1.000.

Analysis of the sample using our standard screening procedure using Gas Chromatography/Mass Spectrometry gave three detectable metabolites of STEROIDS: METHANDIENONE (Dianabol); NORTESTOSTERONE (Testosterone); STANOZOLOL (Winstrol).

The procedure also confirmed the presence of testosterone which is a metabolite of ANDROSTANDIONE (Androsolan). This method was not quantitative for substance.

The natural androgenic steroids were greatly suppressed indicating the possibility of long term steroid use. The testosterone was not detectable while testosterone was easily seen. This could indicate the use of testosterone as an anabolic steroid as well.

Further analysis using high pressure liquid chromatography gave epoandrosterone (E35 ug/ml), 1,4 Nandrostenedione (170ug/ml).

signed

[For Regional Director]
Date 18/1/99

Department of Administrative Services
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