25B-NBOMe
Critical Review Report
Agenda item 4.17

Expert Committee on Drug Dependence
Thirty-sixth Meeting
Geneva, 16-20 June 2014
Acknowledgments

This report has been drafted under the responsibility of the WHO Secretariat, Essential Medicines and Health Products, Policy Access and Rational Use Unit. The WHO Secretariat would like to thank the following people for their contribution in producing this critical review report: Dr Simon Elliott, United Kingdom (literature review and drafting), Dr Caroline Bodenschatz, Switzerland (editing) and Mr David Beran, Switzerland (questionnaire report drafting).
Contents

Summary..................................................................................................................................................................... 7

1. Substance identification ............................................................................................................................................. 8
   A. International Nonproprietary Name (INN) ........................................................................................................... 8
   B. Chemical Abstract Service (CAS) Registry Number .......................................................................................... 8
   C. Other Names ......................................................................................................................................................... 8
   D. Trade Names ......................................................................................................................................................... 8
   E. Street Names ......................................................................................................................................................... 8
   F. Physical properties ............................................................................................................................................... 8
   G. WHO Review History ........................................................................................................................................... 8

2. Chemistry .................................................................................................................................................................. 9
   A. Chemical Name .................................................................................................................................................. 9
   B. Chemical Structure ........................................................................................................................................... 9
   C. Stereoisomers ..................................................................................................................................................... 9
   D. Synthesis .......................................................................................................................................................... 9
   E. Chemical description ....................................................................................................................................... 9
   F. Chemical properties ....................................................................................................................................... 10
   G. Chemical identification ................................................................................................................................... 10

3. Ease of convertibility into controlled substances ............................................................................................ 10

4. General pharmacology ....................................................................................................................................... 10
   4.1. Pharmacodynamics ........................................................................................................................................ 10
   4.2. Routes of administration and dosage ........................................................................................................... 11
   4.3. Pharmacokinetics ......................................................................................................................................... 11

5. Toxicology .......................................................................................................................................................... 12

6. Adverse reactions in humans .................................................................................................................................. 12

7. Dependence potential .......................................................................................................................................... 13

8. Abuse potential .................................................................................................................................................... 13

9. Therapeutic applications and extent of therapeutic use and epidemiology of medical use ......................... 13

10. Listing on the WHO Model List of Essential Medicines .................................................................................... 13

11. Marketing authorizations (as a medicine) ........................................................................................................ 13

12. Industrial use ..................................................................................................................................................... 13

13. Non-medical use, abuse and dependence ......................................................................................................... 13


15. Licit production, consumption and international trade ..................................................................................... 14

16. Illicit manufacture and traffic and related information .................................................................................... 14

17. Current international controls and their impact ............................................................................................... 14
Summary

25B-NBOMe is a substituted phenethylamine and derivative of 2C-B. It is a potent partial agonist of the serotonin 5-HT$_{2A}$ receptor in particular and appears to have stimulant and particularly hallucinogenic effects. It has been associated with a few reported non-fatal intoxications and some deaths, with seized material and use reported in many countries. It has been reportedly sold as LSD or as a ‘legal’ alternative to LSD or “research chemical” usually via Internet websites. The variation in formulations and resultant dosage coupled with its potency results in health risks to the individual. There are not much data concerning the abuse or dependence potential of 25B-NBOMe.
1. Substance identification

A. **International Nonproprietary Name (INN)**
   
   Not applicable

B. **Chemical Abstract Service (CAS) Registry Number**
   
   1026511-90-9

C. **Other Names**
   
   2C-B-NBOMe; 25B-NBOMe; 25B; 2CBNBOMe; 2C-B-NBOMe; NBOMe-2C-B; NBOMe-2CB;
   
   2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine
   
   2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethan-1-amine
   
   4-bromo-2,5-dimethoxy-N-(2-methoxybenzyl)phenethylamine
   
   4-bromo-2,5-dimethoxy-N-(o-methoxybenzyl)phenethylamine
   
   4-bromo-2,5-dimethoxy-N-[(2-methoxyphenyl)methyl]-benzeneethanamine
   
   N-(2-methoxybenzyl)-2,5-dimethoxy-4-bromophenethylamine
   
   N-(2-methoxybenzyl)-4-bromo-2,5-dimethoxyphenethylamine
   
   Cimbi-36 (¹¹C radiolabelled for PET scanning) - Center for Integrated Molecular Brain Imaging (CIMBI)

D. **Trade Names**
   
   None

E. **Street Names**
   
   Nova; 25B; legal acid; NBomb; NE-BOME; New Nexus; NBOMe-2C-B, BOM 2-CB
   
   The drug is most often listed on “research chemical” websites as 25B-NBOMe. 25B refers to the 2,5-dimethoxy-4-bromophenethylamine (2C-B) portion of the structure with NBOMe referring to the N-Benzoylmethoxy moiety (methoxy being OMe in chemical shorthand).

F. **Physical properties**
   
   25B-NBOMe hydrochloride is a powder.

G. **WHO Review History**
   
   25B-NBOMe was not previously pre-reviewed or critically reviewed. A direct critical review is proposed based on information brought to WHO’s attention that 25B-NBOMe is clandestinely manufactured, of especially serious risk to public health and society, and of no recognized therapeutic use by any party. Preliminary data collected from literature and different countries indicated that this substance may cause substantial harm and that it has no medical use.
2. Chemistry

A. Chemical Name

IUPAC Name: 2-(4-bromo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine
CA Index Name: Not applicable

B. Chemical Structure

Free base:

![Chemical Structure Diagram]

Molecular Formula: C\textsubscript{18}H\textsubscript{22}BrNO\textsubscript{3}
Molecular Weight: Free base = 380.2762
Melting point: 156°C (HCl salt) – Heim (2003)
Boiling point: not known
Fusion point: not known

C. Stereoisomers

25B-NBOMe has no chiral centres and therefore no stereoisomers.

D. Synthesis

The synthesis of 25B-NBOMe was first mentioned by Heim in a thesis at the Free University of Berlin (2003). It is a stepwise reductive alkylation where the reducing agent (NaBH\textsubscript{4}) is added after the imine intermediate is formed first by the addition of 2-methoxybenzaldehyde to the starting 2C-B compound (Abdel-Magid et al. 1996). Various researchers have used this process to synthesise a variety of NBOMe structures for chemical testing, including 25B-NBOMe (Casale and Hays, 2012; Hansen et al., 2014). The free base product is a colourless oil. Published methods typically produced the hydrochloride salt.

E. Chemical description

25B-NBOMe is a derivative of 2C-B (4-bromo-2,5 dimethoxyphenethylamine), a known synthetic derivative of phenethylamine with stimulant and hallucinogenic properties. 25B-NBOMe contains the 2C-B substructure, substituted with a ‘N-(2-methoxy)benzyl’ group.

Several NBOMe derivatives exist where the bromine atom is exchanged for another halide element, hydrogen atom or organic functional group, i.e. iodine (25I-NBOMe), chlorine (25C-NBOMe), hydrogen atom (25H-NBOMe), -
36th ECDD (2014) Agenda item 4.17

methyl (25DNBOMe), -ethyl (25E-NBOMe), -nitro (25N-NBOMe) or – isopropyl (25iP-NBOMe).

**F. Chemical properties**

See Section B and G.

**G. Chemical identification**

Given its chemically basic nature, the extraction of 25B-NBOMe is relatively straightforward as is direct analysis of the compound itself (e.g. as a powder or in liquid form) by a number of techniques. However, as detailed elsewhere, in biological fluid, concentrations present after use may be very low and therefore require the application of very sensitive techniques (e.g. tandem mass-spectrometry). Detection methods such as gas chromatography with mass-spectrometry (GC-MS), high performance liquid chromatography with diode-array detection (HPLC-DAD) and/or mass-spectrometry (LC-MS) and accurate mass spectrometry have been published as part of case studies (Soh and Elliott 2013, Casale and Hays 2012, Poklis et al., 2013, 2014). The detection outputs depend on the technique used but for 25I-NBOMe with LC-MS, the pronated molecular ion [M+H] of 380 m/z is observed with fragmentation resulting in a predominant 121 m/z ion of the N-(2-methoxy)-benzyl fragment as well as a 91 m/z fragment ion (Soh and Elliott 2013, Elliott 2014, Casale and Hays 2012, Poklis et al., 2013, 2014). No presumptive test data (including Marquis field tests) exist. There is no known cross-reactivity with commercially-available urine immunoassay tests for the standard drugs of abuse.

**3. Ease of convertibility into controlled substances**

No information available.

**4. General pharmacology**

**4.1. Pharmacodynamics**

*Animal studies*

Data from in vitro studies have shown that 25B-NBOMe has nanomolar affinity for the serotonin 5-HT2A receptor and is a partial agonist, with less affinity for the 5-HT2C receptor (Hansen et al., 2014; Ettrup et al., 2010 and 2011; Finnema et al., 2014, Juncosa et al., 2013). The addition of the 2-methoxybenzyl group significantly enhances the affinity and potency of 25B-NBOMe compared to 2C-B (Blaazer et al., 2008; Juncosa et al., 2013). Stimulation of the 5-HT2A receptors appears to be essential for the hallucinogenic effects of drugs such as LSD (Egan et al. 1998, Marek & Aghajanian, 1996; González-Maeso et al., 2007; Hanks & González-Maeso, 2013; Nelson et al., 1998). Binding (Ki) at the rat 5-HT2A receptor was reported to be 1.01±0.17 nM with activation (ED50) of 0.51±0.19 nM and intrinsic activity of 87% (Ettrup et al., 2011). As part of preclinical assessment of dosage for 25B-NBOMe in PET scanning, and as a potent full agonist for the 5-HT2A receptor Ettrup et al. (2013) studied the effect of 25B-NBOMe on the head twitch behavioural response (HTR) in mice which is used as a surrogate marker of the hallucinogenic effect of 5-HT2A receptor activation in humans (Hanks & González-Maeso, 2013). The study found that
25B-NBOMe induces HTR in mice in a dose dependent manner, with a dose of 0.5 mg/kg i.p inducing significant HTR compared to a saline control. A significant HTR was not elicited by 0.05 mg/kg 25B-NBOMe relative to saline, while doses at and above 2.5 mg/kg had prominent sedative effects.

**Human data**

Although tested in animals, there are no reported human clinical trials with 25B-NBOMe in the scientific literature. However, Juncosa et al. (2013) reported, using human embryonic kidney (HEK) 293 cells expressing wild-type human 5-HT2A receptors, binding (Ki) of 0.19±0.01 nM. Separately, whilst 25B-NBOMe is considered to be not orally active, there are no current human data to confirm or refute this. This perception has seemingly affected the routes of administration of user products (Section 4.2). Based on user reports (Erowid), the initial effects are felt within 15 minutes (sublingual/buccal/insufflated) with a duration of effects of up to 12 hours (no information on dose). Further, unconfirmed timelines following use from collation of the Bluelight forum reports are:

- **Total duration**: 8-10 hours (sublingual/buccal) 6-10 hours (insufflated)
- **Onset**: 20-70 minutes (sublingual/buccal) 5-20 minutes (insufflated)
- **Coming up**: 30-60 minutes (sublingual/buccal) 20-40 minutes (insufflated)
- **Plateau**: 120-240 minutes (sublingual/buccal) 90-240 minutes (insufflated)
- **Coming down**: 1-5 hours (sublingual/buccal) 1-5 hours minutes (insufflated)

**4.2. Routes of administration and dosage**

Reported routes of administration for 25B-NBOMe include sublingual (especially “blotter” paper), buccal, nasal (insufflation and absorption of liquid solutions), oral, injection (intravenous and intramuscular), rectal and smoking. Information from case reports and user websites suggest a range of doses are used that may depend on the route of administration. Example doses reported on the Erowid user website include: ‘400 µg, sublingual’; ‘1250 µg, insufflated liquid’; ‘1250 µg, sublingual’; ‘500 µg, buccal’; ‘400 µg in liquid ethanol, vapoured’; (Erowid). Further examples are provided in Section 6 (see also: Blue Light Forum, Drug Forum).

Information from user websites suggest that 25B-NBOMe may be used on its own as well as in combination with other new psychoactive substances and/or controlled drugs (Erowid, Blue Light Forum, Drug Forum). This is supported by reported non-fatal intoxications and deaths following analysis of biological samples (Section 6).

**4.3. Pharmacokinetics**

**Animal studies**

There do not appear to be any published pharmacokinetic data for 25B-NBOMe in animals.
**Human studies**

Whilst there do not appear to be any published pharmacokinetic data for 25B-NBOMe in humans, Stellpflug et al (2013) and Soh and Elliott (2013) reported the presumed detection of a desmethyl metabolite of 25I-NBOMe and 25C-NBOMe, respectively (through predicted O-demethylation) in casework biological fluid and it would seem likely that 25B-NBOMe may exhibit a similar metabolic route. Although 25H-NBOMe was detected in a case involving 25B-NBOMe (Soh and Elliott, 2013) and also by Stellpflug et al. (2013) in a case involving 25I-NBOMe, this may not be through metabolism (due to the unclear existence of a metabolic pathway that would remove the halogen) and could be due to 25H-NBOMe being present as a contaminant in the product consumed (Stellpflug et al., 2013).

**5. Toxicology**

There are no published pre-clinical safety data available concerning the toxicity, reproductive impact and mutagenic/carcinogenic potential of 25B-NBOMe. However, as part of preclinical assessment of dosage for 25B-NBOMe in PET scanning, Ettrup et al. (2013) extrapolated from animal data that the effective dose of [11C]25B-NBOMe was 5–8 μSv/MBq with 1.5 g of 25B-NBOMe ultimately administered as part of PET studies.

User reports from Erowid described the following subjective effects of self-reported 25B-NBOMe;

“Positive” (including; strong open and closed eye visuals, mood lift, euphoria, empathy, mental and physical stimulation), “Neutral” (including; general change in consciousness, Change in perception of time, time dilation, sleepiness) and “Negative” (including; confusion, nausea and vomiting, paranoia, unwanted and overwhelming feelings).

Adverse effects reported in a single non-fatal case report included; tachycardia, hypertension, seizures, hyperpyrexia (Poklis et al. 2013). In a fatality reported by Soh and Elliott (2013), the deceased was reported to have vomited before becoming unconscious (Elliott 2014).

**6. Adverse reactions in humans**

A single non-fatal intoxication and a death associated with 25B-NBOMe have been reported in the USA (Poklis et al. 2013) and the United Kingdom (Soh and Elliott 2013), respectively. A further death was reported from Switzerland. All cases were analytically confirmed.

For the non-fatal case, a 19 year old male in prior good health was found by his roommates having “jerking movements”. He was taken to hospital. Observed adverse effects (as stated above) included tachycardia, hypertension, seizures and hyperpyrexia (Poklis et al. 2013). The patient required intensive medical treatment including intubation and sedation. He eventually recovered and was fully alert and orientated by day 6. A serum and urine specimen was obtained 39 hours after admission with 25B-NBOMe concentrations measured to be 180 pg/mL (0.18 ng/mL) in the serum and 1900 pg/mL (1.9 ng/mL) in the urine.
For the UK fatal case, in April 2013, a 19 year old male was reported to have vomited before becoming unconscious whereupon an ambulance was called but he was pronounced dead shortly after arrival. 25B-NBOMe was tentatively identified on a DVD (disc) thought to have been used to “snort” a substance. No further case information was available. Analysis of a post-mortem blood and urine specimen detected cannabinoids, paracetamol and 25B-NBOMe (Soh and Elliott 2013, Elliott 2014). The concentrations of 25B-NBOMe in the blood and urine were determined to be less than 6.25 ng/mL, the limit of detection of the assay (Elliott 2014).

In October 2013 in Switzerland, a 20 year old male (with psychiatric problems) died having thought to have used a pump spray containing 10 mL of an odourless liquid identified as 25B-NBOMe. 25B-NBOMe as well as cannabinoids and amphetamine were found in the post-mortem blood in concentrations indicating recent cannabis and amphetamine consumption without being clearly responsible for the death.

7. **Dependence potential**

No studies have examined the dependence potential of 25B-NBOMe in vitro, in animals or in humans.

8. **Abuse potential**

No studies have examined the abuse potential of 25B-NBOMe in vitro, in animals or in humans.

9. **Therapeutic applications and extent of therapeutic use and epidemiology of medical use**

25B-NBOMe has no recorded therapeutic applications or medical use. The use of radio-labelled 25B-NBOMe in medical research is discussed elsewhere.

10. **Listing on the WHO Model List of Essential Medicines**

25B-NBOMe is not listed on the WHO Model List of Essential Medicines.

11. **Marketing authorizations (as a medicine)**

25B-NBOMe has never been marketed as a medicine.

12. **Industrial use**

25B-NBOMe has no industrial use.

13. **Non-medical use, abuse and dependence**

25B-NBOMe use and/or seized material has been reported in Austria, Denmark, Germany, Hungary, Latvia, Spain, Sweden, Switzerland, the United Kingdom and the USA.
Also refer, Annex 1: Report on WHO questionnaire for review of psychoactive substances.

14. Nature and magnitude of public health problems related to misuse, abuse and dependence

Lawn et al undertook a study to examine the characteristics of users of 25B-NBOMe, 25C-NBOMe and 25I-NBOMe through the Global Drugs Survey (Lawn et al., 2014). A total of 22,289 responses were collected in late 2012. One-third (n = 7,360; 33.9%) of respondents were from the UK, 7,784 (35.9%) were from Australia, 3,756 (17.3%) were from the USA, 2,164 (10.0%) were from the rest of Europe, and 618 (2.9%) were from Canada. Most (68.6%) respondents were male and the mean age was 31.4 years (SD = 12.4; range 16 – 100). 2.6% of respondents (n = 582) reported having ever tried one of the three NBOMe drugs and that at 2.0%, 25I-NBOMe was the most popular (n = 442) followed by 25B-NBOMe (n = 267; 1.2%) and 25C-NBOMe (n = 65; 0.8%). Almost all (93.5%) respondents whose last new drug tried was a NBOMe drug and 81.2% of this group administered the drug orally or sublingually/buccally. Subjective effects were similar to comparison serotonergic hallucinogens, though higher 'negative effects while high' and greater 'value for money' were reported. The most common (41.7%) drug source was via a website. Information from seizures, collected samples and user websites suggest that 25B-NBOMe has been commonly sold as a ‘legal’ replacement for LSD or sold as LSD directly on the illicit drug market. In the latter case users may be unaware that they are using 25B-NBOMe. Nevertheless, it also appears to be associated with the purchase of “research chemicals” or equivalent products via the Internet as well clearly stated to be 25B-NBOMe “tabs”. Instances of misuse, abuse and dependence would be limited to such individuals rather than the general population. The mode of use may involve the combinational use (intentionally or unintentionally) of other drugs. However, analysis of various products have shown that the composition can differ (including between that claimed by the retailer) and the user is unlikely to be aware of the exact dose or compound being ingested (by whatever route) which presents an inherent risk to the individual.

Also refer, Annex 1: Report on WHO questionnaire for review of psychoactive substances.

15. Licit production, consumption and international trade

Not applicable.

16. Illicit manufacture and traffic and related information


17. Current international controls and their impact

Not applicable in relation to affecting impact of medical use.
18. **Current and past national controls**

25B-NBOMe is currently controlled under drug control legislation in Brazil, Denmark, Hungary, Israel, Romania, Russia, Sweden and areas of Australia (Queensland and New South Wales). Furthermore it is party to a temporary class order in the United Kingdom (from June 2013 to be reviewed in June 2014) and under temporary Schedule I control in the USA (November 2013).

Also refer, Annex 1: Report on WHO questionnaire for review of psychoactive substances.

19. **Other medical and scientific matters relevant for a recommendation on the scheduling of the substance**

Researchers have used radiolabelled 25B-NBOMe as a tool to study the serotonergic system in the brain (Ettrup et al., 2010, 2011 and 2013) as part of work that ultimately aims to further the understanding of the pathogenesis of human disease in which the serotonergic system may play a role. This includes research into its potential use as a tracer in Positron Emission Tomography (PET) imaging studies (Ettrup et al., 2010, 2011 and 2013).
References


Drug Enforcement Administration (2013). ‘2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe; 2C-I-NBOMe; 25I; Cimbi-5), 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe; 2CC-NBOMe; 25C; Cimbi-82) and 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe; 2C-B-NBOMe; 25B; Cimbi-36).’ Background information and evaluation of ‘Three Factor Analysis’ (Factors 4, 5 and 6) for temporary scheduling.

http://www.regulations.gov/contentStreamer?objectId=090000648147faf9&disposition=attachment&contentType=pdf


Erowid: http://www.erowid.org/experiences/subs/exp_25BNBOMe.shtml


Data were obtained from 72 WHO Member States (18 AFR, 13 AMR, 5 EMR, 29 EUR, 3 SEAR, 4 WPR).

A total of 65 Member States answered the questionnaire for 25B-NBOMe. Of these only 20 respondents (AMR 4, EUR 13, WPR 3) had information on this substance.

LEGITIMATE USE

No respondent reported that 25B-NBOMe was currently authorized or was in the process of being authorized/registered as a medical product in their country nor that it had any other use in health care. Four respondents stated that this substance was used in medical and scientific research. There was no use stated for animal/veterinary care. For legitimate use one each responded only importing, only manufacturing and both manufacturing and importing.

HARMFUL USE

Fourteen respondents confirmed recreational/harmful use; the common route of administration was oral in eight responses and for three this was by oral, inhaling/sniffing. For such use, 11 reported sourcing only via trafficking and one each via diversion plus trafficking and via clandestine manufacturing. Ten respondents reported on the common formulations available - two liquid, two powder, three powder and liquid, one powder and tablet and two tablet forms. Seven respondents described that it was used on blotter paper. Adulteration of other products is also reported. Four responded that it was used only in clubs, three only by the general population and in clubs. In general population, adolescents and young adults are specially mentioned. Three countries reported withdrawal, tolerance and other adverse effects or medical illnesses caused by 25B-NBOMe. These included intoxication, dizziness, headache, difficulty to sleep, agitation, death due to injuries related to intoxication.

One respondent mentions that higher doses of 25B-NBOMe may result in overdose and death. Three deaths were associated with 25B-NBOMe exposure in 2013. Drug induced toxicity and violent, erratic behaviour due to the abuse of 25I-NBOMe, 25C-NBOMe and 25B-NBOMe synthetic substances has led to numerous reports of emergency department admissions and deaths (Kelly et al., 2012; Rose et al., 2012; Rose et al., 2013; Hill et al., 2013; Stellpflug et al., 2013). Deaths have been reported for most routes of administration, including nasal insufflation, liquid solutions applied to nasal membrane, sublingual or buccal administration of blotter paper, and consumption of adulterated food items. Youth appear to be the primary abusers of these synthetic substances, as supported by the available emergency department reports and reports of death. The average age of decedents where 25I-NBOMe, 25C-NBOMe or 25B-NBOMe was confirmed to be a contributing factor in the death is 20 years (n=14). (See also information provided for 25I and C NBOME – these may have similar effects)
CONTROL

Of those with information on this substance, 14 reported that 25B NBOMe was controlled under legislation that was intended to regulate its availability; eight under “controlled substance act”, two under “medicines law”, one each as “temporary ban”, under “generic legislation” and under “analogue legislation”. Another one specified that this was included in a specific section of the national medicines law. Four respondents stated that there were problems with the implementation of this legislation. On illicit activities, two respondents reported processing into the consumer product, 11 reported trafficking, one diversion and 10 an internet market.

Details on seizures are presented below.

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(number of respondents)</td>
<td>(number of respondents)</td>
</tr>
<tr>
<td>Total number of seizures</td>
<td>No data</td>
<td>5 (4)</td>
</tr>
<tr>
<td>Total quantity seized (kg)</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Total quantity seized (other)</td>
<td>No data</td>
<td>Blotters – 280 (3) Tablets - 4,860 (200 mg) in 2013</td>
</tr>
</tbody>
</table>

IMPACT OF SCHEDULING

Nineteen respondents reported that if 25B NBOMe was placed under international control, they would have the laboratory capacity to identify the substance. This substance has no medical use reported.