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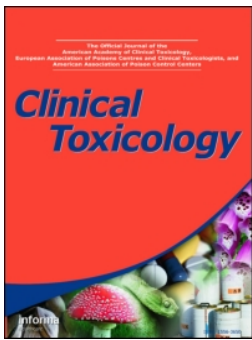
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LETTER TO THE EDITOR

U-47700 Reply

We appreciate the comments by Dr. Vo et al. for our recent case report regarding U-47700.[1] They suggest that the patient we described likely ingested a benzodiazepine that we did not test for, rather than U-47700 having caused a false positive on the drug screen used. As we demonstrated in the report, U-47700 itself can cause a false positive result on the screen used, but only at very high concentration. Therefore, we opined that the positive benzodiazepine screen resulted either from a metabolite of U-47700 or the presence of a benzodiazepine we did not test for. Although the patient denied having used other drugs, histories are not always accurate. Similarly, generalizing drug use patterns to an individual is not necessarily accurate either. Based on the case they describe, we retrospectively reviewed the ultra-performance liquid chromatography time-of-flight mass spectrometry data on the patient we reported and neither found the presence of phenazepam, nor its metabolite 3-hydroxyphenazepam (i.e., no matching exact mass data for either of these compounds). It still remains possible that another untested for benzodiazepine may have been present.

At the time of publication, due to the lack of reference standard, we were not able to definitively identify U-47700. Subsequent to publication, we obtained a reference standard through Cayman Chemicals (Ann Arbor, MI) and based

on a retention time match and high-resolution mass spectrometry data, we confirmed U-47700 was the drug used.

Disclosure statement

Authors report no conflicts of interest.

Reference

- [1] Schneir A, Metushi IG, Sloane C, et al. Near death from a novel synthetic opioid labeled U-47700: emergence of a new opioid class. *Clin Toxicol (Phila)*. 2016. [Epub ahead of print]. doi: 10.1080/15563650.2016.1209764.

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