LISTING OF EVIDENCE ATTACHED

Exhibit 1 - Chapter on FIBROMYALGIA from Harrison's Textbook of Internal Medicine, edition 19, ca. 2017

Exhibit 2 - GEOSPATIAL EFFECT of Ohio, parts of Kentucky and parts of W. Virginia - as shown from Cleveland, OH and Cincinnati, OH with Weather Forecast Radar Map

Exhibit 3 - Report to CDC of Tick Borne New Disease: Fibromyalgia (Scioto)

396 Fibromyalgia

Leslie J. Crofford

DEFINITION

Fibromyalgia (FM) is characterized by chronic widespread musculoskeletal pain and tenderness. Although FM is defined primarily as a pain syndrome, patients also commonly report associated neuropsychological symptoms of fatigue, unrefreshing sleep, cognitive dysfunction, anxiety, and depression. Patients with FM have an increased prevalence of other syndromes associated with pain and fatigue, including chronic fatigue syndrome (Chap. 464e), temporomandibular disorder, chronic headaches, irritable bowel syndrome, interstitial cystitis/painful bladder syndrome, and other pelvic pain syndromes. Available evidence implicates the central nervous system as key to maintaining pain and other core symptoms of FM and related conditions. The presence of FM is associated with substantial negative consequences for physical and social functioning.

EPIDEMIOLOGY

In clinical settings, a diagnosis of FM is made in ~2% of the population and is far more common in women than in men, with a ratio of ~9:1. However, in population-based survey studies worldwide, the prevalence rate is ~2–5%, with a female-to-male ratio of only 2–3:1 and with some variability depending on the method of ascertainment. The prevalence data are similar across socioeconomic classes. Cultural factors may play a role in determining whether patients with FM symptoms seek medical attention; however, even in cultures in which secondary gain is not expected to play a significant role, the prevalence of FM remains in this range.

CLINICAL MANIFESTATIONS

Pain and Tenderness At presentation, patients with FM most commonly report "pain all over." These patients have pain that is typically both above and below the waist on both sides of the body and involves the axial skeleton (neck, back, or chest). The pain attributable to FM is poorly localized, difficult to ignore, severe in its intensity, and associated with a reduced functional capacity. For a diagnosis of FM, pain

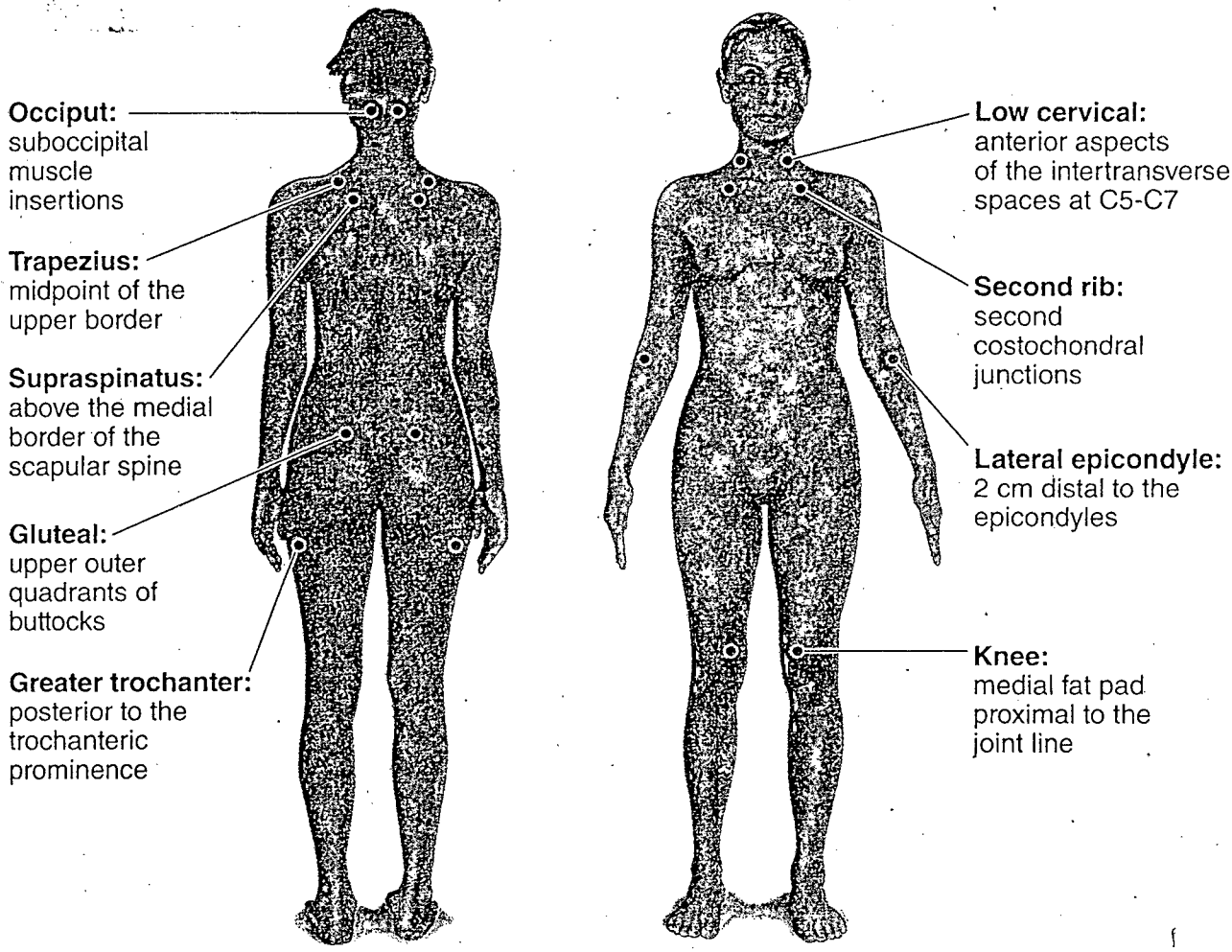


FIGURE 396-1 Tender-point assessment in patients with fibromyalgia.

(Figure created using data from F Wolfe et al: Arthritis Care Res 62:600, 2010.)

EXHIBIT 1

should have been present most of the day on most days for at least 3 months.

The clinical pain of FM is associated with increased evoked pain sensitivity. In clinical practice, this elevated sensitivity may be determined by a tender-point examination in which the examiner uses the thumbnail to exert pressure of ~4 kg/m^2 (or the amount of pressure leading to blanching of the tip of the thumbnail) on well-defined musculotendinous sites (Fig. 396-1). Previously, the classification criteria of the American College of Rheumatology required that 11 of 18 sites be perceived as painful for a diagnosis of FM. In practice, tenderness is a continuous variable, and strict application of a categorical threshold for diagnostic specifics is not necessary. Newer criteria eliminate the need for tender points and focus instead on clinical symptoms of widespread pain and neuropsychological symptoms. The newer criteria perform well in a clinical setting in comparison to the older, tender-point criteria. However, it appears that when the new criteria are applied to populations, the result is an increase in prevalence of FM and a change in the sex ratio (see "Epidemiology," earlier).

Patients with FM often have peripheral pain generators that are thought to serve as triggers for the more widespread pain attributed to central nervous system factors. Potential pain generators such as arthritis, bursitis, tendinitis, neuropathies, and other inflammatory or degenerative conditions should be identified by history and physical examination. More subtle pain generators may include joint hypermobility and scoliosis. In addition, patients may have chronic myalgias triggered by infectious, metabolic, or psychiatric conditions that can also serve as triggers for the development of FM. These conditions are often identified in the differential diagnosis of patients with FM, and a major challenge is to distinguish the ongoing activity of a triggering condition from FM that is occurring as a consequence of a comorbid condition and that should itself be treated.

Neuropsychological Symptoms In addition to widespread pain, FM patients typically report fatigue, stiffness, sleep disturbance, cognitive dysfunction, anxiety, and depression. These symptoms are present to varying degrees in most FM patients but are not present in every patient or at all times in a given patient. Relative to pain, such symptoms may, however, have an equal or even greater impact on function and quality of life. Fatigue is highly prevalent in patients under primary care who ultimately are diagnosed with FM. Pain, stiffness, and fatigue often

are worsened by exercise or unaccustomed activity (postexertional malaise). The sleep complaints include difficulty falling asleep, difficulty staying asleep, and early-morning awakening. Regardless of the specific complaint, patients awake feeling unrefreshed. Patients with FM may meet criteria for restless legs syndrome and sleep-disordered breathing; frank sleep apnea can also be documented. Cognitive issues are characterized as slowness in processing, difficulties with attention or concentration, problems with word retrieval, and short-term memory loss. Studies have demonstrated altered cognitive function in these domains in patients with FM, though speed of processing is age-appropriate. Symptoms of anxiety and depression are common, and the lifetime prevalence of mood disorders in patients with FM approaches 80%. Although depression is neither necessary nor sufficient for the diagnosis of FM, it is important to screen for major depressive disorders by querying for depressed mood and anhedonia. Analysis of genetic factors that are likely to predispose to FM reveals shared neurobiologic pathways with mood disorders, providing the basis for comorbidity (see later in this chapter).

Overlapping Syndromes Because FM can overlap in presentation with other chronic pain conditions, review of systems often reveals headaches, facial/jaw pain, regional myofascial pain particularly involving the neck or back, and arthritis. Visceral pain involving the gastrointestinal tract, bladder, and pelvic or perineal region is often present as well. Patients may or may not meet defined criteria for specific syndromes. It is important for patients to understand that shared pathways may mediate symptoms and that treatment strategies effective for one condition may help with global symptom management.

Comorbid Conditions FM is often comorbid with chronic musculoskeletal, infectious, metabolic, or psychiatric conditions. Whereas FM affects only 2–5% of the general population, it occurs in 20% or more of patients with degenerative or inflammatory rheumatic disorders, likely because these conditions serve as peripheral pain generators to alter central pain-processing pathways. Similarly, chronic infectious, metabolic, or psychiatric diseases associated with musculoskeletal pain can mimic FM and/or serve as a trigger for the development of FM. It is particularly important for clinicians to be sensitive to pain management of these comorbid conditions so that when FM emerges—characterized by pain outside the boundaries of what could reasonably be explained by the triggering condition, development of neuropsychological symptoms, or tenderness on physical examination—treatment of central pain processes will be undertaken as opposed to a continued focus on treatment of peripheral or inflammatory causes of pain.

Psychosocial Considerations Symptoms of FM often have their onset and are exacerbated during periods of high-level real or perceived stress. This pattern may reflect an interaction among central stress physiology, vigilance or anxiety, and central pain-processing pathways. An understanding of current psychosocial stressors will aid in patient management, as many factors that exacerbate symptoms cannot be addressed by pharmacologic approaches. Furthermore, there is a high prevalence of exposure to previous interpersonal and other forms of violence in patients with FM and related conditions. If posttraumatic stress disorder is an issue, the clinician should be aware of it and consider treatment options.

Functional Impairment It is crucial to evaluate the impact of FM symptoms on function and role fulfillment. In defining the success of a management strategy, improved function is a key measure. Functional assessment should include physical, mental, and social domains. A recognition of the ways in which role functioning falls short will be helpful in the establishment of treatment goals.

DIFFERENTIAL DIAGNOSIS

Because musculoskeletal pain is such a common complaint, the differential diagnosis of FM is broad. Table 396-1 lists some of the more common conditions that should be considered. Patients with inflammatory causes for widespread pain should be identifiable on the basis of specific history, physical findings, and laboratory or radiographic tests.

TABLE 396-1 COMMON CONDITIONS IN THE DIFFERENTIAL DIAGNOSIS OF FIBROMYALGIA

Inflammatory
Polymyalgia rheumatica
Inflammatory arthritis: rheumatoid arthritis, spondyloarthritides
Connective tissue diseases: systemic lupus erythematosus, Sjögren's syndrome
Infectious
Hepatitis C
HIV infection
Lyme disease
Parvovirus B19 infection
Epstein-Barr virus infection
Noninflammatory
Degenerative joint/spine/disk disease
Myofascial pain syndromes
Bursitis, tendinitis, repetitive strain injuries
Endocrine
Hypo- or hyperthyroidism
Hyperparathyroidism
Neurologic Diseases
Multiple sclerosis
Neuropathic pain syndromes
Psychiatric Disease
Major depressive disorder
Drugs
Statins
Aromatase inhibitors

LABORATORY OR RADIOGRAPHIC TESTING

Routine laboratory and radiographic tests yield normal results in FM. Thus diagnostic testing is focused on exclusion of other diagnoses and evaluation for pain generators or comorbid conditions (Table 396-2). Most patients with new chronic widespread pain should be assessed for the most common entities in the differential diagnosis. Radiographic testing should be used sparingly and only for diagnosis of inflammatory arthritis. After the patient has been evaluated thoroughly, repeat testing is discouraged unless the symptom complex changes. Particularly to be discouraged is advanced imaging (MRI) of the spine unless there are features suggesting inflammatory spine disease or neurologic symptoms.

GENETICS AND PHYSIOLOGY

As in most complex diseases, it is likely that a number of genes contribute to vulnerability to the development of FM. To date, these genes appear to be in pathways controlling pain and stress

TABLE 396-2 LABORATORY AND RADIOGRAPHIC TESTING IN PATIENTS WITH FIBROMYALGIA SYMPTOMS

Routine
Erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP)
Complete blood count (CBC)
Thyroid-stimulating hormone (TSH)
Guided by History and Physical Examination
Complete metabolic panel
Antinuclear antibody (ANA)
Anti-SSA (anti–Sjögren's syndrome A) and anti-SSB
Rheumatoid factor and anti–cyclic citrullinated peptide (anti-CCP)
Creatine phosphokinase (CPK)
Viral and bacterial serologies
Spine and joint radiographs

Source: LM Arnold et al: J Women's Health 21:231, 2012; MA Fitzcharles et al: J Rheumatol 40:1388, 2013.

2240 responses. Some of the genetic underpinnings of FM are shared across other chronic pain conditions. Genes associated with metabolism, transport, and receptors of serotonin and other monoamines have been implicated in FM and overlapping conditions. Genes associated with other pathways involved in pain transmission have also been described as vulnerability factors for FM. Taken together, the pathways in which polymorphisms have been identified in FM patients further implicate central factors in mediation of the physiology that leads to the clinical manifestations of FM.

Psychophysical testing of patients with FM has demonstrated altered sensory afferent pain processing and impaired descending noxious inhibitory control leading to hyperalgesia and allodynia. Functional MRI and other research imaging procedures clearly demonstrate activation of the brain regions involved in the experience of pain in response to stimuli that are innocuous in study participants without FM. Pain perception in FM patients is influenced by the emotional and cognitive dimensions, such as catastrophizing and perceptions of control, providing a solid basis for recommendations for cognitive and behavioral treatment strategies.

APPROACH TO THE PATIENT: Fibromyalgia

FM is common and has an extraordinary impact on the patient's function and health-related quality of life. However, its symptoms and impact can be managed effectively by physicians and other health professionals. Developing a partnership with patients is essential for improving the outcome of FM, with a goal of understanding the factors involved, implementing a treatment strategy, and choosing appropriate nonpharmacologic and pharmacologic treatments.

TREATMENT FIBROMYALGIA

NONPHARMACOLOGIC TREATMENT

Patients with chronic pain, fatigue, and other neuropsychological symptoms require a framework for understanding the symptoms that have such an important impact on their function and quality of life. Explaining the genetics, triggers, and physiology of FM can be an important adjunct in relieving associated anxiety and in reducing the overall cost of health care resources. In addition, patients must be educated regarding expectations for treatment. The physician should focus on improved function and quality of life rather than elimination of pain. Illness behaviors, such as frequent physician visits, should be discouraged and behaviors that focus on improved function strongly encouraged.

Treatment strategies should include physical conditioning, with encouragement to begin at low levels of aerobic exercise and to proceed with slow but consistent advancement. Patients who have been physically inactive or who report postexertional malaise may do best in supervised or water-based programs at the start. Activities that promote improved physical function with relaxation, such as yoga and Tai Chi, may also be helpful. Strength training may be recommended after patients reach their aerobic goals. Exercise programs are helpful in reducing tenderness and enhancing self-efficacy. Cognitive-behavioral strategies to improve sleep hygiene and reduce illness behaviors can also be helpful in management.

PHARMACOLOGIC APPROACHES

It is essential for the clinician to treat any comorbid triggering condition and to clearly delineate for the patient the treatment goals for each medication. For example, glucocorticoids or nonsteroidal anti-inflammatory drugs may be useful for management of inflammatory triggers but are not effective against FM-related symptoms. At present, the treatment approaches that have proved most successful in FM patients target afferent or descending pain pathways. Table 396-3 lists the drugs with demonstrated effectiveness. It should be emphasized strongly that opioid analgesics are to be avoided in patients with FM. These agents have no demonstrated efficacy in FM and are associated with opioid-induced hyperalgesia that can worsen both symptoms and function. Use of single agents to treat multiple symptom domains is strongly encouraged. For example, if a patient's symptom complex is dominated by pain and sleep disturbance, use of an agent that exerts both analgesic and sleep-promoting effects is desirable. These agents include sedating antidepressants such as amitriptyline and alpha-2-delta ligands such as gabapentin and pregabalin. For patients whose pain is associated with fatigue, anxiety, or depression, drugs that have both analgesic and antidepressant/anxiolytic effects, such as duloxetine or milnacipran, may be the best first choice.

TABLE 396-3 PHARMACOLOGIC AGENTS EFFECTIVE FOR TREATMENT OF FIBROMYALGIA

Antidepressants: balanced serotonin–norepinephrine reuptake inhibitors

- Amitryptiline[a]
- Duloxetine[b,c]
- Milnacipran[b,c]

Anticonvulsants: ligands of the alpha-2-delta subunit of voltage-gated calcium channels

- Gabapentin
- Pregabalin[b]

[a]RA Moore et al: Cochrane Database Syst Rev 12:CD008242, 2012. [b]Approved by the U.S. Food and Drug Administration. [c]W Hauser et al: Cochrane Database Syst Rev 1: CD010292, 2013.

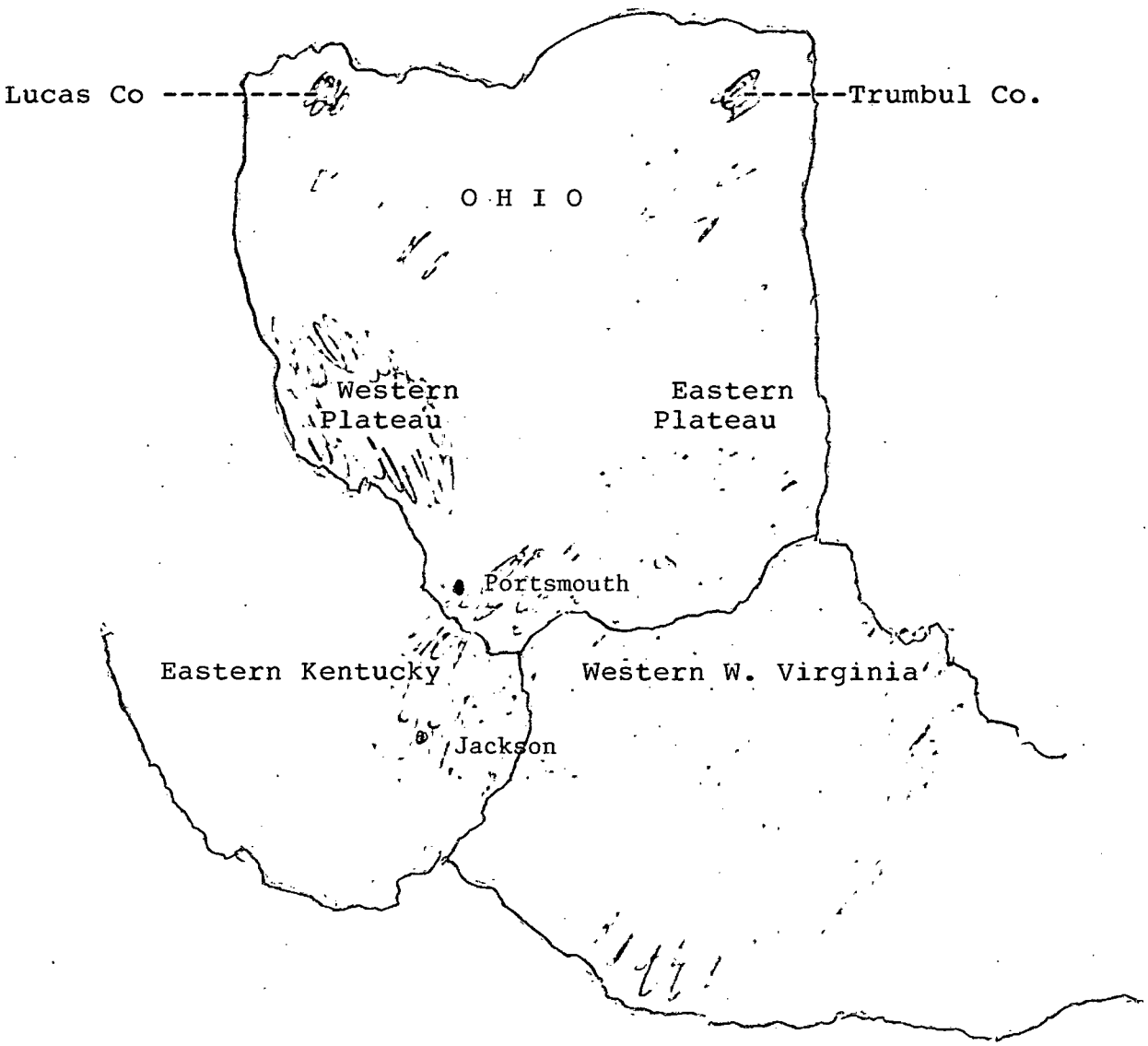
Source: LM Arnold: Arthritis Rheum 56:1336, 2007.

Combined geospatial effect of Ohio,(as seen from Cleveland) and Ohio, Kentucky and W. Virginia (as seen from Cincinnati) on TV Doppler radar weather map - hand drawing

Ohio - 2 eyes, 2 cheeks
Kentucky - solid belt going south from Ohio's Eastern Plate
W. Virginia - Western part displayed on TV is covered

In Ohio geospatial effect is the same as RMSF distribution and Oxycodone use per capits.

Geospatial effect is caused by topography and vegetation.



Evidence # 2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

Tick-Borne Rickettsial Disease Case Report

Use for: Spotted fever rickettsiosis (SFR) including Rocky Mountain spotted fever (RMSF), Ehrlichiosis (*E. chaffeensis*, *E. ewingii*, & undet.), and Anaplasmosis (*A. phagocytophilum* & undet.).
Visit http://www.cdc.gov and use "Search" for complete Case Definition(s) or visit the disease web site(s) for a fillable/downloadable PDF version of this Case Report.

CDC# ____ (1-4)

Form Approved OMB 0920-0009

Date submitted: 04/14/2011 (5-6) (7-8) (9-12) (mm/dd/yyyy)
Physician's name: Christopher Stegawski
Phone no.: 440 781 6240
NETSS ID No.: (if reported) Case ID (13-18) Site (19-21) State (22-23)

1. State of residence: Postal abrv: OH (24-25)
2. County of residence: (26-50) Cuyahoga
History of travel outside county of residence within 30 days of onset of symptoms?: 1 [✓] YES 2 [ ] NO 9 [ ] Unk
3. Zip code: (51-59) 44145
4. Sex: (60) 1 [✓] Male 9 [ ] Unk 2 [ ] Female
5. Date of birth: 12/14/1949 (61-62) (63-64) (65-68) (mm/dd/yyyy)
6. Race: (69) 1 [✓] White 3 [ ] American Indian Alaskan Native 5 [ ] Pacific Islander 2 [ ] Black 4 [ ] Asian 9 [ ] Not specified
7. Hispanic ethnicity: (70) 1 [ ] Yes 2 [✓] No 9 [ ] Unk
8. Indicate Disease (Presumed) To Be Reported: (71) 1 [ ] SFR (including RMSF) 3 [ ] Anaplasmosis - *A. phagocytophilum* 5 [✓] Ehrlichiosis/Anaplasmosis - Undetermined 2 [ ] Ehrlichiosis - *E. chaffeensis* 4 [ ] Ehrlichiosis - *E. ewingii*

9. Was a clinically compatible illness present? If there is no presence of clinical illness, then this is not a case. (72)
Clinical evidence - fever and one or more of the following: rash (primarily SFR), headache, myalgia, anemia, leukopenia (Ehrlich. & Anaplas.), thrombocytopenia, or elevated hepatic transaminases. 1 [✓] YES 2 [ ] NO 9 [ ] Unk
Eschar (aka tache noire) or black, necrotic area around site of known/possible tick bite present? 1 [ ] YES 2 [ ] NO 9 [✓] Unk
10. Date of Onset of Symptoms: 08/15/2010 (73-80) (mm/dd/yyyy)

11. Was an underlying immunosuppressive condition present? (81) 1 [ ] YES 2 [✓] NO 9 [ ] Unk
Specify condition(s): _____
12. Specify any life-threatening complications in the clinical course of illness: (82)
1 [ ] Adult respiratory distress syndrome (ARDS) 3 [ ] Meningitis/encephalitis
2 [ ] Disseminated intravascular coagulopathy (DIC) 4 [ ] Renal failure 9 [✓] None
8 [ ] Other: _____

13. Was the patient hospitalized because of this illness? (83) (If yes, date)
1 [ ] YES 2 [✓] NO 9 [ ] Unk ____ ____ ____ (84-85) (86-87) (88-91) (mm/dd/yyyy)
14. Did the patient die because of this illness? (92) (If yes, date)
1 [ ] YES 2 [✓] NO 9 [ ] Unk ____ ____ ____ (93-94) (95-96) (97-100) (mm/dd/yyyy)

15. Name of laboratory: _____ **City:** _____ **State:** ___ **Zip:** _____ - _____

Below, indicate Y (Yes) or N (No), **ONLY** if the test or procedure was performed. **Lack of selection** indicates that the test or procedure was not performed.

16. Serologic Tests	Serology 1 COLLECTION DATE (mm/dd/yyyy) (101-2) (103-4) (105-8) Titer	Positive?	Serology 2* COLLECTION DATE (mm/dd/yyyy) (109-10) (111-12) (113-16) Titer	Positive?
IFA - IgG	(_____)	1 [ ] YES 2 [ ] NO (117)	(_____)	1 [ ] YES 2 [ ] NO (118)
IFA - IgM	(_____)	1 [ ] YES 2 [ ] NO (119)	(_____)	1 [ ] YES 2 [ ] NO (120)
Other test: (121-130) _____	(_____)	1 [ ] YES 2 [ ] NO (131)	(_____)	1 [ ] YES 2 [ ] NO (132)

*Was there a fourfold change in antibody titer between the two serum specimens? 1 [ ] YES 2 [ ] NO (137)

17. Other Diagnostic Test? (Use #16, S1 for collection date)	Positive?
PCR	1 [ ] YES 2 [ ] NO (133)
Morulae visualization*	1 [ ] YES 2 [ ] NO (134)
Immunostain	1 [ ] YES 2 [ ] NO (135)
Culture	1 [ ] YES 2 [ ] NO (136)

*Visualization of morulae not applicable for SFR.

18. Classify case BASED ON the CDC case definition (see criteria below): (138)
1 [ ] SFR (including RMSF) 2 [ ] Ehrlichiosis - *E. chaffeensis*
3 [ ] Anaplasmosis - *A. phagocytophilum* 4 [ ] Ehrlichiosis - *E. ewingii*
5 [ ] Ehrlichiosis/Anaplasmosis - Undetermined
(139-148)
(149) 1 [ ] CONFIRMED 2 [ ] PROBABLE

State Health Department Official who reviewed this report:
Name: _____
Title: _____ Date: _____ (mm/dd/yyyy)

COMMENTS: This is a case of new disease (rickettsial) which presents as fibromyalgia (Scioto) and responded to antibiotic

Confirmed SFR (including RMSF): A clinically compatible case with evidence of a fourfold change in IgG antibody titer reactive with *Rickettsia rickettsii* or other SFR antigens by IFA between paired serum specimens, one taken during the first week of illness and a second 2-4 weeks later, OR detection of *R. rickettsii* or other SFR DNA in a clinical specimen via amplification of a specific target by PCR assay, OR demonstration of SFR antigen in a biopsy/autopsy specimen by IHC, OR isolation of *R. rickettsia* or other SFR species from a clinical specimen in cell culture.

Probable SFR (including RMSF): A clinically compatible case with evidence of elevated IgG or IgM antibody reactive with *R. rickettsii* or other SFR antigens by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination (CDC uses an IFA IgG cutoff of ≥1:64 and does not use IgM test results as independent diagnostic support criteria.).

Note: Current commercially available ELISA tests cannot evaluate changes in antibody titer. IgM tests may be unreliable because they lack specificity. IgM antibody may persist for lengthy periods of time. When sera demonstrate elevated antibody responses to multiple infectious agents among rickettsial species, and between ehrlichial and anaplasmal species, the greater antibody response is generally directed at the actual agent involved.

Confirmed Ehrlichiosis/Anaplasmosis: A clinically compatible case with evidence of a fourfold change in IgG antibody titer reactive with *Ehrlichia chaffeensis or Anaplasma phagocytophilum* antigen by IFA between paired serum specimens (one taken during the first week of illness and a second 2-4 weeks later) OR detection of *E. chaffeensis* or *A. phagocytophilum* DNA in a clinical specimen via amplification of a specific target by PCR assay, OR demonstration of ehrlichial or anaplasmal antigen in a biopsy/autopsy specimen by IHC, OR isolation of *E. chaffeensis* or *A. phagocytophilum* from a clinical specimen in cell culture.

Probable Ehrlichiosis/Anaplasmosis: A clinically compatible case with evidence of elevated IgG or IgM antibody reactive with *E. chaffeensis* or *A. phagocytophilum* antigen by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or assays in other formats (CDC uses an IFA IgG cutoff of ≥1:64 and does not use IgM test results as independent diagnostic support criteria.), OR identification of morulae in the cytoplasm of monocytes or macrophages (Ehrlichiosis) or in the cytoplasm of neutrophils or eosinophils (Anaplasmosis) by microscopic examination.

Exhibit # 3

No. 20-7438

IN THE

SUPREME COURT OF THE UNITED STATES

CHRISTOPHER STEGAWSKI - PETITIONER

vs,

UNITED STATES OF AMERICA - RESPONDENT

ON PETITION FOR A WRIT OF NEWLY DISCOVERED EVIDENCE MOTION FIBROMYALGIA SCIOTO IN FEDERAL LITIGATION

THE SUPREME COURT OF THE UNITED STATES Denial of Certiorari

(NAME OF COURT THAT LAST RULED ON MERITS OF YOUR CASE)

CHRISTOPHER STEGAWSKI, pro se

REG. 58010-060

FCI Satellite Camp

P.O.Box 6001, Ashland, KY 41105

TABLE OF AUTHORITIES CITED

CASES

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RULES

IN THE SUPREME COURT OF THE UNITED STATES

CHRISTOPHER STEGAWSKI Petitioner-Defendant	)	Case No. 20-7438
v	)	NEWLY DISCOVERED EVIDENCE MOTION
UNITED STATES OF AMERICA Respondent-Plaintiff	)	FIBROMYALGIA SCIOTO IN FEDERAL LITIGATION

Petitioner Christopher Stegawski, prisoner pro se in forma pauperis is bringing instant Motion under FRCvP Rule 60(b)(2) to supplement Petition for Certiorari Rehearing.

The evidence was discovered about August 2020 prompted by denial of §2255 Motion with among others conclusion that Petitioner was not using long acting Oxycontin "as reputable physicians" did. Petitioner conducted search for a case contradictory to above statement , Federal Lawsuit against Purdue Pharma for promoting more dangerous Oxycontin to physicians. That case is: 495 F.Supp 2d 569, 576 (WD VA July 23, 2007) US v Purdue Frederick Co. At the time case settled with payment over 500 millions $, the same Plaintiff filed case against Petitioner, i.a. for not using Oxycontin. Both using and not using Oxycontin was cause of prosecution. Plaintiff obliged to act in the face of massive opiates use was taking any action stemming from the fact: cause of massive opiates use was unknown.

Searching for more cases under "oxycontin" and "fibromyalgia" in the 4th Circuit Petitioner found many cases like:

IN THE SUPREME COURT OF THE UNITED STATES

CHRISTOPHER STEGAWSKI Petitioner-Defendant	)	Case No. 20-7438
v	)	NEWLY DISCOVERED EVIDENCE MOTION
UNITED STATES OF AMERICA Respondent-Plaintiff	)	FIBROMYALGIA SCIOTO IN FEDERAL LITIGATION

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Searching for more cases under "oxycontin" and "fibromyalgia" in the 4th Circuit Petitioner found many cases like:

2018 US Dist Lexis 24994 Frazier v Berryhill Feb 1, 2018, 4th Dist

2014 US Dist Lexis 182497 White v Colvin Sep 3 2014, 4th Dist

2012 US Dist Lexis 127615 Pennington v Astrue Feb 8, 2012, 4th Dist

The defendants in those cases are commissaries of Social Security and cases are for denial of disability coverage. (above cases came from search "oxycontin" "fibromyalgia" "zanaflex" - terms associated with chronic pain treatment).

Surprising in those cases was meticulous description by Magistrate Judges of health problems patients had and consistent with Petitioner's description of Fibromyalgia scioto.

People of all ages

too sick to work --- unable to cope with their disease --- not sick enough for disability.

Typical history is:

Years of various forms of chronic pain, incapable of physical work, easily tired and exhausted, additional anxiety, panic disorder, depression, peripheral neuralgia, headaches, insomnia, memory impairment.

Treated by "twenty doctors", with "fifty medications", including opiates, BZDZs, antidepressants, having invasive pain treatments; and nothing works.

On each visit presenting different, new symptoms. Because of changing complaints and not remembering suspected of malingering, there is something "wrong with his/her head", sent to psychiatrist because the symptoms don't make sense.

Treating physicians and conducting evaluations for disability have "credible doubts about his report of pain or other symptoms"

(in Lawrence v Berryhill), diagnosing "total somatic dysfunction" (in translation: whole body malfunction)- Dr. Pellegrino, leading expert on fibromyalgia. And ALJ "did not adequately evaluate the medical opinion. Just because every doctor has different opinion, including Petitioner, who never before confronted so many unused diagnoses. Number of diagnoses and symptoms is staggering. But patients tell "my whole body hurts".

The pleio- [or pleo] -morphic disease, changing shapes like chameleon colors, multisymptoms disease with transient presentation.

Petitioner prepared two tables:

FIBROMYALGIA in Federal litigation - search on Lexis Law Library

about August 10, 2020

Search for: fibromyalgia AND Oxycodone (Oxy) + or Oxycontin (TIN) or Percocet (CET)

District		Fibromyalgia	+Oxy	+TIN	+CET
I	1991-Present	755	14	9	30
II	2007-Present	1175	37	21	59
III	2005-Present	1088	48	27	63
IV	2012-Present	1500	56	24	71
V	2012-Present	446	10	6	12
VI	2013-Present	1808	44	26	120
VII	2005-Present	1537	38	34	72
VIII	2012-Present	1284	77	29	94
IX	2014-Present	2307	100	25	80
X	2000-Present	1259	23	16	25
XI	2012-Present	1144	32	13	37
DC	Prior-Present	46	0	1	0
	Total	14349			

14.349 people appealed denial of disability to District Courts in last periods. Search by fibromyalgia and Oxycodone, Oxycontin or Percocet. About 10% of people with fibromyalgia also use oxycodone in various forms.

In second table Sixth and Ninth Districts with highest numbers of cases are evaluated in all available on Lexis periods.

District	Period	Fibromyalgia	+Oxy	+TIN	+CET
6th	2013-Present	1808	44	26	120
6th	2004-2012	1165	12	27	43
6th	Prior-2004	92	0	0	1
9th	2014-Present	2307	100	25	80
9th	2011-2013	892	24	17	22
9th	2007-2010	506	15	12	20
9th	1995-2006	173	0	1	1
9th	Prior-1994	3	0	0	0

6th Cir. 2004 - 2012 (8 years) - 1165 cases

2013 - 2020 (7 years) - 1808 cases

9th Cir 2007 - 2013 (6 years) - 1398 cases

2014 - 2020 (6 years) - 2307 cases

It shows increases about 50% between the periods. There is correlation between increases of fibromyalgia cases and increased use of all forms of oxycodone reflecting "opiate epidemic".

There were cases in Courts of Appeals, like :

798 Fed Appx 34, 2020 US app Lexis 8385, Marquardt v Saul, 7thCir

That case originated as:

17-cv-1489 7th Dist

Symptoms were frequent fatigue, memory loss, ADD - causing fatigue, cognitive impairment. And SLE- systemic lupus erythematodes.

Petitioner's comment:"ADD causing fatigue". My perception that ADD is sign of Central Nervous System involvement-CNS, and fatigue is due to muscle disease caused by the same factor: chronic bacterial infection.

Other: SLE is rare autoimmune disease, it's reporting seems to be more frequent with fibromyalgia, also reported as autoimmune disease. There seems to be something to be discovered in this association with fibromyalgia scioto.

Patient's report: take morning walk...return home "to get as much done as I can before my entire cognitive shuts down, and I lose the rest of my day".

That is consistent with Petitioner's observation that attention span, mental exhaustion after short time goes along with physical fatigue and muscle pain - the signs of systemic bacterial infection.

Sofar is only one case in Supreme Court:

Julie Heimeshoff v Hartford Life, 571 US 99 (2013)

- denial of disability benefits
- patient diagnosis: fibromyalgia + SLE

Both diseases considered incurable, autoimmune.

Autoimmune means: suddenly without apparent reason immune system loses identification of its body immune antigenecity, something

to transplant rejection (i.e."host v transplant") and "transplant v host" immune system loses recognition of own tissue, what was encoded in embryonal or neonatal stage and protects the body from self destruction by immune system attacking it's own tissues.

Intracellular bacteria find the way to get in and stay within the cells protected by cellular membrane from gammaglobulins and immune cells. Intracellular diseases were diagnosed by looking under microscope at stained blood smears for inclusions in white cells or for malaria causing Plasmodium vivax in erythrocytes.

Then came Medicare and ruled that first blood culture has to be done for bacteria to multiply and smear looked at after bacterial growth. But intracellular bacteria don't grow on standard media (food). Possibly it was a reason why Lyme disease was not discovered till 1980 and fibromyalgia became autoimmune disease.

Petitioner was not able to have blood smear done on his own blood pretrial because no hospital would do it because of Medicare regulation. Lyme disease and RMSF are diagnosed by PCR technigue like COVID-19 virus.

In 2010 and 2011 descriptions of fibromyalgia were simple:
"fibromyalgia" - "musculoskeletal impairments"
(2010 US Dist Lexis 55875 Reel v Astrue March 2, 2010) 4th Dist
"fibromyalgia - tender points" and "myofascial pain syndrome"
(2010 US Dist Lexis 83043 Davis v Astrue Jan 28 2010)4th Dist
"Fibromyalgia - rheumatic disease, symptoms: significant pain, fatigue, tenderness, stiffness of joints, sleep disturbed"
Diagnosed by 7/18 tender points
(632 F.3d 860 DuPerry v Life INS Jan 24 2011 4th Cir).

Nowadays description in 4th Cir is more complex than in description in Harrison's Textbook of Internal Medicine, Evidence # 1,

Recently Fibromyalgia became recognized as separate disease and got code M79.7 Fibromyalgia (Sep 30, 2019)

"fibromyalgia is diagnosed 'entirely on the basis of patient's reports of pain and other symptoms', "there is no laboratory test to confirm the diagnosis"

(2020 US Dist Lexis 86424 Maria D.C v Saul, May 15, 2020 9th Dist)
Previously as 729.1 - Myalgia and myositis, unspecified)

Petitioner reading descriptions from 9th Cir. noticed difference from 4th Cir. Either it's just impression or there might be difference in symptoms between East and West Coast.

Validity of evidence

Government expressed doubt as to validity of Petitioner discovery of the disease. Following is brief analysis:
1° - Petitioner started diagnosing set of similar symptoms among patients in Fall 2010, not before. Several patients were describing

similar symptoms. Petitioner referred 2-3 patinents to rheumatologist to confirm diagnosis, but it coincided with separation from Callihans. Were patients reports because of new infections, activation previous infection or the finishing of Xanax tapering what made patients more lucid and talkative, is unclear.

2° - Retrospectively many patients were presenting on and off same symptoms during entire year of observation.

3° - Petitioner after "summer malaise" that suggested mild RMSF developed slowly symptoms of fibromyalgia like patients had. It was during firs year of living in Southern Ohio, epicenter of opiate use.

4° - Petitioner took one course of antibiotic. Symptoms went away and relapsed month later.

5° - Published by Ohio Department of Health presentation on Opiate Epidemic contained 5 maps, one looked familiar. Looking again at distribution of RMSF in Ohio Petitioner noticed that both maps opiate use and distribution of RMSF are identical. This observation has very high evidentiary value - conclusion is that tick disease like RMSF leads to massive opiates use. That was in 2012.

6° - In 2014 Petitioner noticed that background of Doppler weather map looks the same as distribution of RMSF and opiate use. The picture imlies that it shows tick habitat.

7° - Finding 14,000 disability cases of people with symptoms of the disease applies for disability and uses opiates for pain. give highly reliable evidence of existence of the disease and association with significant pain

Attached is evidence # 2 with distribution of geospatial effect in Ohio, Kentucky and W.Virginia. Map is hand drawing of radar TV weather map shown in Cleveland and Cincinnati.

Christopher Stegawski
58010-060
FCI Sattelite Camp
P O Box 6001, Ashland, KY 41105

July 5, 2021

Clerk of Supreme Court
First Street NE
Washington, DC 20543

Re: Petition for Rehearing
No 20-7438

Dear Sir,

I mailed Petition for Rehearing few days ago by certified mail. Enclosed are Tables of authorities, index to Newly Discovered Evidence and trade names of medications.

Please attache these to the Petition.

Also enclosed is typed version of Petition for Certiorari which was already denied, just in case as it is easier to read.

Sincerely,

Christopher Stegawski

TABLE OF AUTHORITIES CITED

CASES

STATUTES AND RULES

Case-in-chief documents

Medications listed on page 2240-3

GENERIC AND TRADE NAMES

Amitryptiline

Duloxetine - Cymbalta

Milnacipran - Savella

Gabapentin - Neurontin

Pregabalin - Lyrica

Exhibit 1

TABLE OF AUTHORITIES CITED

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I N D E X

to NEWLY DISCOVERED EVIDENCE MOTION
FIBROMYALGIA SCIOTO IN FEDERAL LITIGATION

Page

Certiorari

Index

~ to Newly Discovered

Evidence Motion

IN THE UNITED STATES SUPREME COURT

CHRISTOPHER STEGAWSKI Petitioner	)	Case No. 20-7438
	)	
	)	Typed copy of the
v	)	PETITION FOR CERTIORARI
	)	
	)	- replacement for hand
UNITED STATES OF AMERICA Respondent	)	written original

Christopher Stegawski, Petitioner pro se, provides typewritten copy of previously filed Petition for Certiorari.

Due to COVID-19 lockdown and restrictions, some of which are still in effect, Petitioner was able only to prepare hand-written version.

Copy has addition of few sentences on page 40 and few insignificant stylistic corrections.

Sincerely,

Christopher Stegawski, pro se
58010-060
FCI Satellite Camp
POBox 6001
Ashland, KY 41105

Cerificate of Service
A copy of this filing is provided to U.S. Attorney Office together with Petition for Rehearing

Christopher Stegawski June 10, 2021

STATEMENT OF THE CASE

QUESTIONS EXPLAINED

STATEMENT OF THE CASE

QUESTIONS EXPLAINED

Q#1 - When pain of more than three months duration becomes chronic pain (by Ohio definition) and dependence (ie. addiction) forms after three months of opiate treatment (by Ohio definition) does it make all chronic pain treatment prescribing to addicts; what closes legal window for chronic pain treatment?

On first day of chronic pain the patient becomes also addicted.

Explanation:

Everyone (100%) of patients taking opiates for longer time (by definition - 3 months in Ohio) becomes dependent on opiates and has withdrawal symptoms if abruptly deprived. (Ground 49, §2255 Motion, and Exhibit, FDA Statement April 9, 2019).

If dependence is defined as addiction or part of it, that makes 100% of chronic pain patients addicted to opiates; and as prosecutors claim addicted patient is an addict,and addict is §802-Addict; than all chronic pain tx - treatment becomes prescribing to addicts, according

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STATUTES AND RULES

Doc 1 §2255 Motion, case 1:19-CV-00428

Ground # 20 - Addicts, witness Steele testimony Question #2

22 - Requested to leave courtroom Question #5

26, 27, 29 - Ineffective Assistance of Counsel

36 - Moore (1975) comparison 12

37 - Conspiracy

38 - §801

39 - §802

40 - §841

45 - Probability of being 7, 40
treated by incompetent physician

FDA Statement, April 9, 2019 - Statement by Douglas Throckmorton, M.D. on new opioid analgesic labeling changes...how to properly taper patients who are physically dependent on opioids 4, 32

to federal law illegal and every physician who prescribes opiates for chronic pain violates the law.

With such interpretation even government medical expert, Dr. Gronbach, testifying at Petitioner's trial commits the same "crime" as Petitioner, since he is prescribing opiates for chronic pain and all his patients are dependent on opiates(1).

Prosecution for dependence (part of addiction) is prosecution for property of medications; when every patient develops dependence, prosecution for dependence becomes "closing the window of chronic pain treatment". Opiates are used despite causing addiction, because there is nothing known equally effective in pain tx. Addiction is caused by presence of opiates, no matter how prescribed and in what dose, taken as prescribed or irregularly. It is somewhat similar to allergy, although it is not immune response(2).

FN (1) - see page 27

FN (2) - see page 6

Footnotes:

(2) During testimony at trial (transcript p.63 and following) Petitioner presented his concept that opiates interfere with our instinct function by creating harmful, instinct-like a QUASI-INSTINCT that is devoid of life supporting. Our instincts give us withdrawal symptoms, like hunger and thirst, opiates do too. That may be the reason why it is so difficult to abstain from opiates. Opiates work through opiate receptors, which are endorphines receptors , part of brain's hormonal system, controlling instinct and hedonism. Giving prednisone for longer time causes adrenal atrophy and require lifetime substitution; does atrophy of endorphines system affect patients' ability to stay off opiates? - is unanswered question by science. The history of judge Baumgartner from Tennessee is a reminder that opiate addiction is a subcortical function, stronger than education and will. Petitioner did not get that far in his clinical practice to answer this question: shall patients coming of opiates be treated like §802-Addicts? The answered question is: Xanax is not addictive, just requires 8-10 months to taper.

Footnotes: [to page 15, and page 16]

(3) Ground 45 of §2255 Motion has calculation of: "Probability of being treated by incompetent physician". For 8 physicians in a row probability is billion times smaller than probability of DNA being wrong.
That implies that systemic error is a reason for physicians prosecution.

(4) "A controversy existed for fifty years" - that was 45 years ago.

Q#2 - Is chronic pain patient a §802-Addict and chronic pain treatment prescribing to addicts, and shall chronic pain treatment and prescribing to addicts be prosecuted the same way?

Explanation:

"in interpretation of a criminal statute subject to the rule of lenity the U.S. Supreme Court cannot give the text a meaning that is different from its' ordinary, accepted meaning, and that disfavors the defendant".

(Moskal v. U.S., 498 US 103, 107-8 (1990))

In common language, term addiction describes both dependence and psychological addiction, person suffering from addiction is an addict, person using street drugs and medical opiates is an addict, drug seeker (deprived of opiates) is also an addict. In medicine addiction has been divided into: 1° - dependence, giving need to take next dose and causing acute withdrawal and 2° -

psychological addiction causing cravings and leading to relapses. "Addiction syndrome" - is genetic tendency to become addicted psychologically; person addicted to one substance has 7 times higher probability to become addicted to the next substance; common substances are: alcohol, nicotine, opiates including heroin. About 20% of population has addiction syndrome, 100% - will develop dependence. Petitioner's perception is that persons with addiction syndrome will have more problems during addiction treatment and more relapses than other 80% of people, but they will be majority of patients undergoing addiction treatment.

Among petitioner's patients about 98-99% patients were also nicotine smokers (and all patients-witnesses testifying who were asked). Kentucky that has one of the highest rates of smoking at 35% also is one of the states having highest opiate use for pain.

Federal law is based on classic, common language understanding of addict and addiction; medical division into dependence and psychological addiction is not reflected in federal law. Person taking opiates is addicted and addicted person is an addict. And person deprived opiates is an addict.

Federal law does not recognize pain, chronic pain and chronic pain treatment; there is no pain and pain treatment. There is only Legitimate Medical Purpose of §1306.04, that is not defined, but undergoes case-by-case analysis, (in 736 F.3d 1013 U.S. v Volkman, 6th Cir 2013).

> "we have endorsed a broad approach to determining what conduct falls outside the accepted bounds of professional practice so as to constitute a CSA violation, eschewing a preestablished list of prohibited acts in favor of a case-by-case approach"
> (see U.S. v Kirk 584 f.2d 773, 784 6th Cir 1978)

Prosecution used the difference between common language meaning of addiction/addict and medical division of addiction into dependence and addiction in witness Steele testimony. Prosecutor asked her

if patients, who's name he red from the list and she confirmed for each one that he is (in 2015, not in 2010) an addict, because he had withdrawal symptoms. These patients were not available as witnesses for confrontation. This way lay witness gave common language of word addict as medical diagnosis of addiction, but it only indicated that those patients were dependent. Prosecutor used this as bait-n-switch to conclude that all patients were addicts and Petitioner was prescribing to addicts, meaning §802-Addicts.

When pain is disregarded, with the absence of Federal Chronic Pain Treatment Law, all use of opiates for chronic pain becomes treating patients without Legitimate Medical Purpose, ie. prescribing to addicts. With all chronic pain patients developing dependence all chronic pain treatment becomes illegal, because of using common language word "addiction" to describe "medical dependence"; chronic pain treatment window becomes shut.

Steele testimony is Ground 20 of the §2255 Motion.

Ground 36 is comparision of

- Moore (1975) - case of providing freely methadone to heroine addicted people

with

- case-in-chief - Stegawski (2015) - tapering of multimedication treatment of chronic pain that resulted in elimination of overdose mortality, while opiates (oxycodone) were restricted to below textbook daily dose for chronic pain of 240 mg. Multiple physicians treating the same patients for years before and after Petitioner by issuing prescriptions certified that patients had Legitimate Medical Purpose (indications) for such treatment.

Unexpected was discovery of Fibromyalgia scioto, tick transmitted disease that causes chronic pain.

Q#3 - Is retroactive denial of Legitimate Medical Purpose, instead of prospective approval, a cause for prosecution of physicians treating chronic pain and reason for Prettyman and Katzenbach Commissions failure?

Explanation:

After years of going to several doctors for chronic pain treatment a new doctor has difficulty to establish history of treatment. All previous records were seized by law enforcement including initial letter from another specialist indicating need for treatment for chronic pain. Indication for treatment is difficult to reconstruct. Patient taking Xanax for years does not have good recollection.

Creation of commissionqualifying patient for chronic pain treatment, like SSA disability, evaluating patient for opiate and other controlled substances treatment would give physician permission

to prescribe medications. At the same time Guardian for Medications, a family member, could be established to help patient administer medications and alert physicians to problems patients don't disclose. Qualification would be like a credit card patient can show to a doctor, pharmacist, law enforcement. Record of it can be kept with PMP - Prescription Monitoring Program)like OARRS in Ohio) and be accessible to members of qualifying commission (physician, pharmacist, DEA, State Medical and Pharmacy Boards, social worker, Patient's Medication Guardian).

Petitioner got this idea when realizing that we trust patients more than doctors. Doctors are prohibited from prescribing controlled, addictive substances for themselves, but patients have full, unlimited authority and access to their medications. Family members don't have rights to supervise the patients, to give early warning that

things are not going right.

Petitioner was prosecuted for prescribing to addicts, when patients were receiving medications previously prescribed by several other physicians[3] and three other physicians in the same office: Dr. Woodward, Dr. Lee and Dr. Khan, before, concurrently and after Petitioner, all four certifying by issuing prescriptions for the same controlled substances, a Legitimate Medical Purpose, indication for treatment, their names and copies of prescriptions in the charts.

Despite this prosecutors brought lay witness, Steele, to testify that patients were addicts, what government expert witness, Dr. Gronbach, did not confirm. Prosecutors used lay witness testimony to provide medical diagnosis of addiction.

With prior approval from Treatment Qualifying Commission wrongful prosecution for Lack of LMP would not be possible.

FN (3) - see page 7

Prettyman and Katzenbach Commissions were to establish a way to protect physicians from wrongful prosecutions for using opiate treatment, and allow them to prescribe without fear (U.S. v Moore, 423 US 122, 143-144, [10])[4].

Prospective qualification of patient for treatment, that DEA and law enforcement can contest ahead of treatment would meet the goal of above commissions.

Patients would benefit by not being exposed to abrupt deprivation and inability to find another physician.

FN (4) - see page 7

Q#4 - Is chronic pain treatment a §846-Conspiracy or §1306.04 Usual Course of Medical [Professional] Practice; why enter illegal conspiracy when Legitimate Practice offers authorized physician all the benefits without legal hurdle?

Why would Petitioner knowingly and intentionally join conspiracy when Petitioner could knowingly and intentionally conduct all activities he conducted based on authorization coming from Ohio Medical and DEA licenses without the risks of conspiracy?

Explanation:

Indictment charged Petitioner with §846-Conspiracy. Prosecution did not establish need to join conspiracy or benefit from it. Prosecutor Parker objected when defense attorney Cheselka asked Petitioner about conspiracy and Cheselka quit asking.

Jury did not find Petitioner guilty of conspiracy. District Court added §846-Conspiracy to the sentence.

Conspiracy to exist has to be clandestine; is conducted in secrecy, usually conducted without leaving a record. Petitioner:

- obtained DEA license for every office address he worked at
- kept all records of purchases, distributions and prescriptions to end users
- all medications were accounted for, inventory was conducted daily (required every 2 years), there was not one pill missing
- Petitioner as first customer of distributor, PTL, arranged and conducted sending report to OARRS of all dispensing, like pharmacies do
- registered as Limited Liability Co. with the State of Ohio
- used business checking account for business activity only
- answered codefendant's Callihan question: Why did you start sending information about distributions to OARRS, DEA will know about it?, with: I want them to know what I am doing!

(Conspiracy is Ground 37 of §2255 Motion)

Q#5 - Did District Court err by not addressing Petitioner's involuntary removal from Courtroom for presentation of evidence session and did Court of Appeals err by not checking the record in the de novo review, when District Court in denial of Ground #22 of §2255 Motion stated that record indicates that Petitioner was present, but did not indicate where in the record to find it? Shall the case be remanded for new trial based on FRCrP Rule 43 violation?

Explanation:

Defendant was ordered by defense counsel Cheselka to leave the courtroom for presentation of evidence session. Counsel's explanation was that defendant in criminal case may not know evidence against himself. Defendant stayed in the hallway of the court during the session. Defendant was not told what happened during the session and his requests for transcripts from trial were denied by District Court. Defense counsel never spent time with Defendant to learn the

content of patient charts and where in the charts to find information. Defendant's charts contain information that contradicts claims of improper or deficient patient's care made by prosecution during trial.

If present during the session Petitioner would have told defense counsel or objected himself to incorrect prosecutors presentation.

Prosecutors had trial strategy: when patients-witnesses testified their charts were not available; when expert Gronbach testified about alleged abnormalities in charts, patients were not available for confrontation. When witness Steele declared patients to be addicts neither their charts nor patients themselves were available for confrontation. When witness Elliot testified of taking 35 pills daily, her chart was not available, neither she was cross examined what kind of pills those were or where she was getting pills from, because Petitioner would not prescribe that many opiate pills; she was taking methadone and Petitioner initiated rotation

out of methadone.

Strategy of not having charts with the patients had purpose of avoiding controversies, preventing correction by defense of evidentiary errors or patient testimonies.

Appeal defense counsel, Wettle, did not raise the issue on appeal and did not inform Petitioner about Rule 43.

Without knowing what transpired during session and being unable to obtain transcripts Petitioner is unable to asses how prejudicial removal from courtroom was.

Issue was raised as Ground #22 in §2255 Motion.

Q#6 - Did Court of Appeals err by condoning District Court's recharacterization of 3 Motions as "first" §2255 Motion and another recharacterization of actual §2255 Motion as "second", "futile", "amended" §2255 Motion (without party's motion to amend), and declaring that any error was harmless" because District Court "ultimately denied all claims"?

While Clerk of Court docketed disposition of motions without indicating recharacterization. The case became "off docket" denial of two recharacterized §2255 Motions. (Castro v United States, 540 US 375 (2003)). Petitioner filed Motion to merge Rule 33 Motion and amended Motion into his §2255 Motion as new evidence Claims corresponded with trial Grounds of §2255 Motion in order to avoid "already adjudicated" confusion of "new" and "old" evidence.

District Court recharacterized Motions #216 (Discovery), # 227 (Rule 33 newely discovered evidence), #228 (amendment to rule 33 newely discovered evidence) as "first" §2255 Motion and denied it. Next day Clerk of Court after having docketed denial of "first" §2255 Motion as Doc # 230 11/15/2019 Motions # 216, # 227, # 228,

229 05/20/2019 Motion to Merge renamed 11/15/2019 as Motion to Amend/ Correct.

Petitioner filed two (# 232 and # 233) Motions for Reconsideration according to Rule 59(e) which both were docketed on 12/23/19.

Petitioner also filed Notice of Appeal for denial of Motions # 216, 227, 228, 229 in both civil and criminal case.

Petitioner's §2255 Motion, named by District Court second §2255 Motion was denied in civil case 1:19-cv-00428 as Doc # 5 12/06/19 as futile amendment to §2255 Motion, without Petitioner asking for recharacterization. District Court explained that if first recharacterization was in error, it was harmless error because both motions and all Grounds were ultimately denied.

It appeared to petitioner that all Motions, Newly

Discovered Evidence and §2255 Motions were denied in order to justify all recharacterizations and made error harmless.

District Court also denied COA and Court of Appeals also denied COA.

Newly Discovered Evidence Motions (# 227, 228) were denied as §2255 Motion giving as reason failure to raise it at trial and direct appeal.

One of the Newly Discovered Evidence claims was addressing prosecution of Petitioner for using short acting Oxycodone, not as respectable physicians using Oxycontin, and prosecuting Purdue Pharma in National Opiate Litigation for promoting use of Oxycontin. It was both way prosecution: Petitioner for using Oxycodone, not Oxycontin and Purdue Pharma for promoting unsafe Oxycontin use to physicians.

It was reversible argument in petitioner's case, because Oxycontin is causing more overdoses than Oxycodone. In Motion for Reconsideration after denial of New Trial (Doc # 167) Petitioner enclosed medical publication indicating that introduction of Oxycontin in Toronto, Canada lead to doubling of overdose mortality.

During Petitioner's trial medical expert Dr. Gronbach was also blaiming Petitioner for not using Oxycontin.

Petitioner requested to merge "new evidence" and "old" trial evidence because it prevented litigation of same issues twice. District Court denied "new" evidence claims on §2255 Rules and then denied corresponding Grounds because those were already denied in the "first" 2255 Motion.

FOOTNOTES

(1) Prosecutors accused Petitioner of recommending for an expert physicians who were convicted for doing the same defendant was doing (Appeal, Doc # 50, p.1)- "by inviting convicted doctors to vouch for Stegawski's issuance of opiate prescriptions", p.5 - "All Stegawski gave his attorney was ... a list of doctors who had been convicted and are doing time in federal prisons... We break no new ground in holding that it is a 'sound trial strategy', Strickland 466 U.S. at 689, for a criminal defense lawyer to resist putting an expert on the stand who was convicted for doing what the defendant was indicted for doing" p.8 - "it's safe to say that, when [defense attorney] Cheselka refused to hire doctors because of their previous convictions for similar offenses..."

In instant case prosecutors have hired an expert who was doing the same defendant was doing, "a kettle was blaiming the pot". Even worse, Dr. Gronbach was starting opiate treatments, Petitioner was only accepting patients who were for years receiving opiates and tapering their medications.

Federal chronic pain treatment law

When cancer pain treatment became introduced it turned into overwhelming success. When chronic pain treatment State Laws were legislated in 1990s the difference was noted: cancer patients life expectancy was not as important as pain relief; chronic pain patients life expectancy became longer with elimination of Hemingway's solution, and expectation for life expectation became 70 for 20 years old. Unexplained was rapid increase in people using opiates for pain, with clustering of the cases; for law enforcement it was obvious, the crime, the criminal minds of doctors and their patients, but unlike post-Vietnam, this time epidemic crossed all socio-economic barriers. Another point was added by CDC researcher, the per capita use of opiates between low and high state was 10 times.

Petitioner getting involved in November 2009, experienced for 30 years in iv. opiate administration with BZDZs-benzodiazepines and newer "conscious sedation", when every patient goes to sleep, and has no recollection and some going through apnea and giving consideration to published increasing overdose mortality, decided to lower medications, starting with BZDZs, which are not pain medications, give withdrawal seizures and impair memory. So Petitioner initiated tapering of Xanax and Valium as fast as patients allowed; BZDZ withdrawal gives aggressiveness, nervousness, insomnia. Patients on Valium were protesting, but switch to Xanax allowed withdrawal. Tapering all patients at the same time created a wave; patients were all developing changes at the same time. Opiates use for long time makes them safer than other sedatives, that is part of tolerance. Reading in PDR about Soma, that is

prodrug of Meprobamate, medication banned in 1970s because of abuse and addiction, was reason to discontinue it in all patients. DEA, instead warning physicians and petitioning FDA, was arresting physicians for using it. Prosecutor Oakley in a gesture as if it was a crime presented during trial that Petitioner prescribed Soma, but did not show prescription or copy of it, but pointed to list of medications prescribed by previous physician.

First sign was non-textbook back pain patients were reporting. Standard examination of lower back, directed to bone structures was not correlating well with patients reports of pain. Explanation came in September-October-November- December 2010. If raid of the clinic was conducted 3 months earlier, Petitioner would not solve the puzzle of massive opiate use and discovery of the disease and role of BZDZs in masking the symptoms.

Lowering of medications that led to elimination of overdose mortality was presented by prosecution as:

"Junkies and addicts were coming to drug houses for dope". (actual words used by prosecutor), indicating in opening and closing statement that Petitioner is guilty, what took away from Jury right to make a decision and gave the Jury function of copycat and changed Justice system to prosecutorial dictatorship. Using term pill-mill in closing statement without expalanation what it means, when Petitioner's average daily volume was 26.7 patients, spending 1 hour to 1 hour 45 minutes with new patients, writing all prescriptions in the presence of the patients, except taking once written prescriptions to patient's home, after reviewing her condition over the phone - she became office manager after separating from Callihans and purpose of the change was to look for offices to rent, and establish plan to separate from Callihans.

Two critical issues during trial were:

1° - lay witness Steele testifying that named by prosecutor Oakley patients were addicts, because they had withdrawal when deprived medications. She took dependence that affects all chronic pain patients to be in common language addiction. The FDA Statement on April 9, 2019 is explanation for prosecution of physicians for maintaining addiction, whereas it is dependence affecting all patients, described in question #1.

2° - Government expert made mistakes giving testimony on urine toxicology tests, he did /not know how to interpret the results. §3563e- Results of drug testing, and §3583 (d) - Conditions of supervised release have information on problems with instant readout urine tests. Expert's errors are described in Doc #47 - Supplement to defense reply brief of appeal and were not taken into consideration in appeal.

Above two issues invalidate prosecution, and were not presented to the Jury.

Performance of defense trial counsel and appeal defense counsel.

Trial attorney Mr. Cheselka was hired and agreed to take case to trial, but:

- did not investigate even one witness, including key witnesses and did not call anyone to testify
- had another trial scheduled for next week
- first during trial - arranged guilty plea conference and when that failed
- entered into agreement with prosecutors to finish trial on February 13, 2015
- Prosecutors to accomodate him cancelled testimony of several witnesses, including urine laboratory technician
- refused to cross examine all witnesses and examined few when Petitioner insisted to conduct some examinations pro se, but prevented cross examination of government expert, which could have easily taken 1-2 days.
- refused to present reduction of medications and discovery of a new disease
- did not examine Petitioner on issues from expert witness testimony, as a result expert testimony was not adversarily tested.

- was suspended from practice for 2 years for other clients representation.

Appeal attorney Wettle:

- never came to detention center close to Cincinnati and to prison in Ashland, KY to talk to Petitioner
- never called on attorney-client phone line
- did not respond to 19 letters with case description, did not comment
- raised only 2 issues in appeal that were already adjudicated in Rule 33 Motion
- in §2255 Motion several claims were denied by District Court, because not raised on appeal, including case Arny v. United States (137 F Supp 3d 981, 6th Dist)
- refused to file panel and en banc rehearing when requested
- filed unauthorized certiorari, what caused Petitioner's certiorari rejection
- previously lost over 40 appeals and certioraris. His representation was guaranteed failure. Public Defender's office did not disclose it to Petitioner.

Both attorneys were constitutionally ineffective, but courts did not acknowledged it in §2255 Ground

REASONS FOR GRANTING THE PETITION

Petitioner found the way out of massive opiate use, by lowering and tapering medications, without overdose mortality, without switch to heroin, fentanyl, and other drugs and documented it on patients who previously were taking pain medications for years.

Comparing maps of distribution of opiates use per capita in Ohio with incidence of Rocky Mountains Spotted Fever cases which look very similar Petitioner realized that the same vector transmits RMSF and chronic pain causing disease, leading to massive opiates use for treatment of pain. Within one year 2009-2010 Petitioner established protocol how to lower and terminate medications used for chronic pain without mortality and with patients approval in voluntary out-patient treatment.

Finding new disease Petitioner explained massive drive to medical opiates use and found that traditional antibiotic is effective in Fibromyalgia scioto, how he named the disease.

Classical fibromyalgia was described as autoimmune disease causing rheumatic symptoms.

Fibromyalgia scioto includes central nervous system involvement giving headaches, memory loss, anxiety, panic attacks, depression, peripheral neuralgia on top of "my whole body hurts", symptoms presenting differently from patient to patient.

Trial was unfair by not allowing time for the defense and presentation of Petitioner's work. Government expert was not cross examined, while he made many errors of urine toxicology tests interpretation, he apparently never worked with. Petitioner requested to cross examine expert, but was denied right to self representation.

Where law enforcement explained clustering of cases as occuring because of criminal minds of doctors and their patients, Petitioner found endemic infectious disease.

Defense trial counsel had next trial scheduled and arranged to finish trial early, without conducting defense part. Prosecutors cancelled witnesses to accomodate defense counsel need to leave early. He was suspended from practice for two years by claims from his other clients.

Appeal counsel chose only two already adjudicated issues of trial counsel ineffective assistance. Several other appealable issues were indicated in appeal and denial of both §2255 Motions. Appeal counsel lost also over 40 other appeals and certioraris he conducted, all of them. Appeal was not fair.

District Court denied all Grounds in two recharacterized §2255 Motions. Court of appeals also denied COA.

Despite objective results of Petitioner's patient care (Petitioner was only pain physician who lowered medications in 2010 and only one who did not have patients mortality) and explanation of cause of massive

opiates use, Petitioner lost trial because of lack of adversarial process, lack of defense expert and inability to cross examine government expert witness. Defense attorney hardly ever objected and only for the record, cross examined few witnesses only when after his refusal, Petitioner wanted to cross examine himself.

The 4 questions refer to overbroad prosecution, that "closes the legal window for chronic pain treatment" in the absence of federal chronic pain treatment law, similar to Oregon Death With Dignity Act established in Gonzales v Oregon after interpretive rule which ended in clear legislation establishing new application for opiates and other controlled substances use.

In the lack of legal distinction between §802-Addict and chronic pain patient prosecutors use 106 years old law prohibiting prescribing to addicts to prosecute for chronic pain treatment

established by States about 30 years ago, basing prosecution on Moore(1975) treating patients without pain but addicted to Schedule I heroin with unlimited supply of methadone, i.e. using case law prohibiting treatment to close the window of chronic pain treatment by converting §3741 (OH law) physicians into §841 drug dealers.

Using also §846, 856, 1056, 841 - to describe Usual Course of Professional [Medical] Practice of §1306.04 by retroactively cancelling "driving license" after the accident, i.e. denying "Except as authorized" clause after closing the clinic and opening §841 door to drug trafficking with indictment.

Presenting cash acceptance as drug trafficking and acceptance of insurance as insurance fraud closes the window of business side of medicine in a strategy "heads I win, tails you lose".

How did it happen that physician who knew how to modify chronic pain treatment, knew the law, was aware of legal risks, was conducting practice with expectation of inspection, converting renewal of medications into rescue mission, explaining the mystery of massive opiate use by putting together medical puzzle of subnoise signal detection of new disease, discovers that innocent people serve the longest sentences? DNA may be explanation; when cases prosecuted according to law and legal process get reversed by one test, DNA, it indicates existence of a flaw. Indication of that flaw in instant case is: when 8 physicians in a row certify by issuing prescription for opiates that patient has indication for treatment and one or more of them get prosecuted it implies system error. Probability of 8 physicians in a row being wrong is billion times lower than probability of DNA being wrong.

*** part below is added when retyping ***

It also indicates another problem:

Physicians are not prosecuted according to medical knowledge they have, but according to what prosecutors consider to be prosecutable, but is not medical knowledge , basing their actions on public opinion of the jurors what is not medically sound.

A clash of two different cultures: one having patients best outcome and other finding best way to prosecute.

Physicians and patients became victims of a war between medical organizations establishing chronic pain treatment and another organization that wanted to eliminate it into oblivion.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

Tick-Borne Rickettsial Disease Case Report

Use for: Spotted fever rickettsiosis (SFR) including Rocky Mountain spotted fever (RMSF), Ehrlichiosis (*E. chaffeensis*, *E. ewingii*, & undet.), and Anaplasmosis (*A. phagocytophilum* & undet.).
Visit http://www.cdc.gov and use "Search" for complete Case Definition(s) or visit the disease web site(s) for a fillable/downloadable PDF version of this Case Report.

Form Approved OMB 0920-0009

CDC# ____ (1-4)

[redacted]

Date submitted: 04/14/2011 (5-6) (7-8) (9-12) (mm/dd/yyyy)
Physician's name: Christopher Stegawski
Phone no.: 440 781 6240
NETSS ID No.: (if reported) Case ID (13-18) Site (19-21) State (22-23)

1. State of residence: Postal abrv: O H (24-25)

2. County of residence: (26-50) Cuyahoga
History of travel outside county of residence within 30 days of onset of symptoms? 1 ☑ YES 2 ☐ NO 9 ☐ Unk

3. Zip code: (51-59) 44145-

4. Sex: (60) 1 ☑ Male 9 ☐ Unk 2 ☐ Female

5. Date of birth: 12/14/1949 (61-62) (63-64) (65-68) (mm/dd/yyyy)

6. Race: (69) 1 ☑ White 3 ☐ American Indian Alaskan Native 5 ☐ Pacific Islander 2 ☐ Black 4 ☐ Asian 9 ☐ Not specified

7. Hispanic ethnicity: (70) 1 ☐ Yes 2 ☑ No 9 ☐ Unk

8. Indicate Disease (Presumed) To Be Reported: (71)
1 ☐ SFR (including RMSF) 3 ☐ Anaplasmosis - *A. phagocytophilum* 5 ☑ Ehrlichiosis/Anaplasmosis - Undetermined
2 ☐ Ehrlichiosis - *E. chaffeensis* 4 ☐ Ehrlichiosis - *E. ewingii*

9. Was a clinically compatible illness present? If there is no presence of clinical illness, then this is not a case. (72)
Clinical evidence - fever and one or more of the following: rash (primarily SFR), headache, myalgia, anemia, leukopenia (Ehrlich. & Anaplas.), thrombocytopenia, or elevated hepatic transaminases. 1 ☑ YES 2 ☐ NO 9 ☐ Unk
Eschar (aka tache noire) or black, necrotic area around site of known/possible tick bite present? 1 ☐ YES 2 ☐ NO 9 ☑ Unk

10. Date of Onset of Symptoms: 08/15/2010 (73-80) (mm/dd/yyyy)

11. Was an underlying immunosuppressive condition present? (81)
1 ☐ YES 2 ☑ NO 9 ☐ Unk
Specify condition(s):

12. Specify any life-threatening complications in the clinical course of illness: (82)
1 ☐ Adult respiratory distress syndrome (ARDS) 3 ☐ Meningitis/encephalitis
2 ☐ Disseminated intravascular coagulopathy (DIC) 4 ☐ Renal failure 9 ☑ None
8 ☐ Other:

13. Was the patient hospitalized because of this illness? (83) (If yes, date)
1 ☐ YES 2 ☑ NO 9 ☐ Unk ____ (84-85) (86-87) (88-91) (mm/dd/yyyy)

14. Did the patient die because of this illness? (92) (If yes, date)
1 ☐ YES 2 ☑ NO 9 ☐ Unk ____ (93-94) (95-96) (97-100) (mm/dd/yyyy)

15. Name of laboratory: City: State: Zip:

Below, indicate Y (Yes) or N (No), **ONLY** if the test or procedure was performed. **Lack of selection** indicates that the test or procedure was not performed.

16. Serologic Tests	Serology 1 COLLECTION DATE (mm/dd/yyyy) (101-2) (103-4) (105-8) Titer	Positive?	Serology 2* COLLECTION DATE (mm/dd/yyyy) (109-10) (111-12) (113-16) Titer	Positive?
IFA - IgG	(_____)	1 ☐ YES 2 ☐ NO (117)	(_____)	1 ☐ YES 2 ☐ NO (118)
IFA - IgM	(_____)	1 ☐ YES 2 ☐ NO (119)	(_____)	1 ☐ YES 2 ☐ NO (120)
Other test: (121-130)	(_____)	1 ☐ YES 2 ☐ NO (131)	(_____)	1 ☐ YES 2 ☐ NO (132)

* Was there a fourfold change in antibody titer between the two serum specimens? 1 ☐ YES 2 ☐ NO (137)

17. Other Diagnostic Test? (Use #16, S1 for collection date)	Positive?
PCR	1 ☐ YES 2 ☐ NO (133)
Morulae visualization*	1 ☐ YES 2 ☐ NO (134)
Immunostain	1 ☐ YES 2 ☐ NO (135)
Culture	1 ☐ YES 2 ☐ NO (136)

* Visualization of morulae not applicable for SFR.

18. Classify case BASED ON the CDC case definition (see criteria below): (138)
1 ☐ SFR (including RMSF) 2 ☐ Ehrlichiosis - *E. chaffeensis*
3 ☐ Anaplasmosis - *A. phagocytophilum* 4 ☐ Ehrlichiosis - *E. ewingii*
5 ☐ Ehrlichiosis/Anaplasmosis - Undetermined
(139-148)

(149) 1 ☐ CONFIRMED 2 ☐ PROBABLE

State Health Department Official who reviewed this report:
Name:
Title: Date: (mm/dd/yyyy)

COMMENTS: This is a case of new disease (rickettsial) which presents as fibromyalgia (Scioto) and responded to antibiotic

Confirmed SFR (including RMSF): A clinically compatible case with evidence of a fourfold change in IgG antibody titer reactive with *Rickettsia rickettsii* or other SFR antigens by IFA between paired serum specimens, one taken during the first week of illness and a second 2-4 weeks later, OR detection of *R. rickettsii* or other SFR DNA in a clinical specimen via amplification of a specific target by PCR assay, OR demonstration of SFR antigen in a biopsy/autopsy specimen by IHC, OR isolation of *R. rickettsii* or other SFR species from a clinical specimen in cell culture.

Probable SFR (including RMSF): A clinically compatible case with evidence of elevated IgG or IgM antibody reactive with *R. rickettsii* or other SFR antigens by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination (CDC uses an IFA IgG cutoff of ≥1:64 and does not use IgM test results as independent diagnostic support criteria.).

Note: Current commercially available ELISA tests cannot evaluate changes in antibody titer. IgM tests may be unreliable because they lack specificity. IgM antibody may persist for lengthy periods of time. When sera demonstrate elevated antibody responses to multiple infectious agents among rickettsial species, and between ehrlichial and anaplasmal species, the greater antibody response is generally directed at the actual agent involved.

Confirmed Ehrlichiosis/Anaplasmosis: A clinically compatible case with evidence of a fourfold change in IgG antibody titer reactive with *Ehrlichia chaffeensis or Anaplasma phagocytophilum* antigen by IFA between paired serum specimens (one taken during the first week of illness and a second 2-4 weeks later) OR detection of *E. chaffeensis* or *A. phagocytophilum* DNA in a clinical specimen via amplification of a specific target by PCR assay, OR demonstration of ehrlichial or anaplasmal antigen in a biospy/autopsy specimen by IHC, OR isolation of *E. chaffeensis* or *A. phagocytophilum* from a clinical specimen in cell culture.

Probable Ehrlichiosis/Anaplasmosis: A clinically compatible case with evidence of elevated IgG or IgM antibody reactive with *E. chaffeensis* or *A. phagocytophilum* antigen by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or assays in other formats (CDC uses an IFA IgG cutoff of ≥1:64 and does not use IgM test results as independent diagnostic support criteria.), OR identification of morulae in the cytoplasm of monocytes or macrophages (Ehrlichiosis) or in the cytoplasm of neutrophils or eosinophils (Anaplasmosis) by microscopic examination.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

Christopher Stegawski

Date: February 11, 2021