

PHARMACEUTICAL COMPOSITIONS AND METHODS OF TREATMENT

FIELD

5 The present invention relates to pharmaceutical compositions that can be used for the treatment of obesity and related metabolic disorders and for treating addiction to psychoactive substances, in particular nicotine.

BACKGROUND

10 Obesity is now recognized as a chronic disease that requires treatment to reduce its associated health risks. The increase in obesity is of concern because of the health risks associated with obesity, including coronary heart disease, strokes, hypertension, type 2 diabetes mellitus, dyslipidemia, sleep apnea, osteoarthritis, gall bladder disease, depression, and certain forms of cancer (e.g., endometrial, breast, prostate, and colon). The negative health consequences of obesity make it the second leading cause of preventable death in the United States. See, McGinnis M, Foege W H., *"Actual Causes of Death in the United States,"* JAMA, 15 270, 2207 12 (1993).

It is believed that 5-10% reduction of body weight can substantially improve metabolic values, such as blood glucose, blood pressure, and lipid concentrations.

20 Currently available prescription drugs for managing obesity generally reduce weight by inducing satiety or decreasing dietary fat absorption. Satiety is achieved by increasing synaptic levels of norepinephrine, serotonin, or both. For example, stimulation of serotonin receptor subtypes 1B, 1D, and 2C and 1- and 2-adrenergic receptors decreases food intake by regulating satiety. See, Bray G A, *"The New Era of Drug Treatment. Pharmacologic Treatment of Obesity: Symposium Overview,"* Obes. Res., 3(suppl 4), (1995). Adrenergic agents (e.g., 25 diethylpropion, benzphetamine, phendimetrazine, mazindol, and phentermine) act by modulating central norepinephrine and dopamine receptors through the promotion of catecholamine release. Older adrenergic weight-loss drugs (e.g., amphetamine, methamphetamine, and phenmetrazine), which strongly engage in dopamine pathways, are no longer recommended because of the risk of their abuse. Fenfluramine and dexfenfluramine, both serotonergic agents used to regulate 30 appetite, are no longer available for use.

Because of the side effects expressed and the development of addiction resulting from the use of these psychoactive substances, an effective and safe medicine of central effect is still not available. Thus, there still exists a need for a more effective and safe therapeutic treatment for reducing or preventing obesity and related metabolic disorders.

In addition to obesity, there also exists an unmet need for treatment of substance addiction.

Tobacco addiction represents the most important preventable cause of illness and death in our society, responsible for thousands of deaths each year. Half of all smokers will die of diseases directly related to tobacco use, and many smokers will suffer significant morbidity. Approximately 15 million smokers try to quit, but only one million of those succeed in smoking cessation each year.

Cigarette smoke contains a large number of very complex substances the most important of which is nicotine, this being the substance to which cigarette smokers develop an addiction. Several pharmacotherapies have proven effective for the treatment of tobacco addiction. These include nicotine replacement therapies in the form of gum, patch, nasal spray and inhaler. Non-nicotine pharmacologic therapies have been developed as a method of treating nicotine addiction. Possible reagents include nicotine blockade therapy, drugs affecting serotonergic neurotransmission, anti-depressants, anxiolytics, clonidine and airway sensory replacement (Rose, 1996; and Cinciripini et al., 1998 *Oncology* 12: 249-256). Nicotine blockade therapy (also referred to as nicotine receptor antagonists) utilizes compounds that occupy nicotine receptors, thereby attenuating the reward received from tobacco usage (Clarke, 1991 *Br. J. Addict.* 86: 501-505). However, there is a need for more effective treatment for tobacco addiction.

The cannabinoid receptors are a class of cell membrane receptors under the G protein-coupled receptor superfamily. Cannabinoid receptors are activated by three major groups of ligands, (a) endocannabinoids (produced by the mammalian body), (b) plant cannabinoids (such as THC, produced by the cannabis plant) and (c) synthetic cannabinoids (such as HU-210, first synthesized in 1988 from (1R,5S)-Myrtenol). These cannabinoids exert their effects by binding to cannabinoid receptors located in the cell membrane. Endocannabinoids have been implicated in a wide variety of physiological and pathophysiological processes. To date, most drugs used to interact with the endocannabinoid system are derived from cannabis. Cannabis has received the

most popularity as a raw material for products such as marijuana and hashish and its regular use can result in the development of dependence.

Two cannabinoid receptors have been characterized: cannabinoid receptor 1 (CB1), a central receptor found in the mammalian brain and peripheral tissues and cannabinoid receptor 2 (CB2), a peripheral receptor found only in the peripheral tissues. The CB1 receptor is mainly expressed in several brain areas including the limbic system (amygdala, hippocampus), hypothalamus, cerebral cortex, cerebellum, and basal ganglia. Compounds that are agonists or antagonists for one or both of these receptors have been shown to provide a variety of pharmacological effects. See, for example, Pertwee, R.G., *Pharmacology of cannabinoid CB1 and CB2 receptors*, Pharmacol. Ther., (1997) 74:129-180 and Di Marzo, V., Melck, D., Bisogno, T., DePetrocellis, L., *Endocannabinoids: endogenous cannabinoid receptor ligands with neuromodulatory action*, Trends Neurosci. (1998) 21:521-528.

The therapeutic effect of an extremely diluted (or ultra-low) form of antibodies potentized by homeopathic technology (activated potentiated form) has been discovered by the inventor of the present patent application, Dr. Oleg I. Epshtein. U.S. Patent No. 7,582,294 discloses a medicament for treating Benign Prostatic Hyperplasia or prostatitis by administration of a homeopathically activated form of antibodies to prostate specific antigen (PSA).

The S-100 protein is an acidic cytoplasmic protein expressed in the nervous system. It has been suggested that the S-100 protein has a role in anxiety. See Ackermann et al., *S100A1-deficient male mice exhibit increased exploratory activity and reduced anxiety-related response*, Biochim. Biophys. Acta. 2006, 63(11):1307-19; Diehl et al., *Long lasting sex-specific effects upon behavior and S100b levels after maternal separation and exposure to a model of post-traumatic stress disorder in rats*, Brain Res., 2007, 144:107-16, all of which are incorporated herein by reference.

Ultra-low doses of antibodies to S-100 protein have been shown to have anxiolytic, anti-asthenic, anti-aggressive, stress-protective, anti-hypoxic, anti-ischemic, neuroprotective and nootropic activity. See Castagne V. et al., *Antibodies to S100 proteins have anxiolytic-like activity at ultra-low doses in the adult rat*, J. Pharm. Pharmacol. 2008, 60(3):309-16; Epshtein O. I., *Antibodies to calcium-binding S100B protein block the conditioning of long-term sensitization in the terrestrial snail*, Pharmacol. Biochem. Behav., 2009, 94(1):37-42; Voronina T.A. et al.,

Chapter 8. *Antibodies to S-100 protein in anxiety-depressive disorders in experimental and clinical conditions*. In “*Animal models in biological psychiatry*”, Ed. Kalueff A.V. N-Y, “Nova Science Publishers, Inc.”, 2006, pp. 137-152, all of which are incorporated herein by reference.

There is a continuing need for new drug products with desired therapeutic efficacy for treatment of excess body mass or obesity and substance addiction.

SUMMARY

In one aspect of the present disclosure, there is provided a pharmaceutical composition comprising a homeopathically potentized form of an antibody to human cannabinoid receptor.

In one embodiment, the present disclosure provides a pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor. Preferably, the human cannabinoid receptor is cannabinoid receptor 1 (CB1). It is contemplated that the activated-potentiated form of an antibody of this embodiment of the present disclosure is to the entire human cannabinoid receptor 1. Specific sequences provided in the detailed description of the present disclosure are specifically contemplated. It is contemplated that the activated-potentiated form of an antibody is to a polypeptide fragment of the human cannabinoid receptor 1. Preferably, the activated-potentiated form of an antibody is in the form of a mixture of C12, C30, and C200 homeopathic dilutions. In the particularly preferred variant, the activated-potentiated form of an antibody is in the form of a mixture of C12, C30, and C200 homeopathic dilutions impregnated onto a solid carrier. It is contemplated that the activated-potentiated form of an antibody to a human cannabinoid-receptor is a monoclonal, polyclonal or natural antibody. Preferably, the activated-potentiated form of an antibody to a human cannabinoid receptor is a polyclonal antibody. The antibody to human cannabinoid receptor may be prepared by successive centesimal dilutions coupled with shaking of every dilution.

In another embodiment, the present disclosure provides a method of treating obesity and related metabolic disorders, said method comprising administering the pharmaceutical composition of any variant or embodiment of the pharmaceutical composition embodiment of the present disclosure. The pharmaceutical composition may be administered to a patient as one or two unit dosage forms from once daily to four times daily. Twice daily administration is specifically contemplated.

In another embodiment, the present disclosure provides a method of nicotine addiction, said method comprising administering the pharmaceutical composition of any variant or embodiment of the pharmaceutical composition embodiment of the present disclosure. The pharmaceutical composition may be

administered to a patient as one or two unit dosage forms from once daily to four times daily. Twice daily administration is specifically contemplated.

In another embodiment, the present disclosure provides a method of altering anthropometric parameters of a mammal expected to benefit from such alteration, said method comprising administering the pharmaceutical composition of any variant or embodiment of the pharmaceutical composition embodiment of the present disclosure. In one embodiment, the anthropometric parameter is waist circumference. In one embodiment, the anthropometric parameter is waist-height ratio. In another embodiment, the anthropometric parameter is waist-to-hip ratio. Various variants are provided.

In another embodiment, the present disclosure provides method of reducing body mass of a mammal, said method comprising administering the pharmaceutical composition of any variant or embodiment of the pharmaceutical composition embodiment of the present disclosure. In one variant, the body mass is reduced by at least 5%. In another variant, the body mass is reduced by at least 10%. body mass is reduced by at least 15%. In another variant, the body mass is reduced by less than 15%.

In another embodiment, the present disclosure provides a method of reducing body mass growth of a mammal, said method comprising administering the pharmaceutical composition of any variant or embodiment of the pharmaceutical composition embodiment of the present disclosure. In one variant, the body mass growth is reduced by at least 10%. In another variant, the body mass growth is reduced by at least 30%.

In another embodiment, the present disclosure provides a method of facilitating a reduction of food consumption in a mammal expected to benefit from such reduction, said method comprising administering the pharmaceutical composition of any variant or embodiment of the pharmaceutical composition embodiment of the present disclosure.

In another embodiment, the present disclosure provides a pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor and an activated-potentiated form of an antibody to S-100 protein. In one variant, the antibody to the S-100 protein is an antibody to the entire S-100 protein. Sequences for S-100 protein are provided in the specification. Preferably, the antibody to the S-100 protein is in the form of mixture of C12, C30, and C200 homeopathic dilutions impregnated onto the solid carrier. The pharmaceutical

composition of this embodiment of the present disclosure may contain antibody to S-100 protein which is a monoclonal, polyclonal or natural antibody. Preferably, the antibody to the S-100 protein is a polyclonal antibody. The antibody to the S-100 protein may be prepared by successive centesimal dilutions coupled with shaking of every dilution.

In another embodiment, the present disclosure provides a method of treating a patient suffering from a psychoactive substance addiction, said method comprising administering the pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor and an activated-potentiated form of an antibody to S-100 protein. Preferably, the psychoactive substance is nicotine. Preferably, the administration of said combination leads to a statistically significant improvement in the ability to tolerate the quitting of smoking as measured by analysis of data of the MPSS test. Preferably, the administration of said combination leads to a statistically significant reduction of smoking of in patients with moderate nicotine addiction as measured by the Fagerström Test for Nicotine Dependence Test. Preferably, the administration of said combination leads to a statistically significant reduction of smoking of in patients with heavy nicotine addiction as measured by the Fagerström Test for Nicotine Dependence Test.

In another embodiment, the present disclosure provides a pharmaceutical composition for use in treating a patient suffering from a psychoactive substance addiction, said composition having been obtained by providing a) a potentiated solution of an antibody to human cannabinoid receptor, and b) a potentiated solution of an activated-potentiated form of an antibody to S-100 protein, each prepared by consecutive repeated dilution and multiple vertical shaking of each obtained solution in accordance with homeopathic technology, and then either combining the potentiated solutions by mixing them, or, alternatively, impregnating a carrier mass with said combined solution or with the solutions separately.

In another embodiment, the present disclosure provides pharmaceutical composition for use in treating obesity and related metabolic disorders, said composition having been obtained by providing a potentiated solution of an antibody to human cannabinoid receptor, prepared by consecutive repeated dilution and multiple vertical shaking of each obtained solution in accordance with homeopathic technology, and then optionally impregnating a carrier mass with said solution.

BRIEF DESCRIPTION OF THE DRAWINGS

Figure 1 – Shows the effect of ULD anti-CB1 and subutramine on growth in body mass and feed consumption.

Figure 2 – Shows the reduction in body mass after administration of ULD anti-CB1.

Figure 3 – Shows reduction of weight of 5% or more in patients.

DETAILED DESCRIPTION

The invention is defined with reference to the appended claims. With respect to the claims, the glossary that follows provides the relevant definitions.

The term “antibody” as used herein shall mean an immunoglobulin that specifically binds to, and is thereby defined as complementary with, a particular spatial and polar organization of another molecule. Antibodies as recited in the claims may include a complete immunoglobulin or fragment thereof, may be natural, polyclonal or monoclonal, and may include various classes and isotypes, such as IgA, IgD, IgE, IgG1, IgG2a, IgG2b and IgG3, IgM, etc. Fragments thereof may include Fab, Fv and F(ab')₂, Fab', and the like. The singular “antibody” includes plural “antibodies.”

The term “activated-potentiated form” or “potentiated form” respectively, with respect to antibodies recited herein is used to denote a product of homeopathic potentization of any initial solution of antibodies. “Homeopathic potentization” denotes the use of methods of homeopathy to impart homeopathic potency to an initial solution of relevant substance. Although not so limited, ‘homeopathic potentization’ may involve, for example, repeated consecutive dilutions combined with external treatment, particularly (mechanical) shaking. In other words, an initial solution of antibody is subjected to consecutive repeated dilution and multiple vertical shaking of each obtained solution in accordance with homeopathic technology. The preferred concentration of the initial solution of antibody in the solvent, preferably water or a water-ethyl alcohol mixture, ranges from about 0.5 to about 5.0 mg/ml. The preferred procedure for preparing each component, i.e. antibody solution, is the use of the mixture of three aqueous or aqueous-alcohol dilutions of the primary matrix solution (mother tincture) of antibodies diluted 100¹², 100³⁰ and 100²⁰⁰ times, respectively, which is equivalent to centesimal homeopathic dilutions C12, C30 and C200. Examples of homeopathic potentization are described in U.S. Patent Nos. 7,572,441

and 7,582,294, which are incorporated herein by reference in their entirety and for the purpose stated. While the term “activated-potentiated form” is used in the claims, the term “ultra-low doses” is used in the examples. The term “ultra-low doses” became a term of art in the field of art created by study and use of homeopathically diluted and potentized form of substance. The term “ultra-low dose” or “ultra-low doses” is meant as fully supportive and primarily synonymous with the term ‘activated-potentiated’ form used in the claims.

In other words, an antibody is in the “activated-potentiated” or “potentiated” form when three factors are present. First, the “activated-potentiated” form of the antibody is a product of a preparation process well accepted in the homeopathic art. Second, the “activated-potentiated” form of antibody must have biological activity determined by methods well accepted in modern pharmacology. And third, the biological activity exhibited by the “activated potentiated” form of the antibody cannot be explained by the presence of the molecular form of the antibody in the final product of the homeopathic process.

For example, the activated potentiated form of antibodies may be prepared by subjecting an initial, isolated antibody in a molecular form to consecutive multiple dilutions coupled with an external impact, such as mechanical shaking. The external treatment in the course of concentration reduction may also be accomplished, for example, by exposure to ultrasonic, electromagnetic, or other physical factors. V. Schwabe "Homeopathic medicines", M., 1967, U.S. Patents Nos. 7,229,648 and 4,311,897, which are incorporated by reference in their entirety and for the purpose stated, describe such processes which are well accepted methods of homeopathic potentiation in the homeopathic art. This procedure gives rise to a uniform decrease in molecular concentration of the initial molecular form of the antibody. This procedure is repeated until the desired homeopathic potency is obtained. For the individual antibody, the required homeopathic potency can be determined by subjecting the intermediate dilutions to biological testing in the desired pharmacological model. Although not so limited, ‘homeopathic potentization’ may involve, for example, repeated consecutive dilutions combined with external treatment, particularly vertical (mechanical) shaking. In other words, an initial solution of antibody is subjected to consecutive repeated dilution and multiple vertical shaking of each obtained solution in accordance with homeopathic technology. The preferred concentration of the initial solution of antibody in the solvent, preferably, water or a water-ethyl alcohol mixture, ranges from about 0.5 to about 5.0 mg/ml. The preferred procedure for

preparing each component, i.e. antibody solution, is the use of the mixture of three aqueous or aqueous-alcohol dilutions of the primary matrix solution (mother tincture) of antibodies diluted 100^{12} , 100^{30} and 100^{200} times, respectively, which is equivalent to centesimal homeopathic dilutions C12, C30 and C200. Examples of how to obtain the desired potency are also provided, for example, in U.S. Patents Nos. 7,229,648 and 4,311,897, which are incorporated by reference for the purpose stated. The procedure applicable to the “activated potentiated” form of the antibodies described herein is described in more detail below.

There has been a considerable amount of controversy regarding homeopathic treatment of human subjects. While the present invention relies on accepted homeopathic processes to obtain the “activated-potentiated” form of antibodies, it does not rely solely on homeopathy in human subjects for evidence of activity. It has been surprisingly discovered by the inventor of the present application and amply demonstrated in the accepted pharmacological models that the solvent ultimately obtained from consecutive multiple dilution of a starting molecular form of an antibody has definitive activity unrelated to the presence of the traces of the molecular form of the antibody in the target dilution. The “activated-potentiated” form of the antibody provided herein are tested for biological activity in well accepted pharmacological models of activity, either in appropriate *in vitro* experiments, or *in vivo* in suitable animal models. The experiments provided further below provide evidence of biological activity in such models. The human clinical studies, also provided herein below, *inter alia* provide evidence that the activity observed in the animal model is well translated to human therapy. The human study also provide evidence of availability of the “activated potentiated” forms described herein to treat specified human diseases or disorders well accepted as pathological conditions in the medical science.

Also, the claimed “activated-potentiated” form of antibody encompass only solutions or solid preparations the biological activity of which cannot be explained by the presence of the molecular form of the antibody remaining from the initial, starting solution. In other words, while it is contemplated that the “activated-potentiated” form of the antibody may contain traces of the initial molecular form of the antibody, one skilled in the art could not attribute the observed biological activity in the accepted pharmacological models to the remaining molecular form of the antibody with any degree of plausibility due to the extremely low concentrations of the molecular form of the antibody remaining after the consecutive dilutions. While the invention is not limited by any specific theory, the biological activity of the “activated-potentiated” form of the antibodies of the present invention is not attributable to the initial

molecular form of the antibody. Preferred is the “activated-potentiated” form of antibody in liquid or solid form in which the concentration of the molecular form of the antibody is below the limit of detection of the accepted analytical techniques, such as capillary electrophoresis and High Performance Liquid Chromatography. Particularly preferred is the “activated-potentiated” form of antibody in liquid or solid form in which the concentration of the molecular form of the antibody is below the Avogadro number. In the pharmacology of molecular forms of therapeutic substances, it is common practice to create a dose-response curve in which the level of pharmacological response is plotted against the concentration of the active drug administered to the subject or tested in vitro. The minimal level of the drug which produces any detectable response is known as a threshold dose. It is specifically contemplated and preferred that the “activated-potentiated” form of the antibodies contains molecular antibody, if any, at a concentration below the threshold dose for the molecular form of the antibody in the given biological model.

The term “CB1 receptor” has its general meaning in the art, and may include naturally occurring CB1 receptor and variants and modified forms thereof. The CB1 receptor can be from any source, but typically is mammalian.

The term “obesity” denotes a range of weight that is greater than what is generally considered healthy for a given height. Obesity ranges are determined by using weight and height to calculate a number called the “body mass index” (BMI). An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. BMI formula as follows:

$$\text{Weight} - (\text{Height in inches})^2 \times 703 = \text{BMI}$$

BMI does not always accurately indicate the degree of fatness. An increasing number of papers indicate that the degree of central fat (central obesity) distribution may be more closely tied to metabolic risks than BMI. It appears that measurement of the degree of central fat distribution appears to be important for the early detection of subsequent health risks, even among individuals of normal weight. S D Hsieh, H Yoshinaga and T Muto, International Journal of Obesity (2003) 27, 610–616. See also, Price GM, Uauy R, Breeze E, Bulpitt CJ, Fletcher AE (August 2006). “*Weight, shape, and mortality risk in older persons: elevated waist-hip ratio, not high body mass index, is associated with a greater risk of death*” Am. J. Clin. Nutr. 84 (2): 449–60. Waist circumference and waist circumference-derived indices such as waist-to-hip ratio and waist-to-height ratio have been used as proxy measures of central obesity. Sung et. al., *Waist*

circumference and waist-to-height ratio of Hong Kong Chinese children, BMC Public Health 2008, 8:324. Thus, measurement of anthropometric parameters, for example, waist circumference, waist-to-hip ratio and waist-to-height ratio, is believed to be an indicator of degree of fatness.

The term “waist-to-hip ratio” is the ratio of the circumference of the waist to that of the hips. The waist-hip ratio equals the waist circumference divided by the hip circumference. A waist-to-hip ratio of greater than 0.9 in women, and 1.0 in men, is associated with an increased risk for cardiovascular disease, and is an indication for treatment of obesity. Ideally, women should have a waist-to-hip ratio of 0.8 or less and men should have a waist-to-hip ratio of 0.95 or less.

The term “waist-to-height ratio” of a person is defined as the person's waist circumference, divided by the person's height. For people under 40, a waist-to-height ratio of over 0.5 is critical; for people in the age group between 40 and 50 the critical value is between 0.5 and 0.6, and for people over 50 the critical values start at 0.6.

The term “obesity-related metabolic disorders” refers to chronic diseases that require treatment to reduce the excessive health risks associated with obesity and exemplary disorders include type 2 diabetes mellitus, cardiovascular disorders and hypertension, hyperlipidaemia and fibrinolytic abnormalities.

The term “Fagerström test” refers to a standard test for nicotine dependence which is a test for assessing the intensity of nicotine addiction. See Heatherton, T.F., Kozlowski, L.T., Frecker, R.C., Fagerström, K.O. The Fagerström test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire. Br J Addict 1991; 86:1119-27. The test consists of a brief, self-report survey that measures nicotine dependence on a scale of 0-10, with 10 being the highest level of dependence.

The term “Mood and Physical Symptoms Scale” (MPSS) refers to a scale developed in the early 1980s used to assess cigarette withdrawal symptoms. (West R, Hajek P: Evaluation of the mood and physical symptoms scale (MPSS) to assess cigarette withdrawal. *Psychopharmacology* 2004, 177(1-2):195-199). The core elements of MPSS involve 5-point rating of depressed mood, irritability, restlessness, difficulty concentrating and hunger and 6-point rating of strength of urges to smoke and time spent with these urges.

The term "Hospital Anxiety and Depression Scale" (HADS) refers to a subjective scale for screening of signs of anxiety and depression in in-patients and out-patients. See Zigmond, A. S., Snaith, R.P., *The Hospital Anxiety and Depression scale*, Acta Psychiatr. Scand., 1983, Vol. 67, pages 361-370.

The present invention provides a pharmaceutical composition for administration to a patient in need thereof, the pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor.

The present invention further provides a pharmaceutical composition for administration to a patient in need thereof, the pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor and b) an activated-potentiated form of an antibody to protein S-100.

The pharmaceutical composition in accordance with this aspect of the invention may be in the liquid form or in solid form. Each of the activated potentiated forms of the antibodies included in the pharmaceutical composition is prepared from an initial molecular form of the antibody via a process accepted in homeopathic art. The starting antibodies may be monoclonal, or polyclonal antibodies prepared in accordance with known processes, for example, as described in *Immunotechniques*, G. Frimel, M., "Meditsyna", 1987, p. 9-33; "Hum. Antibodies. Monoclonal and recombinant antibodies, 30 years after" by Laffly E., Sodoyer R. – 2005 – Vol. 14. – N 1-2, pages 33-55, both incorporated herein by reference.

It is contemplated that the pharmaceutical combination for treating obesity and nicotine addiction is administered in the amount of 6-8 tablets per day. In one variant, the mode of administration includes 2 tablets, 3 times per day. In another variant, the mode of administration includes 3 tablets, 2 times per day. In another variant, the mode of administration includes 4 tablets, 2 times per day. In another variant, the mode of administration includes 1 tablets, 6 times per day. In another variant, the mode of administration includes 2 tablets, 4 times per day.

Monoclonal antibodies may be obtained, e.g., by means of hybridoma technology. The initial stage of the process includes immunization based on the principles already developed in the course of polyclonal antisera preparation. Further stages of work involve production of hybrid cells generating clones of antibodies with identical specificity. Their separate isolation is performed using the same methods as in the case of polyclonal antisera preparation.

Polyclonal antibodies may be obtained via active immunization of animals. For this purpose, for example, suitable animals (e.g. rabbits) receive a series of injections of the appropriate antigen, either human cannabinoid receptor or protein S-100. The animals' immune system generates corresponding antibodies, which are collected from the animals in a known manner. This procedure enables preparation of a monospecific antibody-rich serum.

If desired, the serum containing antibodies may be purified, e.g., using affine chromatography, fractionation by salt precipitation, or ion-exchange chromatography. The resulting purified, antibody-enriched serum may be used as a starting material for the preparation of the activated-potentiated form of the antibodies. The preferred concentration of the resulting initial solution of antibody in the solvent, preferably water or water-ethyl alcohol mixture, ranges from about 0.5 to about 5.0 mg/ml.

The preferred procedure for preparing the activated-potentiated form of antibodies of the present invention or the combination antibodies according to the present invention, is the use of the mixture of three aqueous-alcohol dilutions of the primary matrix solution of antibodies diluted 100^{12} , 100^{30} and 100^{200} times, respectively, which is equivalent to centesimal homeopathic dilutions C12, C30 and C200. To prepare a solid dosage form, a solid carrier is treated with the desired dilution obtained via the homeopathic process. To obtain a solid unit dosage form of the combination of the invention, the carrier mass is impregnated with each of the dilutions. Both orders of impregnation are suitable to prepare the desired combination dosage form.

In a preferred embodiment, the starting material for the preparation of the activated potentiated form that comprise the invention is polyclonal, animal-raised antibody to the corresponding antigen, namely, human cannabinoid receptor and/or protein S-100.

To obtain the activated-potentiated form of polyclonal antibodies to human cannabinoid receptor, the desired antigen may be injected as immunogen into a laboratory animal, preferably rabbits. In order to obtain polyclonal antibodies to human cannabinoid receptor, it is possible to use the entire molecule of human cannabinoid receptor. The following sequence (SEQ. ID. NO:1) of the human cannabinoid receptor is specifically contemplated as suitable antigen:

SEQ. ID. NO:1 HUMAN CBI RECEPTOR

Met	Lys	Ser	Ile	Leu	Asp	Gly	Leu	Ala	Asp	Thr	Thr	Phe	Arg	Thr
1				5					10					15
Ile	Thr	Thr	Asp	Leu	Leu	Tyr	Val	Gly	Ser	Asn	Asp	Ile	Gln	Tyr
16				20					25					30
Glu	Asp	Ile	Lys	Gly	Asp	Met	Ala	Ser	Lys	Leu	Gly	Tyr	Phe	Pro
31				35					40					45
Gln	Lys	Phe	Pro	Leu	Thr	Ser	Phe	Arg	Gly	Ser	Pro	Phe	Gln	Glu
46				50					55					60
Lys	Met	Thr	Ala	Gly	Asp	Asn	Pro	Gln	Leu	Val	Pro	Ala	Asp	Gln
61				65					70					75
Val	Asn	Ile	Thr	Glu	Phe	Tyr	Asn	Lys	Ser	Leu	Ser	Ser	Phe	Lys
76				80					85					90
Glu	Asn	Glu	Glu	Asn	Ile	Gln	Cys	Gly	Glu	Asn	Phe	Met	Asp	Ile
91				95					100					105
Glu	Cys	Phe	Met	Val	Leu	Asn	Pro	Ser	Gln	Gln	Leu	Ala	Ile	Ala
106				110					115					120
Val	Leu	Ser	Leu	Thr	Leu	Gly	Thr	Phe	Thr	Val	Leu	Glu	Asn	Leu
121				125					130					135
Leu	Val	Leu	Cys	Val	Ile	Leu	His	Ser	Arg	Ser	Leu	Arg	Cys	Arg
136				140					145					150
Pro	Ser	Tyr	His	Phe	Ile	Gly	Ser	Leu	Ala	Val	Ala	Asp	Leu	Leu
151				155					160					165
Gly	Ser	Val	Ile	Phe	Val	Tyr	Ser	Phe	Ile	Asp	Phe	His	Val	Phe
166				170					175					180
His	Arg	Lys	Asp	Ser	Arg	Asn	Val	Phe	Leu	Phe	Lys	Leu	Gly	Gly
181				185					190					195
Val	Thr	Ala	Ser	Phe	Thr	Ala	Ser	Val	Gly	Ser	Leu	Phe	Leu	Thr
196				200					205					210
Ala	Ile	Asp	Arg	Tyr	Ile	Ser	Ile	His	Arg	Pro	Leu	Ala	Tyr	Lys
211				215					220					225
Arg	Ile	Val	Thr	Arg	Pro	Lys	Ala	Val	Val	Ala	Phe	Cys	Leu	Met
226				230					235					240
Trp	Thr	Ile	Ala	Ile	Val	Ile	Ala	Val	Leu	Pro	Leu	Leu	Gly	Trp
241				245					250					255
Asn	Cys	Glu	Lys	Leu	Gln	Ser	Val	Cys	Ser	Asp	Ile	Phe	Pro	His
256				260					265					270
Ile	Asp	Glu	Thr	Tyr	Leu	Met	Phe	Trp	Ile	Gly	Val	Thr	Ser	Val
271				275					280					285
Leu	Leu	Leu	Phe	Ile	Val	Tyr	Ala	Tyr	Met	Tyr	Ile	Leu	Trp	Lys
286				290					295					300
Ala	His	Ser	His	Ala	Val	Arg	Met	Ile	Gln	Arg	Gly	Thr	Gln	Lys
301				305					310					315
Ser	Ile	Ile	Ile	His	Thr	Ser	Glu	Asp	Gly	Lys	Val	Gln	Val	Thr
316				320					325					330
Arg	Pro	Asp	Gln	Ala	Arg	Met	Asp	Ile	Arg	Leu	Ala	Lys	Thr	Leu

331	335	340	345
Val Leu Ile Leu	Val Val Leu Ile Ile	Cys Trp Gly Pro Leu Leu	
346	350	355	360
Ala Ile Met Val	Tyr Asp Val Phe Gly	Lys Met Asn Lys Leu Ile	
361	360	370	375
Lys Thr Val Phe	Ala Phe Cys Ser Met	Leu Cys Leu Leu Asn Ser	
376	375	385	390
Thr Val Asn Pro	Ile Ile Tyr Ala Leu	Arg Ser Lys Asp Leu Arg	
391	395	400	405
His Ala Phe Arg	Ser Met Phe Pro Ser	Cys Glu Gly Thr Ala Gln	
406	410	415	420
Pro Leu Asp Asn	Ser Met Gly Asp Ser	Asp Cys Leu His Lys His	
421	425	430	435
Ala Asn Asn Ala	Ala Ser Val His Arg	Ala Ala Glu Ser Cys Ile	
436	440	445	450
Lys Ser Thr Val	Lys Ile Ala Lys Val	Thr Met Ser Val Ser Thr	
451	455	460	465
Asp Thr Ser Ala	Glu Ala Leu		
466	470	472	

SEQ ID NO:2 HUMAN CB2 RECEPTOR

Met Glu Glu Cys Trp Val Thr Glu Ile Ala Asn Gly Ser Lys Asp	
1	5 10 15
Gly Leu Asp Ser Asn Pro Met Lys Asp Tyr Met Ile Leu Ser Gly	
16	20 25 30
Pro Gln Lys Thr Ala Val Ala Val Leu Cys Thr Leu Leu Gly Leu	
31	35 40 45
Leu Ser Ala Leu Glu Asn Val Ala Val Leu Tyr Leu Ile Leu Ser	
46	50 55 60
Ser His Gln Leu Arg Arg Lys Pro Ser Tyr Leu Phe Ile Gly Ser	
61	65 70 75
Leu Ala Gly Ala Asp Phe Leu Ala Ser Val Val Phe Ala Cys Ser	
76	80 85 90
Phe Val Asn Phe His Val Phe His Gly Val Asp Ser Lys Ala Val	
91	95 100 105
Phe Leu Leu Lys Ile Gly Ser Val Thr Met Thr Phe Thr Ala Ser	
106	110 115 120
Val Gly Ser Leu Leu Leu Thr Ala Ile Asp Arg Tyr Leu Cys Leu	
121	125 130 135
Arg Tyr Pro Pro Ser Tyr Lys Ala Leu Leu Thr Arg Gly Arg Ala	
136	140 145 150
Leu Val Thr Leu Gly Ile Met Trp Val Leu Ser Ala Leu Val Ser	
151	155 160 165
Tyr Leu Pro Leu Met Gly Trp Thr Cys Cys Pro Arg Pro Cys Ser	
166	170 175 180

Glu 181	Leu	Phe	Pro	Leu 185	Ile	Pro	Asn	Asp	Tyr 190	Leu	Leu	Ser	Trp	Leu 195
Leu 196	Phe	Ile	Ala	Phe 200	Leu	Phe	Ser	Gly	Ile 205	Ile	Tyr	Thr	Tyr	Gly 210
His 211	Val	Leu	Trp	Lys 215	Ala	His	Gln	His	Val 220	Ala	Ser	Leu	Ser	Gly 225
His 226	Gln	Asp	Arg	Gln 230	Val	Pro	Gly	Met	Ala 235	Arg	Met	Arg	Leu	Asp 240
Val 241	Arg	Leu	Ala	Lys 245	Thr	Leu	Gly	Leu	Val 250	Leu	Ala	Val	Leu	Leu 255
Ile 256	Cys	Trp	Phe	Pro 260	Val	Leu	Ala	Leu	Met 265	Ala	His	Ser	Leu	Ala 270
Thr 271	Thr	Leu	Ser	Asp 275	Gln	Val	Lys	Lys	Ala 280	Phe	Ala	Phe	Cys	Ser 285
Met 286	Leu	Cys	Leu	Ile 290	Asn	Ser	Met	Val	Asn 295	Pro	Val	Ile	Tyr	Ala 300
Leu 301	Arg	Ser	Gly	Glu 305	Ile	Arg	Ser	Ser	Ala 310	His	His	Cys	Leu	Ala 315
His 316	Trp	Lys	Lys	Cys 320	Val	Arg	Gly	Leu	Gly 325	Ser	Glu	Ala	Lys	Glu 330
Glu 331	Ala	Pro	Arg	Ser 335	Ser	Val	Thr	Glu	Thr 340	Glu	Ala	Asp	Gly	Lys 345
Ile 346	Thr	Pro	Trp	Pro 350	Asp	Ser	Arg	Asp	Leu 355	Asp	Leu	Ser	Asp	Cys 360

Preferably, a polypeptide fragment of human cannabinoid receptor is used as immunogen (antigen) for rabbits' immunization. In order to obtain polyclonal antibodies to obtain a polypeptide fragment of human cannabinoid receptor, it is possible to use a synthetic peptide of human cannabinoid receptor as immunogen (antigen). Suitable sequences (human CB1 receptor) for such antigen are as follows:

Gln Arg Gly Thr Gln Lys
310 315

Ser Ile Ile Ile
316 319

	Glu	Lys	Leu	Gln	Ser	Val	Cys	Ser	Asp	Ile	Phe	Pro	His
	258		260					265					270
Ile	Asp	Glu	Thr	Tyr	Leu								
271				275	276								

								Ile	Gln	Arg	Gly	Thr	Gln	Lys
								309	310					315
Ser	Ile	Ile	Ile	His	Thr	Ser	Glu	Asp	Gly	Lys	Val	Gln	Val	Thr
316				320					325					330
Arg	Pro	Asp	Gln	Ala	Arg	Met								
331				335		337								

														Lys
														300
Ala	His	Ser	His	Ala	Val	Arg	Met	Ile	Gln	Arg	Gly	Thr	Gln	Lys
301				305					310					315
Ser	Ile	Ile	Ile	His	Thr	Ser	Glu	Asp	Gly	Lys	Val	Gln	Val	Thr
316				320					325					330
Arg	Pro	Asp	Gln	Ala	Arg	Met	Asp	Ile	Arg	Leu	Ala	Lys	Thr	
331				335					340				344	

[illegible]

				Thr	Glu	Phe	Tyr	Asn	Lys	Ser	Leu	Ser	Ser	Phe	Lys
				79	80					85					90
Glu	Asn	Glu	Glu	Asn	Ile	Gln	Cys	Gly	Glu	Asn	Phe	Met	Asp	Ile	
91				95					100						105
Glu	Cys	Phe	Met	Val	Leu	Asn	Pro	Ser							
106				110				114							

	Gln	
	420	
Pro Leu Asp Asn Ser Met Gly Asp Ser Asp Cys Leu His Lys	His	
421 425 430	435	
Ala Asn		
436 437		

Gly Thr Gln Lys
312 315

Gly Thr Gln Lys
312 315

Val	Val	Ala	Phe	Cys	Leu	Met
234	235					240

Val	Val	Ala	Phe	Cys	Leu	Met
234	235					240

Gly Ser Pro Phe Gln Glu
55 60

Gly Ser Pro Phe Gln Glu
55 60

Val Asn Ile Thr Glu Phe Tyr Asn Lys Ser Leu
 76 80 85 86

SEQ ID NO: 16.

Ala Tyr Lys
 223 225
 Arg Ile Val Thr Arg Pro Lys Ala Val Val Ala Phe Cys Leu Met
 226 230 235 240
 Trp Thr Ile Ala Ile Val Ile Ala Val Leu Pro Leu Leu Gly Trp
 241 245 250 255
 Asn
 256

The exemplary procedure for preparation of the starting polyclonal antibodies to human cannabinoid receptor may be described as follows. In 7-9 days before blood sampling, 1-3 intravenous injections of the desired antigen are made to the rabbits to increase the level of polyclonal antibodies in the rabbit blood stream. Upon immunization, blood samples are taken to test the antibody level. Typically, the maximum level of immune reaction of the soluble antigen is achieved within 40 to 60 days after the first injection of the antigen. Upon completion of the first immunization cycle, rabbits have a 30-day rehabilitation period, after which re-immunization is performed with another 1-3 intravenous injections.

To obtain antiserum containing the desired antibodies, the immunized rabbits' blood is collected from rabbits and placed in a 50ml centrifuge tube. Product clots formed on the tube sides are removed with a wooden spatula, and a rod is placed into the clot in the tube center. The blood is then placed in a refrigerator for one night at the temperature of about -40°C. On the following day, the clot on the spatula is removed, and the remaining liquid is centrifuged for 10 minutes at 13,000 rotations per minute. Supernatant fluid is the target antiserum. The obtained antiserum is typically yellow. 20% of NaN₃ (weight concentration) is added in the antiserum to the final concentration of 0.02% and stored before use in frozen state at the temperature of -20°C or without NaN₃ at the temperature of -70°C. To separate the target antibodies to cannabinoid receptor from the antiserum, the following solid phase absorption sequence is suitable:

10 ml of the antiserum of rabbits is diluted twofold with 0.15 M NaCl, after which 6.26g Na₂SO₄ is added, mixed and incubated for 12-16 hours at 4°C. The sediment is removed by centrifugation, diluted in 10 ml of phosphate buffer and dialyzed against the same buffer during one night at room temperature. After the sediment is removed, the solution is applied to a DEAE-cellulose column balanced by phosphate buffer. The antibody fraction is determined by measuring the optical density of the eluate at 280 nm.

The isolated crude antibodies are purified using the affine chromatography method by attaching the obtained antibodies to cannabinoid receptor located on the insoluble matrix of the chromatography media, with subsequent elution by concentrated aqueous salt solutions.

The resulting buffer solution is used as the initial solution for the homeopathic dilution process used to prepare the activated potentiated form of the antibodies. The preferred concentration of the initial matrix solution of the antigen-purified polyclonal rabbit antibodies to cannabinoid receptor is 0.5 - 5.0 mg/ml, preferably, 2.0 - 3.0 mg/ml.

The brain-specific S100 protein, expressed by neurons and glial cells (astrocytes and oligodendrocytes), directly or through interactions with other proteins executes in the CNS a number of functions directed at maintaining normal brain functioning, including affecting learning and memory processes, growth and viability of neurons, regulation of metabolic processes in neuronal tissues and others. To obtain polyclonal antibodies to brain-specific protein S-100, brain-specific protein S-100 is used, which physical and chemical properties are described in the article of M. V. Starostin, S. M. Sviridov, Neurospecific Protein S-100, *Progress of Modern Biology*, 1977, Vol. 5, P. 170-178; found in the book M. B. Shtark, *Brain-Specific Protein Antigens and Functions of Neuron*, "Medicine", 1985; P. 12-14. Brain-specific protein S-100 is allocated from brain tissue of the bull by the following technique:

- the bull brain tissue frozen in liquid nitrogen is converted into powder using a specialized mill;
- proteins are extracted in the ratio of 1:3 (weight/volume) using an extracting buffer with homogenization;
- the homogenate is heated for 10 min at 60°C and then cooled to 4°C in an ice bath;
- thermolabile proteins are removed by centrifugation;

- ammonium sulfate fractionation is carried out in stages, with subsequent removal of precipitated proteins;
- the fraction containing S-100 protein is precipitated using 100% saturated ammonium sulfate accomplished by pH drop to 4.0; the desired fraction is collected by centrifugation;
- the precipitate is dissolved in a minimum buffer volume containing EDTA and mercaptoethanol, the precipitate is dialyzed with deionized water and lyophilized;
- fractionation of acidic proteins is followed by chromatography in ion-exchanging media, DEAE-cellulose DE-52 and then DEAE-sephadex A-50;
- the collected and dialyzed fractions, which contain S-100 protein, are divided according to molecular weight by gel filtration on sephadex G-100;
- purified S-100 protein is dialyzed and lyophilized.

The molecular weight of the purified brain-specific protein S-100 is 21000 D.

Owing to the high concentration of asparaginic and glutaminic acids brain-specific protein S-100 is highly acidic and occupies extreme anode position during electroendosmosis in a discontinuous buffer system of polyacrylamide gel which facilitates its identification.

The polyclonal antibodies to S-100 protein may also be obtained by a similar methodology to the methodology described for cannabinoid receptor antibodies using an adjuvant. The entire molecule of S-100 protein may be used as immunogen (antigen) for rabbits' immunization:

SEQ ID NO: 17 - Bovine S100B

Met	Ser	Glu	Leu	Glu	Lys	Ala	Val	Val	Ala	Leu	Ile	Asp	Val	Phe
1				5					10					15
His	Gln	Tyr	Ser	Gly	Arg	Glu	Gly	Asp	Lys	His	Lys	Leu	Lys	Lys
16				20					25					30
Ser	Glu	Leu	Lys	Glu	Leu	Ile	Asn	Asn	Glu	Leu	Ser	His	Phe	Leu
31				35					40					45
Glu	Glu	Ile	Lys	Glu	Gln	Glu	Val	Val	Asp	Lys	Val	Met	Glu	Thr
46				50					55					60
Leu	Asp	Ser	Asp	Gly	Asp	Gly	Glu	Cys	Asp	Phe	Gln	Glu	Phe	Met
61				65					70					75
Ala	Phe	Val	Ala	Met	Ile	Thr	Thr	Ala	Cys	His	Glu	Phe	Phe	Glu
76				80					85					90
His	Glu													
91	92													

SEQ ID 18 - Human S100B

Met	Ser	Glu	Leu	Glu	Lys	Ala	Met	Val	Ala	Leu	Ile	Asp	Val	Phe
1				5					10					15
His	Gln	Tyr	Ser	Gly	Arg	Glu	Gly	Asp	Lys	His	Lys	Leu	Lys	Lys
16				20					25					30
Ser	Glu	Leu	Lys	Glu	Leu	Ile	Asn	Asn	Glu	Leu	Ser	His	Phe	Leu
31				35					40					45
Glu	Glu	Ile	Lys	Glu	Gln	Glu	Val	Val	Asp	Lys	Val	Met	Glu	Thr
46				50					55					60
Leu	Asp	Asn	Asp	Gly	Asp	Gly	Glu	Cys	Asp	Phe	Gln	Glu	Phe	Met
61				65					70					75
Ala	Phe	Val	Ala	Met	Val	Thr	Thr	Ala	Cys	His	Glu	Phe	Phe	Glu
76				80					85					90
His	Glu													
91	92													

SEQ ID NO: 19 - Human S100A1

Met	Gly	Ser	Glu	Leu	Glu	Thr	Ala	Met	Glu	Thr	Leu	Ile	Asn	Val
1				5					10					15
Phe	His	Ala	His	Ser	Gly	Lys	Glu	Gly	Asp	Lys	Tyr	Lys	Leu	Ser
16				20					25					30
Lys	Lys	Glu	Leu	Lys	Glu	Leu	Leu	Gln	Thr	Glu	Leu	Ser	Gly	Phe
31				35					40					45
Leu	Asp	Ala	Gln	Lys	Asp	Val	Asp	Ala	Val	Asp	Lys	Val	Met	Lys
46				50					55					60
Glu	Leu	Asp	Glu	Asn	Gly	Asp	Gly	Glu	Val	Asp	Phe	Gln	Glu	Tyr
61				65					70					75
Val	Val	Leu	Val	Ala	Ala	Leu	Thr	Val	Ala	Cys	Asn	Asn	Phe	Phe
76				80					85					90
Trp	Glu	Asn	Ser											
91			94											

SEQ ID NO 20 - Bovine S100A1

Met	Gly	Ser	Glu	Leu	Glu	Thr	Ala	Met	Glu	Thr	Leu	Ile	Asn	Val
1				5					10					15
Phe	His	Ala	His	Ser	Gly	Lys	Glu	Gly	Asp	Lys	Tyr	Lys	Leu	Ser
16				20					25					30
Lys	Lys	Glu	Leu	Lys	Glu	Leu	Leu	Gln	Thr	Glu	Leu	Ser	Gly	Phe
31				35					40					45
Leu	Asp	Ala	Gln	Lys	Asp	Ala	Asp	Ala	Val	Asp	Lys	Val	Met	Lys
46				50					55					60
Glu	Leu	Asp	Glu	Asn	Gly	Asp	Gly	Glu	Val	Asp	Phe	Gln	Glu	Tyr
61				65					70					75

Val	Val	Leu	Val	Ala	Ala	Leu	Thr	Val	Ala	Cys	Asn	Asn	Phe	Phe
76				80					85					90
Trp	Glu	Asn	Ser											
91			94											

To obtain antiserum, brain-specific S-100 protein or the mixture of S-100 protein s (antigens) in complex with methylated bull serum albumin as the carrying agent with full Freund's adjuvant is prepared and added to allocated brain-specific protein S-100 which is injected subdermally to a laboratory animal – a rabbit into area of back in quantity of 1-2 ml. On 8th, 15th day repeated immunization is made. Blood sampling is made (for example, from a vein in the ear) on the 26th and the 28th day.

The obtained antiserum titre is 1:500 - 1:1000, forms single precipitin band with an extract of nervous tissue but does not react with extracts of heterologous bodies and forms single precipitin peak both with pure protein S-100 and with the extract of nervous tissue indicating that the antiserum obtained is monospecific.

The activated potentiated form of the antibodies of the present invention may be prepared from an initial solution by homeopathic potentization, preferably using the method of proportional concentration decrease by serial dilution of 1 part of each preceding solution (beginning with the initial solution) in 9 parts (for decimal dilution), or in 99 parts (for centesimal dilution), or in 999 parts (for millesimal dilution) of a neutral solvent, starting with a concentration of the initial solution of antibody in the solvent, preferably, water or a water-ethyl alcohol mixture, in the range from about 0.5 to about 5.0 mg/ml, coupled with external impact. Preferably, the external impact involves multiple vertical shaking (dynamization) of each dilution. Preferably, separate containers are used for each subsequent dilution up to the required potency level, or the dilution factor. This method is well-accepted in the homeopathic art. See, e.g. V. Schwabe "*Homeopathic medicines*", M., 1967, p. 14-29, incorporated herein by reference for the purpose stated.

For example, to prepare a 12-centesimal dilution (denoted C12), one part of the initial matrix solution of antibodies to human cannabinoid receptor with the concentration of 3.0 mg/ml is diluted in 99 parts of neutral aqueous or aqueous-alcohol solvent (preferably, 15%-ethyl alcohol) and then vertically shaken many times (10 and more) to create the 1st centesimal dilution (denoted as C1). The 2nd centesimal dilution (C2) is prepared from the 1st centesimal

dilution C1. This procedure is repeated 11 times to prepare the 12th centesimal dilution C12. Thus, the 12th centesimal dilution C12 represents a solution obtained by 12 serial dilutions of one part of the initial matrix solution of antibodies to human cannabinoid receptor with the concentration of 3.0 mg/ml in 99 parts of a neutral solvent in different containers, which is equivalent to the centesimal homeopathic dilution C12. Similar procedures with the relevant dilution factor are performed to obtain dilutions C30 and C200. The intermediate dilutions may be tested in a desired biological model to check activity. The preferred activated potentiated forms for the antibodies comprising the invention are a mixture of C12, C30, and C200 dilutions for each activated-potentiated form. When using the mixture of various homeopathic dilutions (primarily centesimal) of the active substance as biologically active liquid component, each component of the composition (e.g., C12, C30, C200) is prepared separately according to the above-described procedure until the next-to-last dilution is obtained (e.g., until C11, C29, and C199 respectively), and then one part of each component is added in one container according to the mixture composition and mixed with the required quantity of the solvent (e.g. with 97 parts for centesimal dilution).

It is possible to use the active substance as mixture of various homeopathic dilutions, e.g. decimal and/or centesimal (D20, C30, C100 or C12, C30, C50 etc.), the efficiency of which is determined experimentally by testing the dilution in a suitable biological model, for example, in models described in the examples herein.

In course of potentiation and concentration decrease, the vertical shaking may be substituted for external exposure to ultrasound, electromagnetic fields or any similar external impact procedure accepted in the homeopathic art.

Preferably, the pharmaceutical composition of the invention may be in the form of a liquid or in the solid unit dosage form. Where the pharmaceutical composition comprises two antibodies, the liquid form of the pharmaceutical composition comprises a mixture of two antibodies, preferably, at a 1:1 ratio of the activated potentiated form of antibodies to human cannabinoid receptor and the activated potentiated form of antibodies to protein S-100. The preferred liquid carrier is water or water-ethyl alcohol mixture.

The solid unit dosage form of the pharmaceutical composition of the invention may be prepared by using impregnating a solid, pharmaceutically acceptable carrier with the mixture of

the activated potentiated form aqueous or aqueous-alcohol solutions of active components. Where the pharmaceutical composition comprises two antibodies, the active components are mixed, primarily in 1:1 ratio and used in liquid dosage form. Alternatively, the carrier may be impregnated consecutively with each requisite dilution. Both orders of impregnation are acceptable.

Preferably, the pharmaceutical composition in the solid unit dosage form is prepared from granules of the pharmaceutically acceptable carrier which was previously saturated with the aqueous or aqueous-alcoholic dilutions of the activated potentiated form of antibodies. The solid dosage form may be in any form known in the pharmaceutical art, including a tablet, a capsule, a lozenge, and others. As an inactive pharmaceutical ingredients one can use glucose, sucrose, maltose, amylum, isomaltose, isomalt and other mono- oligo- and polysaccharides used in manufacturing of pharmaceuticals as well as technological mixtures of the above mentioned inactive pharmaceutical ingredients with other pharmaceutically acceptable excipients, for example isomalt, crospovidone, sodium cyclamate, sodium saccharine, anhydrous citric acid etc), including lubricants, disintegrants, binders and coloring agents. The preferred carriers are lactose and isomalt. The pharmaceutical dosage form may further include standard pharmaceutical excipients, for example, microcrystalline cellulose and magnesium stearate.

The example of preparation of the solid unit dosage form is set forth below. To prepare the solid oral form, 100-300 μm granules of lactose are impregnated with aqueous or aqueous-alcoholic solutions of the activated potentiated form of antibodies to human cannabinoid receptor and/or the activated potentiated form of antibodies to S-100 in the ratio of 1 kg of antibody solution to 5 or 10 kg of lactose (1:5 to 1:10). To effect impregnation, the lactose granules are exposed to saturation irrigation in the fluidized boiling bed in a boiling bed plant (e.g. "Hüttlin Pilotlab" by Hüttlin GmbH) with subsequent drying via heated air flow at a temperature below 40°C. The estimated quantity of the dried granules (10 to 34 weight parts) saturated with the activated potentiated form of antibodies is placed in the mixer, and mixed with 25 to 45 weight parts of "non-saturated" pure lactose (used for the purposes of cost reduction and simplification and acceleration of the technological process without decreasing the treatment efficiency), together with 0.1 to 1 weight parts of magnesium stearate, and 3 to 10 weight parts of microcrystalline cellulose. The obtained tablet mass is uniformly mixed, and tableted by direct

dry pressing (e.g., in a Korsch – XL 400 tablet press) to form 150 to 500 mg round pills, preferably, 300 mg. After tableting, 300 mg pills are obtained that are saturated with aqueous-alcohol solution (3.0-6.0 mg/pill) of the combination of the activated-potentiated form of antibodies. Each component of the combination used to impregnate the carrier is in the form of a mixture of centesimal homeopathic dilutions, preferably, C12, C30 and C200.

While the invention is not limited to any specific theory, it is believed that the activated potentiated form of the antibodies described herein do not contain the molecular form of the antibody in an amount sufficient to have biological activity attributed to such molecular form. The biological activity of the pharmaceutical composition of the invention and the combination pharmaceutical composition of the invention is amply demonstrated in the appended examples.

The pharmaceutical composition comprising activated-potentiated form of an antibody to human cannabinoid receptor may be used for administration to patients suffering from obesity and related metabolic disorders.

As shown in the appended examples, the administration of the activated potentiated form of the antibody of the present invention results in a reduction of body mass, reduction of body mass growth, reduction of central obesity and facilitating a reduction of food consumption.

In one embodiment, the present invention provides a method of treating obesity and related metabolic disorders by administering pharmaceutical compositions comprising activated potentiated form of an antibody to human cannabinoid receptor, preferably the cannabinoid receptor 1.

In another embodiment, the present invention provides a method of facilitating a reduction of food consumption in a subject expected to benefit from such reduction, by administering a pharmaceutical composition comprising activated-potentiated form of an antibody to human cannabinoid receptor, preferably the cannabinoid receptor 1.

In an embodiment, methods for altering anthropometric parameters, e.g., waist circumference, waist-to-hip ratio and waist-to-height ratio are provided. In one embodiment, methods for reducing waist circumference of a subject are provided, wherein the method comprises administering, to a subject in need thereof, pharmaceutical compositions comprising activated potentiated form of an antibody to human cannabinoid receptor in an amount effective to reduce the waist circumference of the subject. In one embodiment the human cannabinoid

receptor is human cannabinoid receptor 1. In one embodiment, the waist circumference of the subject is reduced by at least about 1%. In other embodiments, the waist circumference of the subject is reduced by at least about 1.5%, 2%, 2.5%, 3% or 3.5%, compared to the subject prior to administration of the pharmaceutical compositions comprising activated potentiated form of an antibody to human cannabinoid receptor. In one embodiment, the waist circumference of the subject is reduced by at least about 1 cm. In other embodiments, the waist circumference of the subject is reduced by at least about 2 cm, 3 cm or 4 cm compared to the subject prior to administration of the pharmaceutical compositions comprising an activated potentiated form of an antibody to human cannabinoid receptor.

In another embodiment, methods for reducing body mass of a subject are provided, wherein the method comprises administering, to a subject in need thereof, pharmaceutical compositions comprising an activated potentiated form of an antibody to human cannabinoid receptor in an amount effective to reduce body mass of the subject. In one embodiment the human cannabinoid receptor is human cannabinoid receptor 1. In one embodiment, the body mass of the subject is reduced by at least about 15%. In other embodiments, the body mass of the subject is reduced by at least about 5%, 10%, or 15% compared to the subject prior to administration of the pharmaceutical compositions comprising an activated potentiated form of an antibody to human cannabinoid receptor.

In another embodiment, methods for reducing the body mass growth of a subject are provided, wherein the method comprises administering, to a subject in need thereof, pharmaceutical compositions comprising an activated potentiated form of an antibody to human cannabinoid receptor in an amount effective to reduce body mass growth of the subject. In one embodiment the human cannabinoid receptor is human cannabinoid receptor 1. In one embodiment, the body mass growth of the subject is reduced by at least about 60%. In other embodiments, the body mass growth of the subject is reduced by at least about 10%, 25%, 30%, 50%, or 60% compared to the subject prior to administration of the pharmaceutical compositions comprising an activated potentiated form of an antibody to human cannabinoid receptor.

The pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor and an activated-potentiated form of an antibody to S-100 protein

may be used for administration to patients suffering from dependence on psychoactive substances, preferably nicotine dependence.

Applicant surprisingly discovered that the combination of an activated-potentiated form of an antibody to human cannabinoid receptor and an activated-potentiated form of an antibody to S-100 protein is useful in the treatment of substance abuse.

In one embodiment the combination of an activated-potentiated form of an antibody to human cannabinoid receptor and an activated-potentiated form of an antibody to S-100 protein is useful in the treatment of nicotine addiction.

The administration of the pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor 1 and an activated-potentiated form of an antibody to S-100 protein for treatment of patients with nicotine addiction improves the life quality parameters evaluated by such criteria as depression and anxiety.

It has been demonstrated experimentally that the administration of the pharmaceutical composition comprising an activated-potentiated form of an antibody to human cannabinoid receptor 1 and an activated-potentiated form of an antibody to S-100 protein for treatment of patients with nicotine addiction improves the ability to tolerate the quitting of smoking more easily and painlessly as measured by analysis of data of the MPSS test.

It has been demonstrated experimentally that the administration of the combination to patients with non-severe nicotine addiction of > 4 as measured by the Fagerström Test for Nicotine Dependence leads to a reduction of smoking of at least 23% in 4 weeks; at least 36% in 8 weeks and at least 41% in 12 weeks. It has also been demonstrated experimentally that the administration of the combination to patients with non-severe nicotine addiction leads to a statistically significant reduction in the initial average number point on the Fagerström test of at least 1.34 ± 0.14 .

It has been demonstrated experimentally that the administration of the combination to patients with severe nicotine addiction of ≥ 7 as measured by the Fagerström Test for Nicotine Dependence leads to a reduction of smoking of at least 11% in 4 weeks; at least 22% in 8 weeks and at least 30% in 12 weeks. It has also been demonstrated experimentally that the administration of the combination to patients with non-severe nicotine addiction leads to a

statistically significant reduction in the initial average number point on the Fagerström test of at least 4.42 ± 0.30 .

In one embodiment separate administration of the two independently prepared unit dosage forms, each containing one of the activated potentiated forms of antibodies of the combination is also contemplated.

The invention is further illustrated with reference to the appended non-limiting examples.

EXAMPLES

EXAMPLE 1.

The effect of ultra-low doses of polyclonal rabbit antibodies to human cannabinoid receptor type 1 (ULD Anti-CB1), purified on antigen, obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, and C200) on functioning of the cannabinoid receptor, type 1 was tested *in vitro* in 2 regimes: in the agonist regime and in the antagonist regime.

Agonist regime:

Before introduction in the wells of a plate (96 wells plate, 250 μ l well volume), the cells were suspended in HBSS buffer (Invitrogen), which contained 20 mM HEPES (pH=7.4). The cells were pre-incubated for 10 minutes at room temperature together with the addition of 20 μ l of ULD anti-CB1 preparation. After pre-incubation, the adenylylase activator NKH477 was added. The cells were incubated for 10 minutes at 37°C and lysed. A fluorescent acceptor (cAMF, marked D2) and a fluorescent donor (cAMF antibodies, marked by europium cryptate) were introduced in the wells.

As the basal control, the cell suspension was pre-incubated in the presence of HBSS buffer (20 μ l) instead of the ULD anti-CB1. As the stimulated control, the cell suspension was pre-incubated in the presence of the reference CP 55940 agonist (20 μ l) instead of ULD anti-CB1.

The functional activity (cAMF concentration) was evaluated by the homogeneous fluorescence method with time resolution (HTRF). Fluorescence intensity in the basal control

was considered the background, and its value was deducted from the fluorescence intensities in the experimental data (ULD anti-CB1) and control (CP 55940):

The measured specific response of the cell to the introduction of ULD anti-CB1 was calculated according to the formula: fluorescence intensity in experiment (ULD anti-CB1) – fluorescence intensity in basal control.

The measured specific response of the cell to the introduction of the reference agonist (CP 55940) was calculated according to the formula: fluorescence intensity in the control (CP 55940) – fluorescence intensity in basal control.

The results were expressed in percentages of the specific response of the cell to the introduction of the reference agonist in the stimulated control:

Percent of response of reference agonist = ((measured specific response / specific response in control to introduction of reference agonist) x 100%).

Antagonist regime:

Before introduction in the wells of a plate (96 well plate, 250 µl well volume), the cells were suspended in HBSS buffer (Invitrogen), which contained 20 mM HEPES (pH=7.4). The cells were pre-incubated for 5 minutes at room temperature together with 20 µl of ULD anti-CB1. After addition in the wells of the reference CP 55940 agonist, the cells were incubated for 10 minutes at a room temperature. Adenylate cyclase activator NKH477 was added to the wells. The cells were incubated for 10 minutes at 37°C and lysed. The fluorescent acceptor (cAMF, marked D2) and the fluorescent donor (cAMF antibodies, marked by europium cryptate) were introduced into the wells.

As the basal control, the cell suspension was pre-incubated in the presence of the reference antagonist AM 281 (20 µl) instead of ULD anti-CB1. The reference CP 55940 agonist was not added in the wells with the basal control. As the stimulated control, the cell suspension was pre-incubated in the presence of HBSS buffer, which contained 20 mM HEPES (pH=7.4), and the reference CP 55940 agonist (20 µl).

Functional activity (cAMF concentration) was evaluated by the homogeneous fluorescence method with time resolution (HTRF). Fluorescence intensity in the basal control was taken as the background, and its value was deducted from the fluorescence intensities in the experiment (ULD anti-Cb1) and control (CP 55940):

The measured specific response of the cell to the introduction of ULD anti-CB1 was calculated according to the formula: fluorescence intensity in experiment (ULD anti-CB1) – fluorescence intensity in basal control.

The measured specific response of the cell to the introduction of the reference agonist (CP 55940) was calculated according to the formula: fluorescence intensity in control (CP 55940) – fluorescence intensity in basal control.

The results were expressed in percentages of the inhibition of specific response of the cell to the introduction of the reference agonist in the control:

Percent of inhibition of response of reference agonist = $100\% - ((\text{measured specific response} / \text{specific response in control to introduction of reference agonist}) \times 100\%)$.

As a result of the investigation, it was shown (see Table 1) that ULD anti-CB1 changes the functional activity of the cannabinoid receptor type 1 as measured by intracellular concentration of cAMF.

The test substance (ultra-low doses of antibodies to cannabinoid receptor type 1 (mixture of homeopathic dilutions C12, C30 and C200) exhibited the cannabinoid receptor type 1 agonist activity. The magnitude of the agonist effect 21% in reference to the effect of standard CP 55940 agonist (standard agonist effect is taken as 100%).

Table 1

Receptor	Test substance	Content of ULD anti-CB1 in the well (volume %) (total volume in the well was 200 microliters)	Agonist regime		Antagonist regime		Explanation
			% of response to ULD anti-CB1	Standard agonist	% inhibition of the antagonist	Standard antagonist	
CB1 receptor	ULD anti-CB1	10%	21	CP 55940	0	AM 281	ULD anti-CB1 possess agonist effect, the magnitude of which is 21% in reference to the effect of standard agonist

EXAMPLE 2

The test substance was in the form of an aqueous solution of ultra-low doses of polyclonal rabbit antibodies to human cannabinoid receptor type 1 (ULD anti-CB1), purified on antigen, obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, and C200).

40 male mice of the C57B1 line were used in the study (weight at the beginning of the study: 13.5-15.5 g). 10 mice received the regular standard feed (standard diet); 30 mice received the standard feed with high calorie additives (high calories diet) and, simultaneously, either distilled water (control, 0.4 ml/mouse) or Subutramine (Meridia 10 mg capsules, *Abbott GmbH*, Germany) (10 mg/Kg) or ULD anti-CB1 (0.4 ml/mouse). All preparations were given intragastrically once a day in the course of 5 months. The mice consumption of feed was measured before test substances were introduced. The mice consumption of feed was also measured each week thereafter. The consumption of feed was evaluated as an average quantity of food (in grams), consumed by a mouse after 1 and 2 months of the study, and as an average quantity of feed per 10 g of mouse body mass.

Over the entire period of observation, the mice on the low calorie diet consumed, on average, 15% less feed than mice on the high calorie diet (Table 2). Both Subutramine and ULD anti-CB1 decreased the consumption of feed. The effect of Subutramine was expressed somewhat higher: the consumption of feed decreased in a week by 19.3% ($p < 0.05$), while ULD anti-CB1 decreased the consumption of feed by 9.3% in reference to the control ($p > 0.05$). Table 2 shows the results of the study, specifically, the effect of ULD anti-CB1 and Subutramine on feed consumption of C57B1 mice (average values over 5 months of observation), $M \pm m$.

Table 2

Preparation	Consumption of feed (g/mouse) per day	Consumption of feed (g per 10 g of body mass) per day
Standard diet	2.95 ± 1.42	1.35 ± 0.05
High calorie diet + distilled water	$3.4 \pm 1.64\#$	$1.54 \pm 0.05\#$
High calorie diet + Subutramine	$2.75 \pm 1.36^{**}$	$1.28 \pm 0.05^{**}$
High calorie diet + ULD anti-CB1	3.10 ± 2.02	1.44 ± 0.08

** - differences from control are statistically significant with $p < 0.01$;

- differences from standard diet are statistically significant with $p < 0.05$.

On the twentieth week of the experiment, mice on the high fat diet that received ULD anti-CB1 consumed more feed in comparison with the first week of the experiment, which is shown in Figure 1. Figure 1 shows the effect of ULD anti-CB1 and Subutramine on the growth of C57B1 mice body mass and consumption of food per 10 g of weight after the last 20th week of the experiment.

A reduction of body mass growth of 51.2% was observed in mice that received ULD anti-CB1 compared to the control. Subutramine on the last twentieth week of the experiment lowered body mass by 51.5% in comparison with the control group.

EXAMPLE 3

The test substance was in the form of an aqueous solution of ultra-low doses of polyclonal rabbit antibodies to human cannabinoid receptor type 1 (ULD anti-CB1), purified on antigen, obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, and C200).

33 male mice of the C57B1 line were used in the study (weight at the beginning of the study: 13.09 ± 0.738 g). The mice received the modified diet with high (45%) fat content and simultaneously either distilled water (control, 0.2 ml/mouse) or Subutramine (10 mg/Kg) or ULD anti-CB1 (0.2 ml/mouse). All ULD anti-CB1 preparations were given intragastrically once a day in the course of 2 months. The mice weight was measured on Philips Cucina HR 239016 (Hungary) electronic scales until beginning to introduce the preparations (initially) and also each week after beginning to introduce them. The body mass growth of the mice was evaluated as a percentage of the initial weight.

Beginning 6 weeks from the introduction, ULD anti-CB1 lowered the body mass growth of the mice that were maintained on the high fat diet. Table 3 depicts the average weekly mass (grams) of the C57B16 mice that received the high fat diet and ULD anti-CB1 (0.2 ml/mouse) or Subutramine (10 mg/Kg) ($M \pm m$). Table 3 shows the body mass growth of the mice.

Table 3

Group	Body mass (grams), weeks of the study								
	0	1	2	3	4	5	6	7	8
Distilled water	12.18 ± 0.501	15.27 ± 0.982	15.27 ± 0.488	16.00 ± 0.972	18.18 ± 0.569	17.27 ± 0.557	20.18 ± 0.501	20.55 ± 0.608	21.45 ± 0.857
Δ to initial		25.4	25.4	31.3	49.3	41.8	65.7	68.7	76.1
Subutramine	13.82 ± 1.094	13.45 ± 0.474	16.73 ± 0.407 *	19.82 ± 0.501 **	20.18 ± 0.784	20.91 ± 0.563 **	22.36 ± 0.927	23.64 ± 1.343	22.91 ± 1.091
Δ to initial		-2.6	21.1	43.4	46.1	51.3	61.8	71.1	65.8
ULD anti-CB1	13.27 ± 0.619	16.18 ± 0.182	17.45 ± 0.282 **	19.64 ± 0.453 **	20.18 ± 0.423 *	20.18 ± 0.423 **	19.82 ± 0.501	21.64 ± 0.364	22.00 ± 0.467
Δ to initial		21.9	31.4	47.9	52.1	52.1	49.43	63.0	65.8

Note: * - $p < 0.05$ compared to the control group;
 ** - $p < 0.001$ compared to the control group

As shown, ULD anti-CB1 lowers the body mass growth of mice on the high fat diet, decreasing food consumption and it is not inferior in efficacy to the known, widely used compound for reduction of body mass, subutramine.

EXAMPLE 4.

300 mg tablets saturated with a water-alcohol solution (6 mg/tablet) of the activated-potentiated form of polyclonal rabbit antibodies to human cannabinoid receptor type 1, purified

on antigen, in ultra-low dose, obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, and C200 (ULD anti-CB1).

80 subjects participated in the study (20 men and 60 women) from 20 to 69 years of age (average age was 40.2 ± 1.26 years), 68.7% of whom suffered from excess body mass or obesity (grade I-III). The subjects were given 1 tablet, 2 times a day. Table 4 depicts the demographic and anthropometric indicators of the patients included in the study. Data of all the subjects who participated in the study ($n=80$) were included in the safety analysis. During the entire subject-observation period, a good tolerance of the preparation was noted. Adverse effects were absent. All subjects of the groups being studied completed the treatment in the time limits established by the study protocol; no patients dropped out early. During evaluation of the effect of ULD anti-CB1 on change in the body mass of the subjects, it was revealed that use of the preparation led to a reduction in the body mass of 56 (70%) patients. In 24 (30%) patients, the weight remained unchanged or insignificantly increased. However, it should be noted that among such patients, 14 (17.5%) initially had normal body mass ($BMI < 25 \text{ Kg/m}^2$).

Table 4

Parameter		Value	
Age (years)	M $\pm$ m	40.2 ± 1.26	
Height (centimeters)	M $\pm$ m	167.1 ± 0.89	
Weight (kg)	M $\pm$ m	80.3 ± 1.85	
Sex	male	20 persons (25 %)	
	female	60 persons (75 %)	
BMI, kg/m^2	M $\pm$ m	28.7 ± 0.6	
BMI, kg/m^2	Less than 25	25 persons (31.3 %)	Normal body mass
	25 – 29.99	28 persons (35 %)	Excess body mass (pre-obesity)
	30 – 34.99	20 persons (25 %)	Obesity of I degree
	35 – 39.99	5 persons (6.2 %)	Obesity II degree

	40 or more	2 persons (2.5 %)	Obesity III degree
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With respect to the patients who responded to the therapy, a statistically significant decrease in body mass ($p < 0.001$) was observed. After only 15 days of administration of ULD anti-CB1, the reduction in body mass was 1.1 Kg (1.3%) and in 1 month it reached 1.9 Kg (2.2%) of the original value (Figure 2).

With respect to the patients who responded to the therapy, a statistically significant ($p < 0.001$) decrease in the circumference of the waist and thighs was observed only one (1) week after the beginning of administration of ULD anti-CB1, which at the end of the therapy reached 2.3% and 2.7%, respectively. Table 5 presents the dynamics of the change in the circumference of the waist and thighs.

Table 5

	Day 1 (initial)	Day 7	Day 14	Day 15	Day 16	Day 22	Day 29	Day 30
circumference of waist. cm								
M $\pm$ m. cm	96.3 $\pm$ 1.97	95.2 $\pm$ 2.07 **	93.7 $\pm$ 1.82 ***	94.2 $\pm$ 1.96 ***	95.1 $\pm$ 2.16 ***	94.5 $\pm$ 2.16 ***	94.3 $\pm$ 2.10 ***	94.1 $\pm$ 2.07 ***
Δ from initial. %		-1.1%	-2.7%	-2.2%	-1.2%	-1.9%	-2.1%	-2.3%
circumference of thighs. cm								
M $\pm$ m. cm	110.8 $\pm$ 1.52	110.8 $\pm$ 1.66 ***	109.3 $\pm$ 1.37 **	109.9 $\pm$ 1.50 ***	108.7 $\pm$ 1.60 ***	108.3 $\pm$ 1.56 ***	108.1 $\pm$ 1.58 ***	107.8 $\pm$ 1.69 ***
Δ from initial. %		0.0%	-1.4%	-0.8%	-1.9%	-2.3%	-2.4%	-2.7%

** - $p < 0.01$ in reference to the initial value; *** - $p < 0.001$ in reference to the initial value

In evaluation of patients' feeling of hunger on the visual analog scale (VAS), the greatest intensity of feeling of hunger was noted in the evening hours. At the end of 1 month after the beginning of administration of ULD anti-CB1, the level of hunger in the evening hours was significantly reduced (with $p < 0.001$) from 49.4 ± 3.75 to 42.0 ± 4.32 points. There was also a noted tendency in the morning and daytime to reduced feelings of hunger (from 20.5 ± 3.23 to 13.6 ± 1.78 points in the morning hours, from 44.7 ± 3.45 to 27.3 ± 3.72 points in the daytime). Although the data related to morning hunger did not reach statistically significant values at the

end of the therapy, which observation could be related to the moderate initial values, the dynamics could not be ignored.

Thus, the clinical study of ULD anti-CB1, which were carried out, confirmed the high tolerance of the test preparation; there were no adverse effects upon taking the test preparation.

EXAMPLE 5. Fagerström Test for Nicotine Dependence

This example provides the test itself. The relevant data are provided separately further herein below. The Fagerström test for nicotine dependence is a test for assessing the intensity of nicotine addiction. See Heatherton, T.F., Kozlowski, L.T., Frecker, R.C., Fagerström, K.O. The Fagerström test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire. Br J Addict 1991; 86:1119-27, incorporated herein by reference. In the studies described further herein below, the patients answered all questions. The total score gives the degree of nicotine dependence. The degree of nicotine dependence is evaluated by the sum of the scores as follows: less than 4 – weak dependence; 4–6 – average degree of dependence; and 7–10 – strong dependence

Table 6

1. How soon after waking up do you smoke your first cigarette?	
More than 60 minutes	0
31-60 minutes	1
6-30 minutes	2
Less than 5 minutes	3
2. Is it difficult for you not to smoke in places where smoking is prohibited, for example, at meetings, on an airplane, at the movies, etc.?	
No	0
Yes	1
3. What cigarette is hardest for you to give up?	
First in the morning	1
From any other	0
4. How many cigarettes do you smoke a day?	
10 or less	0
11-20	1
21-30	2
31 or more	3
5. Do you smoke more the first hours of the morning than at any other time of the day?	
No	0
Yes	1
6. Do you smoke even if you are sick and have to stay in bed most of the day?	

No	0
Yes	1

EXAMPLE 6. Mood and Physical Symptoms Scale Test (MPSS).

This example provides the test itself. The relevant data are provided separately further herein below. In the studies described herein below, the patients who have given up smoking answered 12 questions (the score was assessed from 1 to 5 points for each question), evaluating feelings during the last 24 hours (questions 1-7), attraction to smoking (questions 8-9) and expression of physical symptoms (questions 10-12). The patients circled only one number for each question. The summary of the results can be divided into three domains (M – questions 1-7, C – questions 8-9 and P – questions 10-12) or by the overall score, which can vary from the minimum (12 points) to the maximum (60 points), reflecting the level of nicotine withdrawal symptoms.

Table 7

Please indicate for each question how you have felt during the last 24 hours (*Circle only one number for each question*)

	Was not	To slight degree	Rather strong	Very strong	Extremely strong
1. Depressed	1	2	3	4	5
2. Anxious	1	2	3	4	5
3. Irritated	1	2	3	4	5
4. Worried	1	2	3	4	5
5. Feeling of hunger	1	2	3	4	5
6. Poor attention	1	2	3	4	5
7. Sleep disorder	1	2	3	4	5

8. For how long did you feel like smoking in the last 24 hours? (*Circle only one number*)

Not once	Not very long	Lesser part of day	Most of day	Almost always	Constantly
0	1	2	3	4	5

9. How strong was the desire to smoke? (*Circle only one number*)

None	Slight	Moderate	Strong	Very strong	Extremely strong
0	1	2	3	4	5

Were there any manifestations in the last 24 hours? (*Circle only one number*)

	No	Slight	Moderate	Strong	Very strong
10. Mouth pains	1	2	3	4	5
11. Constipation	1	2	3	4	5

12. Cough/pain in throat	1	2	3	4	5
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West, R., Hajek, P. Evaluation of the mood and physical symptoms scale (MPSS) to assess cigarette withdrawal. *Psychopharmacology*, 2004; Volume 177, Numbers 1-2, 195-199, incorporated herein by reference.

EXAMPLE 7. Hospital Anxiety and Depression Scale (HADS).

This example provides the test itself. The relevant data are provided separately further herein below. Hospital Anxiety and Depression Scale (HADS) is a subjective scale and for screening of signs of anxiety and depression in hospital in-patients and out-patients. See Zigmond, A. S., Snaith, R.P. The Hospital Anxiety and Depression scale // *Acta Psychiatr. Scand.* - 1983. - Vol. 67. - P. 361-370, incorporated herein by reference.

Application method: The scale form is given to the patient to fill out and is accompanied by the following instructions:

“Scientists believe that emotions play an important role in the outset of most illnesses. If your doctor knows more about your experiences, he can better help you. This questionnaire is designed to help your doctor understand how you feel. Do not pay attention to the numbers and letters on the left part of the questionnaire. Carefully read each statement and in the empty space on the left, put an “X” next to the answer that best corresponds to how you have felt the last week. Do not think too much about each statement. Your first reaction will always be the best.”

The scale includes 14 statements divided into 2 subscales: “anxiety” (odd-numbered questions – 1, 3, 5, 7, 9, 11, 13) and “depression” (even-numbered questions – 2, 4, 6, 8, 10, 12, 14). Each statement has 4 possible answers, reflecting the magnitude of the feeling or emotion and incrementally characterizing the seriousness of the symptom from 0 (absence) to 3 (maximum).

In interpreting the results, the overall indicator for each subscale is taken into account, divided into 3 ranges of values: 0–7 indicating “normal” (absence of reliably expressed symptoms of anxiety and depression); 8–10 indicating “subclinical anxiety/depression”; and 11 and above indicating “clinical anxiety/depression.”

Table 8

1	I experience tension, I am not myself --- always --- often --- from time to time, sometimes --- do not at all experience	3 2 1 0
2	What gave me great satisfaction before still gives me the same feeling --- definitely so --- probably so --- only so to a small degree --- not at all so	0 1 2 3
3	I feel afraid as if something bad is about to happen --- definitely so, and the fear is very strong --- yes, that is so, but the fear is not very strong --- sometimes, but it does not worry me --- do not at all experience	3 2 1 0
4	I am able to laugh and see something funny in this or that event --- definitely so --- probably so --- only so to a small degree. --- not at all able	0 1 2 3
5	Disquieting thoughts run through my mind --- constantly --- most of the time --- from time to time --- only sometimes	3 2 1 0
6	I am in good spirits --- not at all --- very rarely --- sometimes --- practically always	3 2 1 0
7	It is easy for me to sit down and relax --- definitely so --- probably so --- only rarely so --- cannot at all	0 1 2 3
8	It seems to me that I have begun to do everything slowly --- practically always --- often --- sometimes --- not at all	3 2 1 0
9	I experience inner tension or trembling --- do not at all experience --- sometimes --- often --- very often	0 1 2 3

10	I do not look after my appearance --- definitely so --- I do not spend as much time on it as I should --- perhaps, I have begun to pay less attention to it --- I look after myself the same as before	3 2 1 0
11	I experience restlessness, as if I constantly have to move --- definitely so --- probably so --- only so to a small degree --- do not at all experience	3 2 1 0
12	I feel that my affairs (pursuits, interests) can bring me a sense of satisfaction --- the same as usual --- yes, but not to the degree as before --- significantly less than usual --- do not at all feel so	0 1 2 3
13	I have sudden feelings of panic --- very often --- rather often --- not so often --- does not at all happen	3 2 1 0
14	I can receive satisfaction from a good book, radio or television program --- often --- sometimes --- rarely --- very rarely	0 1 2 3

Zigmond, A. S., Snaith, R.P. The Hospital Anxiety and Depression scale // Acta Psychiatr. Scand. - 1983. - Vol. 67. - P. 361-370, incorporated herein by reference.

EXAMPLE 8. Comparative, double-blind, placebo-controlled clinical study, to evaluate the combination of ultra-low dose of antibodies to S-100 protein and ultra-low doses of antibodies to CB1 receptor, and ultra-low doses of antibodies to CB1 receptor for treatment of moderate nicotine dependence and obesity.

300 mg tablets saturated with water-alcohol solutions (6 mg/tab) of ultra-low doses of polyclonal rabbit antibodies to brain-specific protein S-100 (ULD anti-S100) and to cannabinoid receptor type 1 (ULD anti-CB1), each obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, and C200) were used in the study (ULD anti-S100 + ULD anti-CB1). Also, 300 mg tablets saturated with a water-alcohol solution (6 mg/tab) of ultra-low doses of polyclonal rabbit antibodies to

cannabinoid receptor type 1 (ULD anti-CB1) obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, and C200) were used in the study.

59 patients having the desire to quit smoking were included in a comparative, double-blind, placebo-controlled study, evaluating the efficacy of the ULD anti-S100 + ULD anti-CB1 combination and anti-CB1 in treating nicotine dependence. 22 patients were included in the active preparation group and were given ULD anti-S100 + ULD anti-CB1, 1 tablet 3 times a day. 17 patients were included in the comparison preparation group and were given ULD anti-Cb1, 1 tablet 3 times a day. 20 patients were included in the placebo group and were given 1 tablet 3 times a day (a tablet of granulated lactose and excipients without any active ingredients). The therapy lasted 12 weeks. All three groups of patients were comparable in the initial demographic, anthropometric, and clinical laboratory indicators. All patients had nicotine dependence of minor degree according to the Fagerström test (less than 4 points), smoked not less than one year, and had degree one (1) obesity (body mass index [BMI] = $30.0\text{--}34.9\text{ kg/m}^2$). All patients in the study completed treatment in the periods required by the study protocol; no patients dropped out early.

Analysis of the data showed that the number of patients who gave up smoking increased among patients who received ULD anti-S100+ULD anti-CB1 and ULD anti-CB1 (Table 9). In the ULD anti-S100+ULD group, the portion of patients who quit smoking in 4 weeks of treatment was 23%; in 8 weeks, 36%; and at the end of 12 weeks, it reached 41%. In the ULD anti-CB1 group, the corresponding indicators were 12%, 24% and 29% (versus 5%, 5% and 10%, respectively, in the placebo group). The difference in the efficacy of treatment in accordance to the main efficacy parameter in comparison with placebo therapy was 31% (for the ULD anti-S100+ULD group) and 19% (for the ULD anti-CB1 group), and it was statistically significant.

The evaluation of the effect of the ULD anti-S100+ULD anti-CB1 showed substantial decrease in nicotine dependence, both for the group as a whole, and for the subgroup of patients who were not able to give up smoking. The initial average total score on the Fagerström test was 2.67 ± 0.14 . In 12 weeks of treatment, it decreased to 1.33 ± 0.14 ; moreover, the decrease was statistically significant, not only in comparison with the initial indicators, but also in comparison

with the placebo group. Patients who received ULD anti-CB1 and who did not quit smoke also demonstrated positive dynamics with respect to manifestation of their nicotine dependence, which at the end of 3 months of therapy was significantly lower in comparison with the initial levels and with placebo.

The analysis of data of the Mood and Physical Symptoms Scale (MPSS) showed that nicotine withdrawal symptoms gradually diminished among patients who gave up smoking, reaching minimum values 12 weeks after the beginning of the treatment for both ULD anti-S100+ULD anti-CB1 and ULD anti-CB1 (Table 9). The lowest total score was recorded in ULD anti-S100+ULD anti-CB1 group, showing that the administration of the ULD anti-S100+ULD anti-CB1 and ULD anti-CB1 combination made it possible to bear the quitting of smoking more easily and painlessly, including in comparison with ULD anti-CB1 alone.

Table 9
Dynamics of basic indicators depending on form of therapy

Period	ULD anti-S100+ULD anti-CB1 (M±SE)	ULD anti-CB1 (M±SE)	Placebos (M±SE)
Fagerström test, points (n – number of smokers)			
Initial	2.64±0.10 (n=22)	2.65±0.12 (n=17)	2.65±0.11 (n=20)
Initial	2.67±0.14 (n=12)	2.58±0.14 (n=12)	2.66±0.11 (n=18)
12 weeks	1.33±0.14* # (n=12)	1.25±0.13* (n=12)	2.39±0.26 (n=18)
Portion of patients who quit smoking, %			
4 weeks	23% (n=5)	12% (n=2)	5% (n=1)
8 weeks	36% (n=8)	24% (n=4)	5% (n=1)
12 weeks	41% (n=10)	29% (n=5)	10% (n=2)
Symptoms scale (MPSS) cancelled, points (n – number giving up smoking)			
4 weeks	33.4±1.25 (n=5)	33.00±2.00 (n=2)	36 (n=1)
8 weeks	28.12±1.02 (n=8)	25.50±2.22 (n=4)	34 (n=1)
12 weeks	14.85± 2.41* ** (n=10)	20.80±1.62* (n=5)	32.50±0.50 (n=2)
Hospital Anxiety and Depression Scale (HADS), points (n – number of patients examined)			
Initial	11.73±0.36 (n=22)	11.41±0.50 (n=17)	11.4±0.44 (n=20)
4 weeks	10.32±0.32 (n=22)	10.47±0.30 (n=17)	11.95±0.45 (n=20)
8 weeks	8.59±0.33 (n=22)	9.88±0.32 (n=17)	12.55±0.35 (n=20)
12 weeks	7.68± 0.46* # (n=22)	9.41±0.35 (n=17)	12.05±0.18 (n=20)

Note: * statistical significance of differences with the placebo group, $p<0.05$;

** statistical significance of differences between the ULD anti-S100+ULD anti-CB1 and ULD anti-CB1 groups, $p<0.05$;

statistical significance of differences with initial values

All groups of patients included in the study had patients with first degree obesity. Body Mass Index (BMI) was measured for patients in all groups in the study at regular intervals. The results of the study are presented in Table 10.

Table 10
Average differences between initial and current weight (in kg) on each visit

Period	ULD anti-S100+ULD anti-CB1 (n=22; M±SE)	ULD anti-CB1 (n=17; M±SE)	Placebo (n=20; M±SE)
0	0±0.0	0±0.0	0±0.0
2 weeks	-1.2±0.5	-0.9±0.3	-0.4±0.2
4 weeks	-1.7±0.4	-1.5±0.5	-0.5±0.4
6 weeks	-2.5±0.4	-2.2±0.6	-1.3±0.4
8 weeks	-3.1±0.7*	-2.8±0.7*	-1.3±0.4
10 weeks	-3.8±0.6*	-3.4±0.8*	-1.8±0.5*
12 weeks	-4.2±0.9*	-3.8±1.0*	-1.8±0.6*

Note: For evaluation of the statistical significance of the change, the Student double-sided criteria in the Dunnett modification was used to make comparisons of weight on the control visit (visit 0) with all subsequent visits.

Significant differences ($p < 0.05$) are noted with asterisks.

As a result of the 12-week course of treatment, the body mass in both test groups significantly decreased in comparison with the placebo. In 3 months of therapy, about half of the patients (52% and 47%) in the two test groups reduced their weight by 5% or more in comparison with the initial state (in comparison with 15% of patients in the placebo group; with $p < 0.05$) (Figure 3).

Evaluation of the safety of the therapy, conducted on the basis of the record of adverse events in the period of treatment and a follow-up study of laboratory indicators, showed good tolerance to both ULD anti-S100+ULD anti-CB1 and ULD anti-CB1. The safety analysis included the data of all patients who participated in the study ($n=59$). No negative effect of the treatment on the central nervous system was revealed; indicators of psychiatric consequences were absent. This conclusion was confirmed by monitoring of indicators using the Hospital Anxiety and Depression Scale (HADS) (Table 9). ULD anti-S100+ULD anti-CB1 demonstrated a positive effect on symptoms of anxiety and depression, which were significantly reduced toward the end of the therapy in comparison with both initial values and placebo. Adverse

events were absent. The laboratory indicators, including general and biochemical analyses of the blood and clinical analysis of urine, did not show any significant deviations from normal values.

Thus, the study demonstrated the efficacy and safety of the ULD anti-S100+ULD anti-CB1 combination and ULD anti-CB1 in the treatment of nicotine dependence. The effects of the treatments were evident from the high percentages of patients who gave up smoking, the reduction in the withdrawal symptoms in the course of the therapy, and the reduction of nicotine dependence in those patients who could not quit smoking. All of the observed effects were statistically significant in comparison with the placebo group. The efficacy of the ULD anti-S100+ULD anti-CB1 combination exceeded the efficacy of ULD anti-CB1 alone. The safety profile was excellent for both ULD anti-S100+ULD anti-CB1 combination and ULD anti-CB1. Both ULD anti-S100+ULD anti-CB1 combination and ULD anti-CB1 did not lead to the appearance of clinically manifested anxiety and/or depression. Also, decrease of body mass in patients with degree 1 obesity was demonstrated.

EXAMPLE 9. Comparative, double-blind, placebo-controlled clinical study, to evaluate the combination of ultra-low dose of antibodies to S-100 protein and ultra-low doses of antibodies to CB1 receptor, and ultra-low doses of antibodies to CB1 receptor for treatment of heavy nicotine dependence.

300 mg tablets saturated with water-alcohol solutions (6 mg/tab) of ultra-low doses of polyclonal rabbit antibodies to brain-specific protein S-100 (ULD anti-S100) and to cannabinoid receptor type 1 (ULD anti-CB1), each obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, C200) were used in the study (ULD anti-S100 + ULD anti-CB1). Also, 300 mg tablets saturated with a water-alcohol solution (6 mg/tab) of ultra-low doses of polyclonal rabbit antibodies to cannabinoid receptor type 1 (ULD anti-CB1) obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, C200) were used in the study.

To evaluate the efficacy of ULD anti-S100 + ULD anti-CB1 in treating heavy nicotine dependence, a comparative, placebo-controlled, double-blind study was carried out with the participation of 61 patients who were randomized in three groups as follows: 18 patients in the

first group (ULD anti-S100 + ULD anti-CB1, 1 tablet, 4 times a day), 22 patients in the second group (ULD anti-CB1, 1 tablet, 4 times a day) and 21 patients in the placebo group (1 tablet, 4 times a day) (a tablet of granulated lactose and excipients without any active ingredients). The therapy lasted 12 weeks. Patients of the three groups were comparable according to initial indicators, including demographic, physical and laboratory. According to the primary results of the Fagerström test, all participants had heavy nicotine dependence (≥ 7 points) and smoked more than three years. In the course of monthly visits, the patients were monitored and given physical and laboratory examinations and tests (Fagerström test, Hospital Anxiety and Depression Scale [HADS]). In patients who gave up smoking, withdrawal symptoms were measured (Mood and Physical Symptoms Scale [MPSS]). All patients completed treatment in the periods established by the study protocol; no patients dropped out early.

The results of the study are presented in Table 11:

Table 11. Dynamics of basic indicators depending on form of therapy

Period	ULD anti-S100 + ULD anti-CB1 (M $\pm$ SE)	ULD anti-CB1 (M $\pm$ SE)	Placebo (M $\pm$ SE)
Fagerström test, points (n – number of smokers)			
Initial	8.78 $\pm$ 0.26 (n=18)	8.55 $\pm$ 0.26 (n=22)	8.52 $\pm$ 0.24 (n=21)
Initial	8.92 $\pm$ 0.34 (n=12)	8.47 $\pm$ 0.24 (n=17)	8.47 $\pm$ 0.25 (n=20)
12 weeks	4.50 $\pm$ 0.26* ** # (n=12)	6.11 $\pm$ 0.26* (n=17)	8.73 $\pm$ 0.23 (n=19)
Portion of patients who quit smoking, %			
4 weeks	11% (n=2)	9% (n=2)	5% (n=1)
8 weeks	22% (n=4)	14% (n=3)	5% (n=1)
12 weeks	30% (n=6)	23% (n=5)	10% (n=2)
Withdrawal symptoms scale (MPSS), points (n – number giving up smoking)			
4 weeks	54.33 $\pm$ 1.2 (n=2)	54.50 $\pm$ 0.50 (n=2)	54 (n=1)
8 weeks	46.75 $\pm$ 1.89 (n=4)	47.33 $\pm$ 0.67 (n=3)	50 (n=1)
12 weeks	38.67 $\pm$ 0.88* ** (n=6)	45.22 $\pm$ 1.11* (n=5)	53.00 $\pm$ 1.00 (n=2)
Hospital Anxiety and Depression Scale (HADS), points (n – number of patients examined)			
Initial	12.61 $\pm$ 0.36 (n=18)	12.50 $\pm$ 0.29 (n=22)	11.81 $\pm$ 0.38 (n=21)
4 weeks	11.17 $\pm$ 0.31 (n=18)	11.95 $\pm$ 0.25 (n=22)	13.05 $\pm$ 0.47 (n=21)
8 weeks	9.56 $\pm$ 0.30 (n=18)	10.86 $\pm$ 0.22 (n=22)	13.24 $\pm$ 0.39 (n=21)
12 weeks	7.72 $\pm$ 0.32* # (n=18)	9.50 $\pm$ 0.19 (n=22)	12.67 $\pm$ 0.23 (n=21)

Note: * differences with the placebo group are statistically significant with $p < 0.05$;

** differences ULD anti-S100 + ULD anti-CB1 and ULD anti-CB1 groups are statistically significant with $p < 0.05$;

differences with the initial parameters are statistically significant with $p < 0.05$.

In the ULD anti-S100 + ULD anti-CB1 group, the portion of patients who quit smoking in 4 weeks of treatment was 11%; in 8 weeks, 22%; and at the end of 12 weeks, it reached 30%. In the ULD anti-CB1 group, the corresponding indicators were 9%, 14% and 23% (versus 5%, 5% and 10%, respectively, in the placebo group).

Manifestations of nicotine dependence substantially decreased upon administration of ULD anti-S100 + ULD anti-CB1, both for the group as a whole and for the subgroup of patients who were not able to give up smoking (see Table 11). Their initial average total points on the Fagerström test was 8.92 ± 0.34 , which in 12 weeks of treatment decreased almost twice, to 4.50 ± 0.26 . Moreover, the decrease was statistically significant not only in comparison with the initial values, but also in comparison with ULD anti-CB1 group and placebo.

Upon administration of ULD anti-S100 + ULD anti-CB1 combination, the patients also exhibited statistically significant decrease in withdrawal symptoms in comparison with both ULD anti-CB1 (with $p < 0.05$) and placebo ($p < 0.005$) based on the data of the MPSS scale, reaching minimal values at 12 weeks after the beginning of the treatment.

The safety evaluation was also conducted. The safety analysis included data from all patients who participated in the study ($n=61$), and it was conducted on the basis of the record of adverse events and follow-up study of laboratory indicators. The results of the study showed not only good tolerance of ULD anti-S100 + ULD anti-CB1 combination and ULD anti-CB1 alone, but also to the lack of any adverse events connected with taking the medicines. No negative effect of the treatment on the central nervous system was revealed; indicators of psychiatric consequences were absent. This conclusion was confirmed by monitoring of indicators using the Hospital Anxiety and Depression Scale (HADS) (Table 11). ULD anti-S100+ULD anti-CB1 demonstrated a positive effect on symptoms of anxiety and depression, which were significantly reduced toward the end of the therapy in comparison with both initial values and placebo. Adverse events were absent. The laboratory indicators, including general and biochemical analyses of the blood and clinical analysis of urine, did not show any significant deviations from normal values.

Thus, the results of the study demonstrated the efficacy and safety of the ULD anti-S100+ULD anti-CB1 in the treatment of heavy nicotine dependence. During the 12-week course

of treatment, almost a third of the smokers were able to free themselves of their dependence on nicotine. As shown on Table 11, the efficacy of ULD anti-S100+ULD anti-CB1 exceeded the efficacy of the placebo in a statistically significant manner. ULD anti-S100+ULD anti-CB1 greatly improved patients' ability to more easily and painlessly endure smoking cessation. Among those patients who could not give up smoking in the course of observation, manifestation of nicotine dependence significantly diminished upon administration of ULD anti-S100+ULD anti-CB1 in comparison with both ULD anti-CB1 and placebo.

Both ULD anti-S100+ULD anti-CB1 and ULD anti-CB1 were characterized by excellent safety profile and absence of adverse effects on central nervous system.

EXAMPLE 10.

The effects of I) the combination of ultra-low doses of polyclonal rabbit antibodies to brain-specific protein S-100 (ULD anti-S100) and ultra-low doses of antibodies to cannabinoid receptor type 1 (ULD anti-CB1), each obtained by hyper-dilution of the initial matrix solution 100^{12} , 100^{30} , 100^{200} times (mixture of centesimal homeopathic dilutions C12, C30, C200) (ULD anti-S100 + ULD anti-CB1), ii) ULD anti-CB1 alone, and iii) ULD anti-S100 alone, on motor activity of mice were studied to evaluate their anti-nicotine properties.

40 white outbred male mice (22-25 g, 1.5 mo.) were used. 10 mice were intact. The rest of the mice were administered nicotine subcutaneously over 4 days at the dose of 0.3 mg/kg. Nicotine administration was preceded (1 hour prior) by intragastrical administration of either distilled water (control, 0.4 ml/mouse), or ULD anti-S100 (0.4 ml/mouse), or ULD anti-CB1 (0.4 ml/mouse), or ULD anti-S100 + ULD anti-CB1 (0.4 ml/mouse). 30 minutes after the last administration of nicotine, an "open field" test was conducted. The animals were placed in the center of a TruScan photo-sensory installation (Coulbourn, USA), where the vertical and horizontal locomotor activity of the animals was automatically recorded in the course of two (2) minutes. The "open field" model makes it possible to evaluate the effect of the compounds on the locomotor activity of the animals (Gershenfield H.K., Neumann P.E., Mathis C., Crawley J.N., Li X., Paul S.M. Mapping quantitative Trait Loci for Open-Field Behavior in Mice. Behavioral Genetics. - 1997. - Vol. 27. - No 3. - p. 201-209, which is incorporated herein by

reference in its entirety and for the purpose stated). The installation parameters: size 270x270x360mm, divided into 64 squares, 2.5 x 2.5, with 25 mm openings situated in the platform floor, illumination of a 150 watt lamp.

Nicotine is an alkaloid found in plants of the Solanaceae family, predominantly in tobacco, and possessing psychotropic activity. The effect of nicotine is believed to be indirect through peripheral and central N-choline receptors. Depending on the dose, introduction of this alkaloid into the body can cause the development of anxiety-depression symptomatology, euphoria, excitation or, vice versa, calmness. Furthermore, prolonged application of nicotine leads to dependence. Preparations used to make it easier to quit smoking, among other things aim to eliminate pathologic changes in the psychoemotional sphere, which facilitates the release of patients from pathologic predilection to tobacco.

In the present study, the administration of nicotine led to an increase in the motor activity of mice: activity time increased by 8.2% ($p < 0.05$), distance travelled by 5.1%, quantity of openings investigated by 78.2% ($p < 0.05$), study reaction time by 76.9%, while immobility time, conversely decreased by as 13.5% ($p < 0.05$) in comparison with the intact animals.

ULD anti-S100 alone did not have a significant effect in reference to the control with respect to specific parameters under investigation. ULD anti-CB1 reduced activity time and travelled distance of the mice in the test group to the level of intact mice. However, ULD anti-CB1 did not have effect on immobility period, quantity of openings and reaction period. At the same time, the combined administration of ULD anti-CB1 and ULD anti-S100 reduced activity time and, correspondingly, increased immobility time to the level of intact animals, considerably reduced travelled distance (by 29.2% in comparison with the control and by 25.5% in comparison with the intact animals) and somewhat decreased the activity (the quantity of openings dropped by 15.3%, reaction time dropped by 17.4%).

Thus, the administration of ULD anti-CB1, and combined administration of ULD anti-CB1 and ULD anti-S100, contributes to the elimination of changes in the behavior of animals caused by the administration of nicotine. Use of an ULD anti-CB1+ULD anti-S100 combination was more effective in comparison with the administration of ULD anti-CB1 alone.

Table 12. Effect of preparations on the motor activity of mice (open field test), $M \pm m$

	Activity time, sec	Distance of motion, cm	Immobility time, sec	Quantity of openings investigated	Reaction study time
Intact	74.1 $\pm$ 1.9	393.6 $\pm$ 19.6	46.0 $\pm$ 2.0	5.5 $\pm$ 1.0	2.6 $\pm$ 0.6
Control	80.2 $\pm$ 1.3*	413.7 $\pm$ 15.4	39.8 $\pm$ 1.3*	9.8 $\pm$ 1.4*	4.6 $\pm$ 0.9#
ULD anti-S100	76.5 $\pm$ 1.4	434.4 $\pm$ 23.5	43.5 $\pm$ 1.4	10.0 $\pm$ 1.1 **	5.1 $\pm$ 1.0#
ULD anti-CB1	72.4 $\pm$ 1.4##	366.3 $\pm$ 19.1	47.6 $\pm$ 1.4##	9.8 $\pm$ 0.8	5.6 $\pm$ 1.1*#
ULD anti-CB1+ULD anti-S100	74.5 $\pm$ 2.8	393.1 $\pm$ 28	45.5 $\pm$ 2.9	8.3 $\pm$ 1.5	3.8 $\pm$ 0.7

differences from the intact are statistically significant: *- with $p < 0.05$; ** - with $p < 0.01$
 difference from the control are statistically significant: # - with $p < 0.05$; ## - with $p < 0.01$

What is claimed is:

1. A pharmaceutical composition comprising a homeopathically potentized form of an antibody to human cannabinoid receptor.
2. The pharmaceutical composition of claim 1, wherein said human cannabinoid receptor is cannabinoid receptor 1 (CB1).
3. The pharmaceutical composition of claim 2, wherein said homeopathically potentized form of an antibody is to the entire human cannabinoid receptor 1.
4. The pharmaceutical composition of claim 3, wherein said entire human cannabinoid receptor 1 consists of sequence provided in SEQ ID No: 1.
5. The pharmaceutical composition of claim 2, wherein said homeopathically potentized form of an antibody is to a polypeptide fragment of the human cannabinoid receptor 1.
6. The pharmaceutical composition of claim 5, wherein said polypeptide fragment of the human cannabinoid receptor 1 is selected from the group consisting of sequences provided in SEQ ID Nos: 3-16.
7. The pharmaceutical composition of claim 1, wherein said homeopathically potentized form of an antibody is in the form of a mixture of C12, C30, and C200 homeopathic dilutions.
8. The pharmaceutical composition of claim 1, wherein said homeopathically potentized form of an antibody is in the form of a mixture of C12, C30, and C200 homeopathic dilutions impregnated onto a solid carrier.
9. The pharmaceutical composition of claim 1, wherein the homeopathically potentized form of an antibody to a human cannabinoid-receptor is a monoclonal, polyclonal or natural antibody.
10. The pharmaceutical composition of claim 9, wherein said homeopathically potentized form of an antibody to a human cannabinoid-receptor is a polyclonal antibody.
11. The pharmaceutical composition of claim 1, wherein the antibody to human cannabinoid receptor is prepared by successive centesimal dilutions coupled with shaking of every dilution.