Tribunal Arbitral du Sport
Court of Arbitration for Sport

CAS 2014/A/3751 [redacted] v. WADA

ARBITRAL AWARD

rendered by the

COURT OF ARBITRATION FOR SPORT

sitting in the following composition:

Sole Arbitrator: Mr. Romano **Subiotto QC**, Solicitor-Advocate, Brussels, Belgium, and London, United Kingdom

Ad hoc Clerk: Mr. Aaron **Krieger**, Attorney-at-law, New York, United States

in the arbitration between

[redacted]

[redacted] Appellant –

and

World Anti-Doping Agency, Lausanne, Switzerland
Represented by Mr. Ross Wenzel of Carrard & Associés, Lausanne, Switzerland

- Respondent -

1. The Parties

1.1 [redacted] (the "Appellant" or "Athlete") is an [redacted] professional tennis player.

1.2 The World Anti-Doping Agency ("WADA" or the "Respondent") is a Swiss private law foundation whose headquarters is in Montreal, Canada, but whose seat is in Lausanne, Switzerland. WADA was created in 1999 to promote, coordinate and monitor the fight against doping in sport in all its forms.

1.3 The Appellant and Respondent are collectively referred to as the "Parties".

2. Background

2.1 This appeal arises out of a September 8, 2014 reversal by the WADA Therapeutic Use Exemption ("TUE") Committee ("TUEC") of a September 4, 2014 decision by the International Tennis Federation ("ITF") TUEC granting the Appellant TUEs for the use of hydrocortisone ("HC") and Dehydroepiandrosterone ("DHEA"). The reversal reduced the allowable dosage of HC and reduced the time during which it could be taken, and immediately withdrew permission to use DHEA (the "Appealed Decision").

2.2 The Appellant has been playing tennis professionally since [redacted]

2.3 The Appellant states that beginning in the 2010 offseason she began experiencing a number of physical ailments, including constant soreness, fatigue, drowsiness, and dizziness. According to the Appellant, these ailments afflicted her throughout the 2010 offseason, the 2011 season, and beyond.

2.4 Towards the end of 2012, as these and other physical ailments continued, [redacted] began seeing Dr. Eric Serrano, a family practice physician in [redacted]. Upon examination and blood and saliva tests, Dr. Serrano recommended a treatment regimen incorporating an assortment of non-prohibited substances and HC, a substance banned in-competition. To that effect, after consultation with Dr. Serrano, [redacted] filed a TUE application with the ITF TUEC seeking permission to use up to 40 mg/day of HC for 6-8 weeks, after which, Dr. Serrano suggested she could be weaned off the drug.

2.5 Dr. Serrano submitted two letters to the ITF TUEC in support of the Athlete's application.

2.6 In his November 7, 2012 letter, Dr. Serrano wrote, in relevant part:

> *"After further examination and lab testing, [redacted] was diagnosed with adrenal insufficiency with very low cortisol levels, DHEA levels, and high CRP."*

2.7 In a letter written just over one month later, on December 11, 2012, Dr. Serrano wrote, in relevant part:

> *"[S]he displays typical symptoms of a patient with adrenal insufficiency stage three, meaning her adrenal glands are in hyper-drive, or making too much cortisol before they burn out . . . The saliva test shows very low levels of cortisol, indicative of an individual in stage three adrenal insufficiency . . . ."*

2.8 The ITF granted the TUE on December 19, 2012 for use through March 19, 2013. The Appellant commenced her treatment with HC thereafter.

2.9 In March 2013, [redacted] filed a renewed TUE application for use of up to 40 mg/day of HC through December 2013. In connection with the renewal application, the Appellant submitted a March 14, 2013 letter from Dr. Serrano in which he described her conditions as:

"*[S]econdary to chronic fatigue, muscle and joint pain and sever Chronic adrenal insufficiency which requires treatment with hydrocortisone*" and stated that "*due to her condition she does not produce enough [hydrocortisone] for her own needs . . .* "

2.10 The renewal application was granted by the ITF TUEC in May 2013 for use through December 19, 2013.

2.11 Beginning in July 2013, after purportedly experiencing further physical ailments, despite her treatment with HC, [redacted] underwent another series of tests at the direction of Dr. Serrano. The results of those tests were used as the basis for the Appellant's October 29, 2013 TUE application for DHEA.

2.12 In his letter accompanying the October 2013 application, Dr. Serrano wrote, in part:

> *'[redacted] as you know from my previous letter has been a difficult case and due to her current complaints I decided to test her for adrenal insufficiency. Her blood and saliva test came back as stage III adrenal insufficiency, which included low Pregnelone* [sic], *DHEA, progesterone, cortisol, aldosterone, and Dehydrotestosteone* [sic] *levels, which means she in in total failure."*
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> For treatment, Dr. Serrano wrote that [redacted] *is going to require close monitoring, multiple hormonal treatments, including Progesterone, hydrocortisone and DHEA."*

2.13 On November 11, 2013, the ITF TUEC responded to [redacted] application stating that she needed a "*medical review from an endocrinologist*" to supplement her application.

2.14 Following the response from the ITF TUEC, the Appellant met with Dr. Chandana Mishra, an endocrinologist located in [redacted]. Dr. Mishra's submission to the ITF TUEC, dated November 21, 2013, stated simply, in relevant part:

"[Athlete] presents with history of Adrenal dysfunction and is currently on Hydrocortisone 20-40 mg/day. In my opinion, [patient] needs to continue treatment with hydrocortisone at this time, and removal of this treatment could potentially result in adrenal crisis which is a life threatening condition. Also, [patient] has had low DHEA on labs in past and DHEA replacement is an appropriate treatment."

2.15 On December 6, 2013, the ITF TUEC approved a renewed TUE for 40 mg/day of HC and a new TUE for 25 mg/day of DHEA until December 5, 2014.

2.16 Following this approval, the Appellant commenced using time release S-DHEA capsules and began participating in competitions full-time. The Appellant reported to Dr. Serrano that she experienced no benefits from the S-DHEA, at which point, in or around February 2014, Dr. Serrano instructed the Appellant to replace the time release capsules with micronized DHEA to be taken sublingually. After commencing use of the sublingual DHEA, which she continued until her permission was revoked by the WADA TUEC, the Appellant reported significant improvements in her symptoms.

2.17 On July 9, 2014, the WADA TUEC issued a decision revoking the Appellant's TUE for use of DHEA. The revocation required the Appellant to cease use of DHEA as of July 23, 2014. WADA's decision was based on a number of grounds, including that:

"DHEA supplementation cannot be justified as necessary to protect this athlete from significant health impairment."

"[T]he potential for testosterone production in a female athlete through the use of an androgenic pre-cursor such as DHEA carries a significant ergogenic potential with performance enhancement consequences across virtually every sport."

"[S]tudies have shown no consistent clinical benefit from DHEA in the treatment of women with adrenal failure."

2.18 To bolster her application, [redacted] met with Dr. John Larrimer, an endocrinologist in [redacted] for a consultation on July 25, 2014.

2.19 On August 17, 2014, the Appellant filed a renewed TUE application with the ITF seeking a TUE for 40 mg/day of HC and 35 mg/day of DHEA for the period from September 1, 2014 through September 1, 2015. The renewed application included reports by Dr. Larrimer and Dr. Serrano.

2.20 Dr. Larrimer's report, dated July 25, 2014, stated, in part:

"Since 2012, the patient has had a multitude of tests and studies done including a cortisol salivary test that showed her cortisol levels to be significantly low. The cause for the low cortisol levels could be considered inconclusive but the patient had no prior history of being on a steroid medication at the time of the test. Upon reviewing the medical history

of the patient in conjunction with the lab reports and after seeing her in person for several hours during my examination, I do believe she has Hypopituitarism along with Adrenal Insufficiency. The patient also has well documented low levels of aldosterone, progesterone, DHEA, pregnenolone, and testosterone. Her hormone levels combined with existing symptoms are very clear of an Adrenal Insufficiency. I do not believe the low levels of DHEA are due to the patient's current daily hydrocortisone dosage, but rather Hypopituitarism and Adrenal Insufficiency."

"Even with this low and appropriate DHEA supplementation, [redacted] *blood Testosterone and Dihydrotestosterone remain on the low range of normal for healthy females her age. It is apparent this DHEA supplementation has improved the patient's daily quality of life and she has had no androgenic side effects with a low dosage of 25mg/day."*

"[I]t is highly advisable to NOT attempt to ween [sic] *her off Hydrocortisone especially when the patient has shown marked improvement in symptoms and her current labs are more consistent with a healthy female of her age. A different approach could be made with a person of a more sedentary job or at such a time when* [redacted] *is no longer dealing with the demands and stresses required of her career."*

"I think they are appropriate for her condition and symptoms."

2.21 Dr. Serrano's report, dated August 17, 2014, was directed to address the international standards used to grant a TUE. He wrote, in part:

"When [redacted] *first came to me she had no prior use of hydrocortisone or any other glucocorticoids that would have suppressed her DHEA serum or cortisol levels. I have also reviewed her recent ACTH test, and as I initially suspected, she has hypopituitarism along with severe secondary adrenal insufficiency that is bordering on Addison's Disease."*

"My initial opinion was and still is that of hypopituitarism, adrenal insufficiency, chronic fatigue and chronic inflammation. I reached this conclusion based on lab work that indicated low cortisol and DHEA levels before the supplemental use of hydrocortisone. I combined that with physical examination, the patient's debilitating symptoms and additional lab results. In some cases Hydrocortisone use can affect ones DHEA blood levels, HOWEVER, in this specific case, the patient saw improvement in blood DHEA levels (WHILE still on Hydrocortisone) with complete physical rest Sept-Dec 2013."

2.22 On August 28, 2014, the ITF TUEC approved the Appellant's renewed application for DHEA through August 31, 2015, but denied the HC TUE request.

2.23 On September 4, 2014, the ITF TUEC approved a TUE for 25 mg/day of DHEA and a TUE for HC at 30 mg/day. The TUEs were for use through August 31, 2015.

2.24 On September 8, 2014, the WADA TUEC reversed the September 4, 2014 TUEs granted by the ITF TUEC, reducing her permitted use of HC and the time during which it could be taken from August 31, 2014 to December 5, 2014, and repealing her DHEA TUE effective immediately (the "Appealed Decision"). The Appealed Decision called into question a number of the conclusions reached by Dr. Serrano and Dr. Larrimer.

2.25 On November 6, 2014, the Parties agreed to a limited stay of the September 8, 2014 decision, permitting the Appellant's continued use of HC beyond December 5, 2014, pending the outcome of this case.

3. Proceedings Before the CAS

3.1 On September 19, 2014, in accordance with Articles R47 of the Code of Sports-related Arbitration (the "Code"), the Appellant filed her statement of appeal of the Appealed Decision. With her statement of appeal, the Appellant nominated Mr. Philippe Sands QC as an arbitrator. The Appellant simultaneously filed an application for a stay of the execution of the Appealed Decision.

3.2 By letter dated September 23, 2014, the CAS Court Office acknowledged receipt of the Statement of Appeal and invited [redacted] to file her appeal brief within the time limit established by Art. R51 of the Code. The Respondent was given ten days to nominate an arbitrator; and ten days to comment on the Appellant's stay application.

3.3 By letter dated October 3, 2014, the Respondent nominated the Honourable Michael Beloff QC as arbitrator. The Respondent also proffered its opposition to Appellant's stay application.

3.4 By letter dated October 7, 2014, the CAS Court Office informed the Parties that Mr. Beloff declined to serve as arbitrator in this proceeding, and invited the Respondent to submit a second nomination.

3.5 By letter dated October 8, 2014, the Appellant requested a 7-day extension of the deadline to submit her brief in support of her appeal. The Appellant noted that the Respondent had been notified of Appellant's request and had no objection.

3.6 By letter dated October 10, 2014, the CAS Court Office informed the Parties that Mr. Sands declined to serve as arbitrator in this proceeding, and invited the Appellant to submit a second nomination.

3.7 By letter dated October 12, 2014, the Respondent requested that its deadline to nominate another arbitrator be deferred until 7 days after the Appellant's deadline to nominate a second arbitrator.

3.8 By letter dated October 13, 2014, the CAS Court Office granted the Respondent's October 12 request. The CAS Court Office also transmitted the Order on Request for a Stay issued by the President of the Appeals Arbitration Division denying the Appellant's stay application.

3.9 On October 17, 2014, after being granted an extension by the CAS, the Appellant timely filed her brief in support of her appeal (the "Appellant's Brief"), in accordance with Article R51 of the Code. On the same date, the Appellant appointed Romano Subiotto QC as her arbitrator.

3.10 By electronic correspondence dated October 27, 2014, the Respondent nominated Professor Massimo Coccia as arbitrator. The correspondence noted that the Appellant had no objection to the nomination being made three days after the nomination was due.

3.11 By letter dated November 5, 2014, the Appellant requested the admission of supplemental evidence (the "Supplemental Evidence"). The Appellant asserted that the Supplemental Evidence, blood tests taken on October 17, 2014, was necessary to demonstrate her current physical condition. The Appellant's letter stated that the relevant blood results were not available prior to the submission of the Appellant's Brief.

3.12 By letters dated November 6, 2014, the Parties notified the CAS Court Office that they agreed to extend the Respondent's deadline to file its answer until November 24, 2014. The Parties also agreed to a limited stay of the September 8, 2014 decision as it related to the Appellant's use of HC.

3.13 By letter dated November 6, 2014, the Respondent informed the CAS Court Office that it would not object to Mr. Subiotto acting as sole arbitrator in this matter. The letter noted that the Appellant likewise did not object to the appointment. In the same letter, the Respondent laid out its objection to the Appellant's request to admit the Supplemental Evidence. The Respondent's objections, in sum, were that (i) under the TUE guidelines, new medical data that was not before the WADA TUEC should not be put before CAS, and (ii) that the Appellant had failed to demonstrate the exceptional circumstances required for admissibility of new evidence.

3.14 By letter dated November 7, 2014, the CAS Court Office confirmed that Mr. Subiotto would serve as sole arbitrator in this matter.

3.15 By letter dated November 7, 2104, the Appellant offered further support of admissibility of the Supplemental Evidence, in particular, asserting that the timing of the submission of the evidence was required by the Appellant's overseas competition schedule and, in any event, was non-prejudicial to the Respondent.

3.16 By letter dated November 18, 2014, the CAS Court Office sent the Order of Procedure to the Parties. That letter also clarified that the Supplement Evidence was admitted "*insofar as such results clarify, confirm or contradict evidence which was before the WADA*

TUEC." The Parties returned a signed copy of the Order of Procedure on November 18 and 24, 2014.

3.17 By electronic correspondence dated November 21, 2014, the Respondent notified the CAS Court Office that the Parties had agreed to the Respondent's request to extend its time to file its answer to November 27, 2014.

3.18 On November 27, 2014, the Respondent timely filed its answer.

3.19 On December 8, 2014, a hearing took place at the offices of Cleary Gottlieb Steen & Hamilton LLP in New York, New York, United States. The Sole Arbitrator was assisted by Mr. Aaron Krieger, Attorney-at-law, New York, United States and Mr. Brent J. Nowicki, CAS Counsel, Lausanne, Switzerland. The following persons attended the hearing in addition to the Parties' counsel:

3.19.1 For the Appellant:

- [redacted]
- [redacted]
- [redacted]
- Dr. Eric Serrano (Appellant's primary treating physician)

3.19.2 For the Respondent:

- Dr. David Handelsman

4. Submissions of the Parties

4.1 In her Appeal Brief, the Appellant requested that the Sole Arbitrator overturn the WADA TUEC decision and reinstate the ITF TUEC's decision on the prinicple basis that she has presented sufficient evidence to meet the TUE requirements set forth in Article 4.1(a)-(d) of the International Standard for use of both HC and DHEA.

4.2 In its Answer, the Respondent requested the Sole Arbitrator to dismiss the Appeal and award legal fees and costs to the Respondent on the principle basis that the Appellant has not satisfied her burden of establishing that she qualifies for a TUE for DHEA or continued use of HC beyond this case.

5. Jurisdiction, Applicable Law, and Admissibility

A. Jurisdiction

5.1 This appeal was assigned to the Appeals Arbitration Division of the CAS pursuant to Article S20 of the Code.

5.2 Article R27 of the Code provides the following: *"These Procedural Rules apply whenever the parties have agreed to refer a sports related dispute to the CAS. Such disputes may arise out of an arbitration clause [...] or may involve an appeal against a decision rendered by a federation, association or sports-related body where the statutes or regulations of such bodies, or a specific agreement provide for an appeal to CAS (appeal arbitration proceedings). [...]".*

5.3 In the case under scrutiny, Article 13.4 of the WADA Code provides: "*Decisions by WADA reversing the grant or denial of a therapeutic use exemption may be appealed exclusively to CAS by the Athlete . . . .*"

5.4 In addition, none of the parties raised any objection regarding the jurisdiction of the CAS to decide on the prayers for relief submitted to it. On the contrary, the Parties confirmed CAS jurisdiction by signing the Order of Procedure.

5.5 In conclusion, the Sole Arbitrator finds that he has jurisdiction to rule upon the present dispute.

B. Applicable Law

5.6 According to Article R58 of the Code, *"The Panel shall decide the dispute according to the applicable regulations and, subsidiarily, to the rules of law chosen by the parties or, in the absence of such a choice, according to the law of the country in which the federation, association or sports-related body which has issued the challenged decision is domiciled or according to the rules of law the Panel deems appropriate. In the latter case, the Panel shall give reasons for its decision".*

5.7 The Appealed Decision was issued under the WADA Code, and there is no dispute that the WADA Code International Standard – Therapeutic Use Exemptions (Jan. 2011) apply to the present matter.

C. Admissibility

5.8 Article R49 of the Code provides as follows: "*In the absence of a time limit set in the statutes or regulations of the federation, association or sports-related body concerned, or of a previous agreement, the time limit for appeal shall be twenty-one days from the receipt of the decision appealed against. After having consulted the parties, the Division President may refuse to entertain an appeal if it is manifestly late.*"

5.9 The WADA TUEC issued the Appealed Decision on September 8, 2014. [redacted] statement of appeal was sent to the CAS Court Office on September 19, 2014.

5.10 Therefore [redacted] appeal was brought within time and is admissible.

6. Merits of the Appeal

6.1 The crux of this matter is whether the Appellant satisfies the requirements for a TUE. The conditions for granting a TUE are set forth in Article 4.1(a)-(d) of the International Standard, which states:

"An Athlete may be grated a TUE if (and only if) he/she can show that each of the following conditions is met:

(a) The Prohibited Substance or Prohibited Method in question is needed to treat an acute or chronic medical condition, such that the Athlete would experience a significant impairment to health if the Prohibited Substance or Prohibited Method were to be withheld.

(b) The Therapeutic Use of the Prohibited Substance or Prohibited Method is highly unlikely to produce any additional enhancement of performance beyond what might be anticipated by a return to the Athlete's normal state of health following the treatment of the acute or chronic medical condition.

(c) There is no reasonable Therapeutic alternative to the Use of the Prohibited Substance or Prohibited Method.

(d) The necessity for the Use of the Prohibited Substance or Prohibited Method is not a consequence, wholly or in part, of the prior Use (without a TUE) of a substance or method which was prohibited at the time of such Use."

6.2 As the title of the section makes clear, a TUE is granted only as an exception to the general rule. As such, it is particularly important that the standards are strictly applied, including that a chronic or medical condition is properly identified.

6.3 At the outset, it is important to note that both of the Parties' medical experts acknowledged that [redacted] was likely suffering from some legitimate medical affliction beyond any adrenal insufficiency, which both Parties concede she currently suffers from. The significant disagreement between the parties, however, was to the nature of that condition and the appropriate treatment.

6.4 It is also important to note that neither the Respondent, nor the Sole Arbitrator, call into question whether [redacted] has, in good faith, sought to identify the medical condition afflicting her and receive appropriate treatment, all within the ground rules laid out by the ITF and WADA, and without any nefarious intent. She is, however, caught in a position where her medical diagnosis may be incorrect and the treatment plan recommended to her may not be an appropriate remedy for her condition.

6.5 Notwithstanding these initial points, it is the Athlete's burden to satisfy the high threshold set-out by the WADA Code and, unfortunately for the Appellant, her medical consultants have failed to meet the basic pre-condition on which a TUE is based – the diagnosis of a medical condition. The evidence presented fails to establish: (1) an adrenal insufficiency at the time of the Appellant's November 2012 application for her first HC TUE, (2) a properly diagnosed medical condition responsible for the adrenal insufficiency afflicting the Appellant since 2013, and (3) that the recommended treatment, and specifically DHEA, relates to her medical condition.

A. Adrenal Insufficiency

6.6 Dr. Serrano's diagnosis of an adrenal insufficiency prior to the Appellant's HC use suffers from a number of difficulties.

6.7 First, there are the apparent inconsistencies between Dr. Serrano's November 7, 2012 letter, in which Dr. Serrano "*diagnosed [Appellant] with adrenal insufficiency with very low cortisol levels, DHEA levels, and high CRP,*" and his letter from just over one month later in which he stated both that the Appellant's adrenal function was in "*hyper-drive*", i.e., "*making too much cortisol,*" but also that the Appellant's "*saliva test shows very low levels of cortisol.*"

6.8 Second, even setting aside the internal inconsistencies in his letters, Dr. Serrano could point to no record of any test that indicated that the Appellant had an adrenal insufficiency prior to her glucocorticoid use. Rather, the Appellant's blood tests collected on September 5, 2012 indicated that the Appellant's DHEA levels were at 321.2 ug/dL where the applicable reference range for her demographic was 98.8-430, i.e., the Appellant's DHEA levels were on the high end of normal. That test noted that cortisol measurements "*Will Follow.*"

6.9 The blood and salivary tests collected by Dr. Serrano on November 22, 2012 told a similar story. The blood tests indicated the Appellant's DHEA levels were actually high – 393.2 ug/dL with a reference range of 98.8-340.0 – and that her cortisol levels were towards the high end of normal – 1.6 Free Cortisol with a reference range of 0.2-1.8 for adults at 8:00 AM. Likewise, the salivary tests also evidenced that the Appellant had DHEA levels at the high end of normal and cortisone levels that were generally high for her demographic range.

6.10 At the hearing, when confronted with these letters and apparent inconsistencies, Dr. Serrano conceded that the allusion to "low cortisol" may have simply been a typographical error, even though as recently as August 17, 2014 he was asserting that the Appellant's lab work "*indicated low cortisol and DHEA levels before the supplemental use of hydrocortisone* (emphasis added), but he was not certain. Further, while he conceded that the tests indicated that at the time the Appellant was not suffering from a cortisol insufficiency, he was concerned that her adrenal function would burn out at its rate of production, but this point was never substantiated at the hearing.

6.11 Beginning with her July 2013 blood tests, the Appellant's cortisol and DHEA levels did drop out of the reference range for her demographic, and, after that point, it was not until she began using DHEA supplementation that her DHEA levels at least began to rise. However, as the Respondent points out, the Appellant's low cortisol and DHEA levels only manifested themselves after approximately seven months of her HC treatment, which is consistent with the Respondent's theory that the glucocorticoid use was a contributing, if not sole, factor in the Appellant's adrenal insufficiency.

6.12 The conclusion from this line of reasoning championed by the Respondent is that one way to increase the Appellant's DHEA levels back to normal, would be to wean her off of HC, which, paradoxically, could be the cause of her reduced DHEA levels.

6.13 Without weighing in on the correctness of this diagnosis, the inconsistencies surrounding Dr. Serrano's diagnoses regarding the Appellant's adrenal insufficiency shed serious doubt on the accuracy of his assessments.[1]

B. Hypopituitarism

6.14 Setting aside the timing and severity of the Appellant's adrenal insufficiency, the Parties also disagree as to the cause of the insufficiency. Although at the hearing counsel for the Appellant questioned whether the source of a medical condition was relevant for TUE purposes, the Sole Arbitrator agrees with counsel for the Respondent that a necessary pre-condition to meet the TUE standards is an accurate diagnosis, i.e., source, of said condition. Without such a diagnosis, assessing the other TUE factors could prove an exercise in futility – it seems axiomatic that a TUEC can only assess the appropriateness of an exception by first understanding the condition.

6.15 In her submissions as part of the TUE application process and this proceeding, both Dr. Serrano and Dr. Larrimer attributed the Appellant's symptoms to hypopituitarism. Dr. Serrano, in his August 17, 2014 letter to the ITF TUEC wrote "*[m]y initial opinion was and still is that of hypopituitarism,*" while Dr. Larrimer concluded in his July 25, 2014 letter, "*I do believe she has Hypopituitarism.*"[2]

6.16 The Respondent challenged the accuracy of that diagnosis in its Answer and at the hearing, on a number of grounds, including submitting evidence that:

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1 The Respondent also took issue with the assertion that the Appellant had "*severe secondary adrenal insufficiency that is bordering on Addison's Disease.*" The Respondent contended that Addison's Disease, which is a primary adrenal failure, is a completely distinct condition from secondary adrenal insufficiency and that the latter can never become the former and so to describe them as a matter of degrees of severity is improper.

2 At the hearing, Dr. Serrano's contemporaneous submission, in which he stated that his initial opinion, presumably dating back to 2012, was hypopituitarism, suggests otherwise.

- Hypopituitarism is a malfunction between the hypothalamus and the pituitary gland. The relationship between the hypothalamus and the pituitary gland plays a critical role in the secretion of several hormones in the body, including the production of cortisol through the adrenal gland. If this relationship was malfunctioning, one would expect that secretion of all, or at least several, of these hormones would be inhibited. The inhibited productions would be demonstrable in blood tests. However, in the blood tests collected closest in time to the Appellant's doctors' diagnosis of hypopituitarism, nothing indicates that any of the hormones that rely on the pituitary gland, other than cortisol, which as discussed appeared depleted beginning in 2013, were at all deficient. This is inconsistent with hypopituitarism.

- The effect of hypopituitarism would be that the adrenal gland could not function without lifetime treatment. This is paradoxical to the Appellant's doctors' assertions that, under the proper supervision and circumstances, the Athlete could been weaned off of hydrocortisone or other cortisol supplementation.

6.17 At the hearing, Dr. Serrano acknowledged that he was not an expert in endocrinology, but conceded a number of the criticisms levied by the Respondent. He also seemingly attempted to backtrack from his own diagnosis of hypopituitarism by suggesting that his diagnosis was based on Dr. Larrimer's diagnosis of the same. Two troubling aspects of this position are that (i) it is at odds with his contemporaneous submission in which he stated that his initial opinion, presumably dating back to 2012, was that the Appellant suffered from hypopituitarism, and (ii) despite apparent reliance Dr. Larrimer's diagnosis, he was unable to offer any insight into how Dr. Larrimer came to his conclusion.[3]

6.18 Accordingly, there is serious doubt that hypopituitarism could be the proper diagnosis of the Appellant's adrenal insufficiency, regardless of when said deficiency manifested itself, meaning that the Appellant has likely still not yet been properly diagnosed.[4]

C. DHEA and Symptoms

6.19 Finally, one matter that raises doubts about the appropriateness of DHEA specifically as a treatment for the Appellant, that has yet to be adequately explained by the Appellant or her expert, is the juxtaposition of the timing of the manifestation of her symptoms, her DHEA use, and her objective blood and salivary tests.

6.20 By her own account, [redacted] symptoms began in 2010 and continued on and off for 2 years before she saw Dr. Serrano and before she was a granted the HC TUE in December 2012.

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3 Because Dr. Larrimer was not available at the hearing, the Sole Arbitrator heard no approach to reconciling the inconsistencies raised by the Respondent.

4 In fact, Dr. Serrano himself seemed to acknowledge these issues, when he stated, rather surprisingly, that he was open to ideas as to how diagnose and treat the Appellant.

6.21 But, as discussed above, the blood and salivary tests from September and November 2012, the period of time before the Appellant began taking HC, unequivocally show that the Appellant's cortisol and DHEA levels were within, or above, the reference range for her demographic. In other words, during one of the periods when the Appellant's impairments were at their worst, her cortisol and DHEA levels were not depleted. Without questioning the Appellant's veracity in stating that she felt better while taking DHEA, it is difficult then to reconcile the objective evidence with her doctors' recommendations that simply increasing her DHEA levels back to normal level today should cure her symptoms (notwithstanding any other potentially beneficial medical reasons to do so).

6.22 Considering all of these points, the Sole Arbitrator must conclude that the lack of a clear diagnosis of an existing medical condition is fatal to the Appellant's appeal.

6.23 Because the failure to adequately identify a medical condition in itself precludes the granting of a TUE, there is no need to address the remaining standards at this time. But nothing in this opinion should be interpreted to suggest that, should the Appellant undergo further examination and receive a verifiable diagnosis – which the Sole Arbitrator strongly advises her to do – any treatment options are precluded, as the Appellant's health is obviously of critical importance.

6.24 In this connection, the Parties agreed that an abrupt termination of the Appellant's HC treatment could adversely affect her health. As a result, she must be given some time to reduce her current intake of HC and replace it by a treatment that addresses her properly diagnosed indication, subject to the cumulative conditions for granting a TUE set forth in Article 4.1(a)-(d) of the International Standard. The Sole Arbitrator considers that the Appellant would have sufficient time to achieve this by April 30, 2015.

6.25 The Appellant must therefore be authorized to continue to take HC, at levels no higher than permitted in the Appealed Decision until the Appellant is granted a new TUE by the ITF TUEC, based on a proper medical diagnosis but in any event no later than April 30, 2015. For the avoidance of doubt, the Appealed Decision's revocation of the DHEA TUE is confirmed.

7. Costs

7.1 The present arbitration is subject to Article R64 of the Code unlike it was erroneously stated in the letter initiating the proceedings and in the Order of Procedure. In fact, the issue of the granting or denial of TUEs cannot be considered as a disciplinary matter, in the sense of Article R65 of the Code. Previous CAS cases about the issues of TUEs have fallen under the provisions of Article R64 of the Code (see for example CAS 2009/A/1948; CAS 2013/A/3437).

7.2 Article R64.4 of the Code provides:

"At the end of the proceedings, the CAS Court Office shall determine the final amount of the cost of arbitration, which shall include:
- the CAS Court Office fee,
- the administrative costs of the CAS calculated in accordance with the CAS scale,
- the costs and fees of the arbitrators,
- the fees of the ad hoc clerk, if any, calculated in accordance with the CAS fee scale,
- a contribution towards the expenses of the CAS, and
- the costs of witnesses, experts and interpreters.
The final account of the arbitration costs may either be included in the award or communicated separately to the parties."

7.3 Article R64.5 of the Code provides:

"In the arbitral award, the Panel shall determine which party shall bear the arbitration costs or in which proportion the parties shall share them. As a general rule, the Panel has discretion to grant the prevailing party a contribution towards its legal fees and other expenses incurred in connection with the proceedings and, in particular, the costs of witnesses and interpreters. When granting such contribution, the Panel shall take into account the complexity and outcome of the proceedings, as well as the conduct and the financial resources of the parties."

7.4 In the case at hand, the appeal is denied. In light of the outcome of this appeal, the Sole Arbitrator determines that the costs of the arbitration, to be calculated by the CAS Court Office and communicated separately to the parties, shall be borne entirely by the Appellant.

7.5 Concerning the Parties' costs of these proceedings, no factor in these proceedings militates in favour of having either party bearing more than its own share.

ON THESE GROUNDS

The Court of Arbitration for Sport rules that:

1. The appeal filed by [redacted] against WADA's decision of September 9, 2014 is dismissed.

2. WADA's September 9, 2014 reversal of the DHEA TUE is upheld, except to the extent that the Appellant's current existing HC TUE is extended until the Appellant is granted a new TUE by the ITF TUEC, based on a proper medical diagnosis, but no later than April 30, 2015.

3. The arbitration costs, to be determined by the CAS Court Office and notified by separate letter to the parties, shall be paid by [redacted]

4. Each party shall bear her/its own legal and other costs incurred in relation with the present proceedings.

5. All further prayers for relief are hereby dismissed.

Seat of the arbitration: Lausanne, Switzerland

Date: 10 February 2015

THE COURT OF ARBITRATION FOR SPORT

Romano F. Subiotto QC
Sole Arbitrator