Cannabis or Cannabinoids: the politics of medical marijuana

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PLEASE STAND BY – WEBINAR WILL BEGIN AT 12:00 PM PST
FOR AUDIO: CALL 866-740-1260 / ACCESS CODE: 764-4915#

Disclosures

• Nothing to disclose
Objectives

- Review the Pharmacology of Marijuana and the impact of various routes of administration
- Examine some of the (possible) role(s) of cannabinoids in medicine
- Explore some practical aspects of prescribing marijuana (herbal cannabis)
- Clinical Traps
The “New” Cannabis

...woody with a hint of mustiness, and as always with just a hint of pine

Dr. Louis Hugo Francescutti, past CMA President

• “It was a court that said we believe there’s benefit and patients should have access to it”, regarding the 2000 Ontario Ruling leading to Ottawa’s initial marijuana regulations
  – “So it was the courts that quite frankly put us in this mess...and trust me, we are in a mess.”
• “You can rest assured,” says Francescutti “there’s going to be more than one physician who’s going to get disciplined over this.”
Pharmacology

• Cannabis is not one drug, it’s a mixture of drugs
  – Primarily interested in CBD and THC
  – Pleasurable effects include
    • Mild euphoria and relaxation
    • Heightened sensory perception
      – Brighter colors
      – Stronger smells
      – Increased appetite (“the munchies”)
  – Distortion of time perception
    • Perceived time goes faster than clock time

Cannabis –yesterday and today

• Cannabis studies done 20 years ago describe a much lower potency drug than today
  – Genetic hybridization / THC optimization
  – Cannabinoid derivatives/synthetics
• No longer just “joints and brownies”
  – Cannabis oil; cannabis butter; blunts; spiffs....
Average Potency Confiscated THC %

The University of Mississippi Potency Monitoring Project

12/20/17

D Gourlay MD, Ontario CANADA

 Adolescence

Monitoringthefuture.org
**Pharmacology**

- Herbal cannabis contains over 500 compounds – in excess of 100 cannabinoids
  - Pharmacology is largely unknown but most potent is $\Delta 9$ THC
  - $\Delta 8$ THC, cannabiol, cannabidiol have additive, synergistic and even antagonist activity wrt $\Delta 9$ THC
  - Cannabis and tobacco are similarly constituted, except for nicotine

*Savage, Seddon et al. Cannabis in Pain Treatment: Clinical and Research Considerations, J of Pain. 17(6), 2016 pp 654-658*

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**Pharmacokinetics**

- $\sim 50\%$ of the THC in a joint is inhaled through smoke
  - Pulmonary absorption is nearly 100%
    - Onset within seconds
  - Bioavailability of oral THC is $\sim 25$-$30\%$ of the pulmonary dose
    - Extensive 1$^{st}$ pass effect in the liver
    - Delayed onset (0.5-$2$hrs) with much prolonged duration due to ongoing absorption from the gut
Pharmacokinetics

- Due to high lipid solubility, cannabinoids accumulate in fatty tissue
  - Elimination $t_{1/2}$ is $\sim 7$ days
- In the brain, cannabinoids are differentially distributed
  - Highest concentrations in neocortical, limbic, sensory and motor areas

Metabolism

- Primarily hepatic, with major metabolite as 11-hydroxy-THC (biologically active)
  - Excretion is $\sim 25\%$ urine, the rest gut (65%)
- This all results in an unpredictable relationship between plasma or urine conc and degree of cannabinoid-induced intoxication
Pharmacology

- 1992, first endogenous ligand for CB receptors was discovered
  - Anandamide (from Sanskrit for “bliss”)
    - Structurally related to prostaglandins not THC
      - Effects are similar to THC
    - Appear to behave as neurotransmitters affecting cAMP formation and Ca\(^{2+}\) and K\(^+\) ion transport
  - THC has been shown to increase dopamine release (via permissive role of opioid pathway)

Sites of Action

- The endocannabinoid system is distributed throughout the brain and spinal cord
  - CB-1 receptors are concentrated in the hippocampus, association cortices, basal ganglia, cerebellum and spinal cord (especially dorsal root ganglia)
  - CB-2 receptors are found in the periphery including lymph tissue as well as in lower amounts in the brain including the periaqueductal gray
- Activation of these receptors results in physiologic responses that would be expected from these regions

Sites of Action

- Examples of such responses include: a feeling of well-being, psychosis, diminished locomotor functioning, impaired memory/cognition, **ANTINOCIPTION, SPASTICITY REDUCING, SLEEP PROMOTING**, and antiemetic action
  - Receptor activation inhibits adenylate cyclase and subsequently the release of multiple neurotransmitters is inhibited when neuronal excitation is present
  - These neurotransmitters include glutamate, acetylcholine and dopamine
- Other neuronal networks may be modulated by endocannabinoids through indirect effects on opiate, N-Methyl D-Aspartate (NMDA), and Gamma Amino Butyric Acid (GABA) receptors


Important Additional Considerations Regarding Medical Marijuana for CNS Disorders

- The concentration of THC as well as the ratio of THC to CBD in specific formulations is what limits (or not) THC’s psychoactive effects
- Key Examples: **Dronabinol**: 2.5mg THC; **Nabilone**: 1mg (CBD); **Sativex®**: 1:1 ratio of THC 2.7mg/CBD mg/spray; **Smoked marijuana**: 4% THC (this number is rising)

Effects of cannabis

• Short Term
  – Effect on mood is *usually* euphorogenic
    • 2.5mg smoked gives a feeling of intoxication, decreased anxiety, tension and increased sociability
      – Duration of action is typically 2hrs or more (dose related)
    • Dysphoric effects include anxiety, aggravation and frank psychosis
  – Effects on Perception
    • Heightened sensitivity, spatial and time distortion
    • Perceived time goes faster than clock time

Effects of Cannabis

• Effects on cognition and psychomotor performance
  – Similar to alcohol and benzodiazepines i.e. slowing of reaction time, motor coordination, specific defects in short-term memory, impaired concentration and complex task performance
    • All effects are *at least* additive with other CNS depressants
  – Tolerance is neither complete nor predictable
Cannabis and Driving

- Cannabis impairs road-driving performance
  - Numerous studies link cannabis with increased motor vehicle accidents
  - In the UK, USA, Australia, New Zealand and many European countries, cannabis is the most common drug (apart from EtOH) detected in drivers involved in fatal accidents or stopped for impaired driving

Chronic Effects of Cannabis Use

- As usual, risk is multifactorial
  - Unfortunately, the risk in adolescence appears to be long term and dose-related
  - Some risk appear to be genetically mediated
    - Risk is not equal for all persons
  - Addiction
  - Psychiatric Comorbidities
  - Schizophrenia – Marijuana Link
Therapeutic Benefits of Cannabinoids

- Importance of separating the molecule from the route of administration

- Clearly Beneficial
  - Chemo induced nausea
  - HIV-associated anorexia and wasting
  - Refractory Glaucoma
  - ? Neuropathic pain and spasm of multiple sclerosis (subjective – YES; objective – NO)

THC/CBD potential benefits

- THC is said to have analgesic, anti-spasmodic, anti-tremor, anti-inflammatory, appetite stimulant and anti-emetic properties, whilst...

- CBD has anti-inflammatory, anticonvulsant, anti-psychotic, anti-oxidant, neuroprotective and immunomodulatory effects.
  - CBD is not intoxicating and indeed it has been postulated that the presence of CBD in cannabis may alleviate some of the potentially unwanted side-effects of THC

http://www.gwpharm.com/types-compounds.aspx
Practical Aspects of *Prescribing* herbal cannabis

- No standardization of dose
  - Concentration of product is highly variable
  - Route of administration (smoking vs oral) leads to vastly different serum levels and effects
- No clear *indications* or *contraindications* to guide the prescriber
- No *practical* means of controlling the amount of drug used

Legal Liability

- **Direct Liability**
  - Complaints to College if you do or don’t complete the forms
  - *Iatrogenic harm* caused by your prescription of cannabis (to the patient)
- **Third Party Liability**
  - If someone else comes to harm as a result of actions of your patient using prescribed/recommended cannabis
Occupational Health and Safety

- Not a lot of ‘hard and fast’ data
  - In the absence facts, ‘rules’ will still be created and enforced
- Things to consider:
  - Having a ‘medical certificate’ will NOT protect employee from ‘dismissal for cause’ based on drug use
  - ‘driving while impaired’ and similar will be prosecuted with or without medical excuse

Summary Points

- Health Canada should explicitly state the indications, precautions and contraindications for medical marijuana, as it does with all other therapeutic medications
- The active ingredient of cannabis, or synthetic cannabinoids, THC, can already be prescribed
- Many subjects in published trials were regular cannabis smokers
- Smoked cannabis poses serious risks, particularly in young people
So, what can you do?

• Unless you can competently discuss the pro/con of herbal cannabis, including indications and contraindications for use i.e. provide informed consent.... you would be wise to consider carefully any decision to prescribe/recommend
  – Until that time....approved pharmaceutical options might be your best choice (with careful documentation of your thoughts and actions)
  • Or.....recommendation that the patient seek evaluation at one of the many cannabis clinics popping up around the country

Clinical Traps

• “But it’s the only thing that works for me!”
  – Most difficult argument to defuse
    • But, if cocaine was the only thing that worked for my nasal stuffiness, would you prescribe?
  – for the most part, those advancing smoked cannabis as the “gold standard” are long-standing pot smokers
    • You can recommend “harm reduction” methods such as vaporizing aka “Vaping” rather than combusted cannabis
Clinical Traps

• Once you legitimize the presence of the analyte in the urine, you’ve lost the ability to monitor use/misuse/diversion
  – This can have serious implications for “return to work” requirements, 3rd party advocacy etc
    • Disability claims
    • Child Protective Services
    • Criminal justice (probation/parole)
    • Operation of a motor vehicle

Clinical Traps

• “Well, I’m still going to use. If you don’t prescribe for me....I’ll just continue to use illicitly. If I go to jail, it’s on you!”
  – When a patient holds you hostage with threats, you (and the patient) are on very shaky therapeutic grounds
    • Would you prescribe opioids under these terms?
  – Consider having a 3rd party in the room for these discussions – DOCUMENT EVERYTHING
Conclusion

• Dried cannabis is NOT a medication in any traditional sense of the word
  – That doesn’t mean cannabinoids have no legitimate indication as therapeutic agents
    • But smoking anything for your health in 2017 is oxymoronic: proceed with care!

• Canada’s Medical Marijuana Program is about political policy, not about resolving an unmet medical need

Resources

• Medical Marijuana (aka Marihuana)
  – Act repealed March 31st, 2014 - CANADA

• College of Family Physicians of Canada

• CMPA April 2014 update

• Cannabis in Pain Treatment: Clinical and Research Considerations

• Should doctors prescribe cannabinoids?
  – www.bmj.com/content/348/bmj.g2737

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