Cannabis should be avoided?

• Every other medication we prescribe has standard dosing and potency; no other medication is smoked. Inhaled cannabis contains 400+ compounds, and it’s unclear which are important and how they interact. On top of that, each inhaled puff can be different from the last.

• There is no evidence that cannabis is superior to prescription cannabinoids; therefore regulated & approved prescription cannabinoids should always be preferred.

• In clinical trials, benefits are typically small and may just be a placebo effect. Meanwhile, adverse events are common. We have a professional duty to only prescribe medications when it can be done safely, and with cannabis the harms almost always outweigh the benefits. These harms may not be fully appreciated by patients.

• If we routinely authorize cannabis today, will it mirror the opioid crisis tomorrow?

Cannabis is useful?

• Some patients have tried a dozen or so standard medications without success, and now are trying, or want to try cannabis. If these patients find success with cannabis, and we help them do so safely, we will have done a great service for them.

• When patients say a medication helps, we should listen to them, just as we listen when patients tell us the antidepressant or anti-emetic we prescribed is helping.

• By developing products with a higher CBD-to-THC ratio, many tolerability concerns will be overcome.

• If cannabis helps our patients use less opioids, that’s an attractive tradeoff.

• I plan to discuss what would constitute success, set realistic expectations, and conduct a trial over 4-12 weeks, after which any benefits vs harms will be assessed along with the decision on whether to continue or discontinue.

A final thought: If a patient told you they were getting benefit from ibuprofen over-the-counter, you might recommend they continue taking it. You might feel the same way if the patient was using 6 grams of ibuprofen per day? Or if the patient insisted that the ibuprofen was improving their blood sugar control? Or if the patient had a history of GI bleeds? (The risk with medical cannabinoids is unstudied.)

PERSPECTIVES ON Medical Cannabis

Do Cannabinoids Work (Medically)?

Note: See "Challenges with the evidence" comments, above

Cannabinoids may (limited, low quality evidence for benefit, compared to placebo):

• ↓ chronic neuropathic pain NNT=11 for ≥30% reduction over ~4 wks.2,15 (Balance of evidence for ↓pain, but some ↑harms of shared decision making) 78,79
• ↓ chemotherapy-induced nausea & vomiting NNT=3 for control of nausea/vomiting over ~1 day.7
• ↓ spasticity of multiple sclerosis or spinal cord injury NNT=10 for ≥30% ↓spasticity over ~6 wks.68
• ↓ seizures in Lennox-Gastaut & Dravet syndrome with CBD NNT=4-7 for ≥50% reduction in seizure frequency over ~14 wks.2
• ↓ cachexia in HIV/AIDS, cancer, palliative care: weak evidence.

Are Cannabinoids Safe?

Adverse effects (AE) are very common with cannabinoids. Approximately 8-9 patients out of 10 will develop an adverse effect to cannabis therapy and ~1 patient in 10 will stop therapy because of an adverse effect.2 Notable AEs include feeling “high” NNH=4; sedation NNH=5; speech disorders NNH=5; dizziness NNH=5; and ataxia/muscle twitching NNH=6.2 Additional concerns include driving impairment, addiction risk, euphoria, and psychosis. Some cannabinoids may be safer than others, but this is not well studied (including specific THC/CBD ratios). See next page. Option, but caution in older adults.75 Cannabis use disorder is associated with self-harm & overdose death in youth.74

Cannabis for pain, or Opioids …

Trial evidence comparing cannabinoids and opioids is limited.57 But they do have some similarities and differences to consider:

• Efficacy: For both drug classes, RCT evidence is of low quality and short duration, and tends to show only a modest reduction in pain. Longer trials tend to show less benefit. However, despite the relative lack of quality evidence, patients often have strong beliefs about the value of each drug class. (Ask “Who is using? How are they using?, & Why...?”)

• Adverse effects: Nausea, sedation, and euphoria are adverse effects of both drug classes. Opioids can cause constipation;25 cannabinoids can cause psychiatric disturbances (e.g. anxiety, agitation, amotivation, psychosis).25 Adverse effects appear dose-related (↑dose = ↑AE). Both drug classes may be used by patients as an “escape”.

• Addiction risk: With prescription opioids, estimated to be 5.5%.25 With non-medical cannabis, estimated to be ~9%.75 (The risk with medical cannabinoids is unstudied.)

• Fatal overdose risk: With prescription opioids, 0.23% with >100mg morphine per day (↑risk with ↑dose).25 With cannabis, fatal overdose risk appears to be negligible.2

For both drug classes, the concept of an n=1 trial with an exit strategy is important. Not all patients will respond to, or function well on, these medications.

... Or Something Better?

If patients are wanting an escape from pain – physical or emotional – there are often better choices! Non-pharmacological approaches to coping and living well with pain will be essential for success!
### Cannabinoids: Comparison Chart

#### Medical Cannabis (Plant)

<table>
<thead>
<tr>
<th><strong>Generic/TRADE</strong></th>
<th><strong>Indications &amp; Comments</strong></th>
<th><strong>DOSING</strong></th>
<th><strong>$/30d</strong></th>
<th><strong>Adverse Events AE / Contraindications CI / Drug Interactions DI / Monitor M</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Nabilone CESAMET, g</strong>&lt;br&gt;synthetic THC analogue</td>
<td>Preferred over cannabis; CYP3A4</td>
<td>Initial: 0.25-5.0mg po HS&lt;br&gt;Usual: 1-2mg po daily-BID for CINV&lt;br&gt;Usual max: 6mg/day&lt;br&gt;(Onset 60-90min; duration 8-12 hrs)</td>
<td>$233-36 g</td>
<td>Some notes on adverse effects:&lt;br&gt;• percentages below are often “worst case scenarios” from systematic reviews, yet due to trial-design issues could also be underestimates.&lt;br&gt;• adverse effects dose-related (↑dose = ↑AE), &amp; more common with THC products&lt;br&gt;• it is difficult to compare AE rates between agents, due to few head-to-head trials.&lt;br&gt;• Nabilone appears to be the main component responsible for causing a “high”, low-quality evidence.31 CBD appears safer than THC, but some of its psychotropic effects are underappreciated (e.g. vs placebo in predominately pediatric trials: aggression/agner 3-5% vs &lt;1%; irritability/aggitation 5-9% vs 2%; somnolence 25% vs 8%).32</td>
</tr>
<tr>
<td><strong>Nabiximols SATIVEX, £</strong>&lt;br&gt;extracted THC/CBD</td>
<td>Preferred over cannabis; CYP1A2</td>
<td></td>
<td>$252-494 g $252 g $736 g $1100</td>
<td><strong>Psychiatric disturbances</strong> up to 17% across cannabinoids, and up to 27% with inhaled cannabinoids, including depression, anxiety, panic, paranoia, hallucination. In Colorado, accounts for ~25% of cannabinol related hospital visits. Monch '19&lt;br&gt;<strong>Drowsiness</strong> up to 15%, and feeling “high” up to 35% across cannabinoids.2&lt;br&gt;<strong>Acute psychosis or dissociation</strong> up to 5% across cannabinoids.2&lt;br&gt;<strong>1st episode psychosis</strong> daily cannabis ↑ 3x &amp; THC ≥10% ↑ 5x vs never users. Font '19&lt;br&gt;<strong>Schizophrenia</strong> unmasking: cannabis may hasten first psychotic episode by 2-6 yrs.8&lt;br&gt;<strong>Speech disorders</strong> up to 32%, and axotaxis up to 30% across cannabinoids.2&lt;br&gt;<strong>Impaired memory</strong> up to 11%.2 Also: impaired cognitive performance (for up &lt;28days) irribility or agitation up to 9%, and anger or aggression up to 5% with CBD.31&lt;br&gt;<strong>Appetite changes</strong> decreased appetite in up to 22% of patients on CBD, but conversely increased appetite in up to 38% of patients on dronabinol.8&lt;br&gt;<strong>GI issues</strong>: dry mouth; diarrhea up to 20%, vomiting ≥ 15% with CBD.31&lt;br&gt;<strong>Conversely</strong> nausea in up to 20% of pts with dronabinol.2&lt;br&gt;<strong>Sativex</strong> mouth irritation. Monch '19&lt;br&gt;<strong>Cannabinoid hyperemesis syndrome</strong>: severe abdominal pain/vomiting; requires drug discontinuation; relieved by hot shower; applying capsicain to abdomen useful.32&lt;br&gt;<strong>Pneumonia</strong> up to 8% with oral CBD.8&lt;br&gt;<strong>UTI</strong> up to 16% of pts on CBD.18&lt;br&gt;<strong>Related to concomitant valproate/clobazam.</strong> driving impairment: risk of fatal car crash approximately doubles with THC.2855&lt;br&gt;<strong>Withdrawal with abrupt discontinuation</strong> (see withdrawal symptoms on next page) red eyes reported with non-medical use of oral and smoked THC.2855&lt;br&gt;<strong>Rrare or uncertain</strong>: sexual problems, ?cancer testicular, ?-BMD, ?pancreatitis.</td>
</tr>
<tr>
<td><strong>Cannabidiol EPIDIOLEX</strong>&lt;br&gt;extracted CBD, 98%</td>
<td>100mg/mL solution F0A18</td>
<td>3 vial pack = $673 (50/50 spray/IV)&lt;br&gt;$750 (IV)</td>
<td>$107</td>
<td><strong>Cannabinoids</strong> pharmacologic trade</td>
</tr>
<tr>
<td><strong>Dronabinol MARINOL synthetic THC</strong>&lt;br&gt;USA only:</td>
<td>Preferred over cannabis; CYP1A2</td>
<td>Initial: 2.5mg po HS&lt;br&gt;Usual: 2.5-5mg po TID-QID for chemo nausea/vomiting (“5mg/m”)&lt;br&gt;2.5mg po BC acidunch and sufor for anorexia(ADS 3)</td>
<td>$7</td>
<td><strong>D/C from Canadian market</strong></td>
</tr>
<tr>
<td><strong>Oral Cannabis Oils x THC/CBD in various ratios</strong>, e.g.:</td>
<td>No official indication. May be medically authorized in Canada to any patient for any indication (i.e., “off-label use”).</td>
<td><strong>Max</strong>: 20mg/day</td>
<td>$20-70</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>25mg THC / 0mg CBD per mL</td>
<td>THC detected in urine drug screen up to 4 weeks after last dose. (esp. chronic/heavy users)</td>
<td><strong>Seizures</strong>: Lennox-Gastaut syndrome O</td>
<td>$18-250</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>1mg THC / 20mg CBD, per mL</td>
<td></td>
<td>Dravet syndrome in patients &amp; Tuberous sclerosis complex 14 yrs</td>
<td>$75-290</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>2mg THC / 3mg CBD capsule</td>
<td></td>
<td>Not detected in UK urine screen</td>
<td>$25-350</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>many other formulations &amp; potencies available.</td>
<td></td>
<td></td>
<td>$25-350</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>Veteran's Affairs: coverage available for some patients</td>
<td></td>
<td></td>
<td>$25-350</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td><strong>Dried Cannabis x THC/CBD in various ratios</strong>, often to smoke/vape, e.g.:</td>
<td><strong>severe nausea/vomiting from cancer chemotherapy</strong></td>
<td>Initial: 1-2puffs inhaled HS&lt;br&gt;(1 puff of joint = 1-10mg THC. Variation is due to inhalation depth, puff size, THC potency, smoked vs vaporized, joint size, etc.)</td>
<td>$12-24 for 1-2 puff HS</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>12.5% THC</td>
<td><strong>Food increases absorption.</strong></td>
<td>Usual: Uncertain due to lack of randomized trials. Titrate slowly.</td>
<td>$180 for 750mg/day</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>4% THC / 10% CBD</td>
<td></td>
<td>(Consider: dronabinol &amp; nabiximols labelling suggest max doses of 25-30mg THC per day.)</td>
<td>$720 for 3g/day</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>1% THC / 13% CBD</td>
<td></td>
<td><strong>Seizures</strong>: Lennox-Gastaut syndrome or Dravet syndrome in patients &amp; Tuberous sclerosis complex 14 yrs</td>
<td>$252-494 g</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>many other potencies available.</td>
<td></td>
<td>Not detected in UK urine screen</td>
<td>$252 g</td>
<td><strong>Notes</strong></td>
</tr>
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<td><strong>Veteran's Affairs</strong>: coverage available for some patients</td>
<td></td>
<td></td>
<td>$736 g</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td><strong>Trend</strong>: toward ↑ potency products.54 (e.g. 4% THC in 1995 → 12% in 2016; some may now be in the ~20% range)</td>
<td></td>
<td></td>
<td>$1100</td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td><strong>Average joint</strong>: 0.3g dried cannabis.56</td>
<td></td>
<td></td>
<td></td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td><strong>Medical use in US</strong>: 33 States &amp; D.C. Recreational use USA: 15 States &amp; D.C.</td>
<td></td>
<td></td>
<td></td>
<td><strong>Notes</strong></td>
</tr>
</tbody>
</table>

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**Diagnosis & Treatment**

**Cannabis as a treatment for anxiety**

- **Cannabis** may have a potential role in anxiety treatment.
- Some studies have shown reductions in anxiety symptoms with cannabis use.

**Cannabis and Depression**

- Cannabinoids may have potential antidepressant effects.
- Preclinical and clinical studies have suggested that cannabis or cannabinoids may have antidepressant properties.

**Cannabis and Substance Abuse**

- Cannabis use may increase the risk of substance abuse disorders.
- Abstinence or a reduction in cannabis use may be necessary to reduce the risk of substance abuse.

---

**Notes**

- The above information is based on scientific literature and clinical studies.
- Further research is needed to fully understand the effects of cannabis on anxiety, depression, and substance abuse.

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**References**

Who could be a candidate for cannabinoid therapy?

- Cannabinoids are generally not considered first- or second-line therapy for any indication. Reserve use for patients who have failed other therapies. Conduct a trial over 4-12 weeks; review benefit vs harm, e.g. may consider if tried ≥3 drugs for neuropathic pain or ≥2 drugs for palliative pain or if refractory to standard therapies for CINV, spasticity in MS or SCI, or cachexia [or refractory pediatric seizure]
- Watch for relative contraindications such as pregnancy, breastfeeding, age <21-25, a history of psychosis/schizophrenia, or substance abuse history. For more details, see RxFiles Cannabis Q and A.

Prescribing/Authorizing Cannabinoids Safely

Cannabinoids are potential drugs of abuse; caution is needed when prescribing. In general, follow similar principles to prescribing opioids (see page 131-132). A summary of these principles is as follows:

- Optimize suitable non-cannabinoids therapy first (drug and non-drug)
- Check Prescription Drug Monitoring Programs (e.g. PIP in SK) at baseline & at each visit. These programs do not record medical cannabis. Opt to check order hx with Licensed Producer. Document cannabis use on local EMR (just like tobacco, alcohol, etc.).
- Baseline urine drug screen, and randomly thereafter
- THC metabolite detected = THC-COOH. Note: urine drug screens in SK do not test for CBD.
- Search “agreement” at www.rxfiles.ca for a sample cannabinoid tx agreement. Agreement includes safe storage – especially important if kids nearby167
- Monitor for benefits & harms. Exit Strategy: stop (often taper) if trial unsuccessful. Possible taper to prevent withdrawal: ↓ by 25% q1week. Monitor more vigilantly in those at higher risk, esp where quality evidence/guidelines lacking.

Choosing Between Products

<table>
<thead>
<tr>
<th>Prescription Cannabinoids</th>
<th>Cannabis</th>
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<tbody>
<tr>
<td>e.g. nabilone, nabiximols</td>
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Quality Control

- Standardized.
- Some indications and dosing are Health Canada approved.
- Will show up on the electronic medical record (e.g. PIP in Saskatchewan).

Dosing & Guidance

- Challenging. e.g. THC in 1 puff of cannabis joint can range from 1 to >10mg. No "standardized dose".
- Prescriber may pick strain/ratio and max quantity allowed for patient. May limit duration, e.g. "one 60mL bottle of CBD oil, then see prescriber for further authorization."
- Overall, less control than prescription products (e.g. “dosing interval” does not exist).

Note: despite prescriber attempts to guide product and dosing, patients may supplement with retail cannabis against medical advice.

Access

- Dispensed by community pharmacy.
- Exclusively by mail/courier.
- At cannabis retail store; online ordering possible too.

Paperwork

- Written or electronic prescription.
- See Paperwork Required for Medical Cannabis box, right.
- None.

Coverage

- Occasional private insurance coverage.
- SK EDS and prior approval criteria for specific indications.
- Occasional private insurance coverage (e.g. Manulife and Sunlife on a case-by-case basis as of 2018).
- Veteran’s affairs coverage (max 3g/day dried cannabis)
- Average price still uncertain (Ranges from $28-20/g). Note: Costs vary dramatically across provinces. [Note: Pharmacologic tx, e.g. naltrexone, appears ineffective at this time] (Courtney)39

Medical users (vs recreational):

- Use more frequently
- Use products other than dried flower & trend towards low THC/high CBD

In primary care, watch for:
- respiratory problems
- depression/anxiety/amotivation
- issues functioning/concentrating (e.g. in studies, work, relationships)
- those at ↑↑ risk of self-injury/harm (e.g. veterans - suicidality, seniors - AEs, Dis)

Medication

- nabilone, nabiximols (e.g. nabilone, nabiximols) (Health Canada licensed producer). Production standards exist, including testing for pesticides & THC/CBD concentrations. In SK, complete treatment agreement form Search “agreement” at www.rxfiles.ca for a sample cannabinoid tx agreement. Agreement includes safe storage – especially important if kids nearby167
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The College’s bylaw which regulates physician authorization of medical marihuana is now in effect. The bylaw is numbered Bylaw 19.2 of the regulatory bylaws of the College and is available at the College’s website. Visit: http://www.cps.sk.ca/imis/CPSS/CPSS/Programs_and_Services/Medical_Marijuana/Medical_Cannabis.aspx. A summary of the bylaw follows:

1. The bylaw begins with a statement that there has not been sufficient scientific or clinical assessment to provide evidence about the safety and efficacy of marihuana for medical purposes. The bylaw begins with an acknowledgement that federal government regulations have authorized the use of marihuana for medical purposes.

2. A physician cannot authorize the use of marihuana for a patient unless the physician is also the treating physician for the condition for which the patient is authorized to use marihuana. For example, if a patient is to be authorized to use medical marihuana to deal with symptoms of MS, the physician must also be the treating physician for the patient’s MS.

3. A physician must review the patient’s medical history, review relevant records pertaining to the condition for which the use of marihuana is authorized and conduct an appropriate physical examination before authorizing the patient’s use of marihuana.

4. The patient must sign a written treatment agreement which contains the following:
   A) A statement from the patient that the patient will not seek a prescription for marihuana from any other physician during the period for which the marihuana is prescribed;
   B) A statement by the patient that the patient will utilize the marihuana as prescribed, and will not use the marihuana in larger amounts or more frequently than is prescribed;
   C) A statement by the patient that the patient will not give or sell the prescribed marihuana to anyone else, including family members;
   D) A statement by the patient that the patient will store the marihuana in a safe place

Sample treatment agreement: http://www.cps.sk.ca/iMIS/Documents/Programs%20and%20Services/Patient%20Agreement%20Template%20-%20Medical%20Cannabis.pdf

Or visit www.RxFiles.ca and search "agreement".

5. The physician’s record for the patient must include the requirements for all medical records and, in addition, contain the following:
   A) The treatment agreement signed by the patient;
   B) The diagnosis for which the patient was authorized to purchase marihuana;
   C) A statement of what other treatments have been attempted for the condition for which the use of marihuana was prescribed and the effect of such treatments;
   D) A statement of what, if anything, the patient has been advised about the risks of the use of marihuana;
   E) A statement that in the physician’s medical opinion the patient is likely to receive therapeutic or palliative benefit from the use of marihuana to treat the patient’s condition.

6. The physician must retain a single record, separate from other patient records, which can be inspected by the College, and which contains:
   A) The patient’s name, health services number and date of birth;
   B) The quantity and duration for which marihuana was prescribed;
   C) The medical condition for which marihuana was prescribed;
   D) The name of the licensed producer from which the marihuana will be obtained, if known to the physician.

7. Physicians who prescribe marihuana will be required to provide the College with the information referenced in paragraph 6:
   A) Every twelve months if the physician has prescribed marihuana to fewer than 20 patients in the preceding 12 months;
   B) Every six months if the physician has prescribed marihuana to 20 or more patients in the preceding 12 months.

8. The bylaw prohibits physicians from diagnosing or treating patients at the premises of a licensed producer;

9. The bylaw prohibits physicians who prescribe marihuana from having an economic or management interest in a licensed producer;

10. The bylaw prohibits physicians from storing or dispensing marihuana from any location where the physician practices medicine.
Submitting Adverse Effect information to Health Canada:

Tips on filling out Part D (for cannabis products i.e. dried cannabis or cannabis oils)

- DIN or NPN is not required
- Include: brand name, strain name, lot #, licensed holder name, intended use (medical or non-medical)
- If the product was not purchased from a legal retailer it can still be reported but it would be useful to indicate if it was purchased from a non legal source so it can be processed properly in our database.

<table>
<thead>
<tr>
<th>Cannabinoid</th>
<th>139</th>
</tr>
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<td>Cannabinoid Use Disorder</td>
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<td>THC</td>
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References: Cannabinoid Chart – [www.RxFiles.ca](http://www.RxFiles.ca)


35. Aldington S, Williams M, Nowitz M, Weatherall M, Pritchard A, McNaughton A,Robinson G, Beasley R. THE EFFECTS OF CANNABIS ON PULMONARY STRUCTURE, FUNCTION AND SYMPTOMS. Thorax. 2007 Jul 31; [Epub ahead of print] Smoking cannabis was associated with a dose-related impairment of large airways function resulting in airflow obstruction and hyperinflation. In contrast, cannabis smoking was seldom associated with macroscopic emphysema. The 1:2.5 to 5 dose equivalence between cannabis joints and tobacco cigarettes for adverse effects on lung function is of major public health significance.


Cannabis, from plant to pill

12:e192574.


Doss MK et al. Δ9-Tetrahydrocannabinol at retrieval drives false recollection of neutral and emotional memories. Biol Psychiatry 2018 May 9.


Freeman TP, Hindocha C, Green SF, Bloomfield MAP. Medicinal use of cannabis based products and cannabinoids. BMJ. 2019 Apr 4;365:L1141.


Gulland A. Sixty seconds on marijuana smoke. BMJ. 2018 Sep 15:e21140.


