Clinical Obervations

Case Report Abstract by Tod Mikuriya, MD

ATROPHIE BLANCHE TREATED WITH CANNABIS AND/OR THC

Introduction: Atrophie blanche / livedoid vasculitis, is a chronic non-palpable primary cutaneous purpuric clotting disorder with petechiae of autoimmune etiology. Clinically, there is recurrent breakdown of tissue with edema, pain, and secondary infection.

Method: L.H.R., 56 year old single caucasian accountant was evaluated for eligibility for the California Compassionate Use Act.

History: He contracted this rare condition after infection of his feet. While incarcerated in prison he abstained from using cannabis. The condition gradually worsened for the next four years until his release from a halfway house. (A course of antihypertensive drugs may have also aggravated during the onset stages.) He underwent venous stripping and numerous courses of topical and systemic antibiotics without relief.

The recurrent attacks of painful breakdown of skin and underlying tissue with edema caused him to be immobilized and housebound. He experienced significant reactive depression secondary to pain and immobility.

After release he resumed his use of cannabis (begun at age 15). He noted significant relief of symptoms and decreased frequency of attacks using high-grade cannabis smoked twice daily.

He is currently maintained on coumadin 5mg daily, digoxin 0.25 mg daily.

Findings: The feet exhibited some thinning, tightening, and rubor of the skin with mild atrophic changes. The patient walked gingerly but with essentially normal gait.

Results: Marinol 10 mg 1 – 2 Q6 PRN was begun. The patient reports excellent results using 10 mg BID with no relapses. His depression has gradually lifted, commensurate with his improved mobility.

Conclusion: THC and cannabis would appear to have analgesic immunomodulative and antidepressive properties.

Three Consecutive Patients in a Therapeutic Cannabis Medical Practice

By Philip A. Denney, MD

R.C., a 53-year-old insurance attorney, sustained a cervical spine fracture at C-4 and C-5 in a surfing accident in a surfing accident in 1991. The injury required surgical fusion with bone grafting and internal fixation, resulting in chronic pain. He has used cannabis successfully for pain mangement over the last eight years at a stable dose of 1/4 ounce per week. He weaned himself completely from narcotics and benzodiapenes (Valium). "That stuff was killing me." He denies any adverse effects of cannabis use.

Comment: This is a very typical patient in my practice. Chronic pain is the presenting complaint for as many as 1/2 my patients. —PAD

B.M., a 20-year-old student, presents with a diagnosis of Crohn's Disease discovered at age 15. He gives a history of chronic abdominal pain, severe weight loss and rectal bleeding, poorly controlled with multiple medications. He was introduced to cannabis by another Crohn's Disease patient two years ago and noted immediate improvement. He has had significant weight gain, marked reduction in abdominal symptoms including rectal bleeding and has had no hospitalizations since beginning therapeutic cannabis. He uses 1/2 ounce per week and has stopped all pain medications. He continues to use Asacol to treat his underlying disease.

Comment: Chronic gastrointestinal diseases, particularly those with painful cramping, nausea or anorexia, respond well to cannabis in my experience. —PAD

R.S., a 31-year-old nanny with a history of longterm morbid obesity, underwent gastric bypass surgery in 2001. Post-operatively she experienced anorexia and severe nausea, resulting in profound weight loss (from 260 lbs down to 96 lbs). She was treated with multiple medications. "They even sent me to a psychiatrist." When a feeding tube and parenteral nutrition were discussed, a friend insisted that she try cannabis. R.S. reports that cannabis controlled her nausea, "better than any other medication I've tried." Her weight has stablized at 120 lbs. She states that cannabis not only helps her nausea and appetite, but has helped her deal with the life-changing effects of her profound weight loss.

Comment: another example of the benefit of cannabis use in gastrointestinal disorders. Also illustrates the benefits for patients with life-changing illnesses. —PAD

Notes *re:* Patterns of Use

By Tom O'Connell, MD

Since the Fall of 2001 I have conducted interviews of patients seeking a 'medical' designation in the San Francisco Bay Area.

Over the first seven months the interviews became more focused and I developed a standardized set of questions that was asked of all candidates. Recently I began analyzing data provided by 625 patients, who were all seen between July 1 and Dec. 31, 2002.

• 80% were men (average age 33); 20% women (average age 39).

• 70% (of all) were Caucasian; 15% were African-American; 7.5% Hispanic and the rest split between Asian and "Other."

My patients typically made appointments to be seen at cannabis clubs. While they range in age from 18 to 91, there were very few over the age of 56 —perhaps reflecting that most people who will ever use cannabis try it before the age of 21. Many did not have health insurance. Others (generally members of Kaiser Permanente) reported that their doctors would not discuss cannabis with them.

While most cited 'somatic' symptoms/conditions— especially chronic pain— as their reason for using cannabis, the intensity (and validity) were quite variable. A careful chronology almost invariably reveals that cannabis use was chronic before the painful condition existed.

More than 90%, when asked directly, acknowledged "stress," "anxiety," "insomnia" "agorophobia," " anorexia," and other indications of emotional distress. An inescapable conclusion is that much initial use is motivated by psychic rather than —or as well as— physical pain.

Patterns of use

• 95% were using five or six days per week and had been for years —or decades.

• The average amount used varied from 1/16 to more than an ounce per week, but the great majority admit to between 1/8 and 1/4 oz per week.

• Marijuana is smoked or otherwise ingested in multiple small doses with an emphasis on avoiding becoming "stoned."

• Some always smoke in the morning. Others never smoke in the morning; Many will smoke in the morning— but only on days off. In other words, work schedule —and fear of exposure— play a big role in usage. There also seems to be an avoidance of daytime use for other reasons.

• Although all age groups are represented, the great majority —92.9%— were under the age of 56.

• The vast majority —84%— had first sampled ("initiated") cannabis in either high school or junior high.

• The average age of initiation has been declining steadily —from older than 16 in the late 1960s to under 15 in the late '90s.

• Essentially all had initiated alcohol and most (93%) had also tried tobacco at average ages remaining more or less constant at about 15.

• The rate of addiction to tobacco was extraordinarily high; 70 % became "every day smokers." All had quit or were trying to quit, but only about half had succeeded by the time of the interview. The rest remain unwilling "inveterate" smokers.

• Aggressive drinking —manifested by binge drinking in high school or college, black-outs, and DUI citations— had also been exceptionally high. Those who became daily cannabis smokers moderated their drinking spontaneously, whether they thought about it or not. The "substitution" effect of cannabis for alcohol is dramatically demonstrated in this population. One almost never sees simultaneous problem drinking in this group of daily pot smokers— even though two-thirds of them had been problem drinkers in their youth.

• Lifetime initiation rates for other drugs were unexpectedly high:

Mushrooms:	76%
LSD:	67%
Peyote/Mescvaline:	40%
coke:	67%
meth	60%
MDMA (ecstasy)	49%
heroin:	18%

Looking for environmental factors that might explain such high rates of illicit drug use, I began taking increasingly detailed family histories. It soon emerged that there was a common pattern: the biologic father had not played a positive, supportive role in their lives between pre-school and the sixth grade —roughly ages four through 12.

The most common reasons were:

–an unknown father

–early (before 7) death or divorce

–an alcoholic/workaholic father

–a stern, punitive father.

There are other, less common scenarios involving an invalid or an elderly father, or a recent immigrant who cannot communicate in English.

• Many of my patients reported early self-esteem problems which were made worse by the following:

—any learning or reading disability

—being in a racial minority

— being teased (for any reason)

—frequent moves and attendant school changes.

Quite a few of the younger ones were evaluated for/identified with ADD; many of the older ones would probably have qualified.

The bottom line is that most of the people who use cannabis regularly and were forced to come to buyers' clubs for their "recommendations" —either because they don't have a doctor, or their own doctor wouldn't discuss it with them— were/are using seeking to control an emotional "disorder' rooted in low self-esteem."

Cannabis was clearly only one of several agents they'd tried— along with alcohol and tobacco. Any of these agents may be able to control the underlying emotional disorder for a while, but pot is —for them, at least— the safest and least harmful, especially over the long haul.

"Initiating" heroin seems an unquestionable indicator that the underlying emotional disturbance is severe. Those who tried heroin also tried cocaine and mushrooms at rates over 90%, and had the highest rates of problem drinking... There's some preliminary data that access to cannabis predisposes against addiction to heroin.

It appears that most adolescent drug use may be motivated by the same basic causative factor: low self-esteem in its many guises.

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