Commentary

Our Unique Research Opportunity

By Jeffrey Hergenrather, MD, president of the Society of Cannabis Clinicians

The Society of Cannabis Clinicians was founded in 2000 with several related purposes. One was making care accessible to people who could benefit from the medical use of cannabis. Another was educating ourselves, other physicians, and the public about cannabinoids and the body's own endocannabinoid system. A third was conducting research based on our own patients' reports.

As the number of people seeking to use cannabis under state law increased, so did the number of doctors joining or creating cannabis-oriented practices. The media typically call them "Pot Docs," a term that fits into a headline but has derogatory overtones.

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The truth is: among physicians issuing cannabis approvals there is a spectrum of expertise, and there are varying approaches to patient care, ranging from superficial to thorough. Members of the Society of Cannabis Clinicians get invaluable feedback from our patients about the conditions they have been treating with various cannabis-based medicines, and the effects they're experiencing. We attend conferences organized by the International Cannabinoid Research Society, the International Association for Cannabinoid Medicines, and Patients Out of Time to keep updated on the science underlying our emerging specialty.

Mainstream members of the medical profession have largely refrained from approving cannabis use. Most doctors lack understanding of the endocannabinoid system and fear reprisals from the government, state medical boards, specialty boards, and healthcare system employers.

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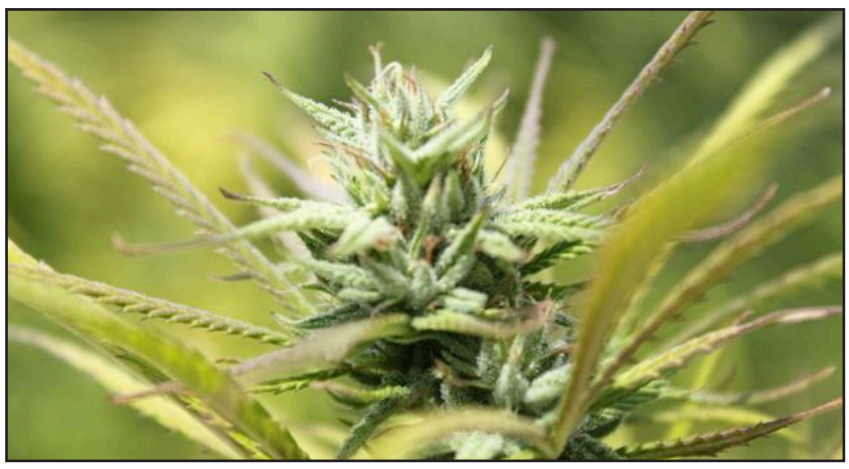
As SCC founder Tod Mikuriya, MD, pointed out, cannabis does not fit into any of the drug categories defined by the CSA. He called it "a unique immunomodulator best defined as an 'easement." He thought it should be descheduled, placed on a schedule all its own, or regulated as a "food supplement" by the FDA, as are most herbs used for health purposes.

Who is pressuring the government to maintain the status quo? Big Pharma has an obvious vested interest and a vast team of powerful lobbyists, many of whom came through the "revolving door" from NIH, FDA, and other regulatory agencies. The drug companies that fund everything from specialty journals to new wings at university hospitals have great sway with the biomedical establishment. Eli Lilly, Pfizer, Merck *et al* do not want their products to face competition from herbal cannabis.

The files of every SCC doctor document the extent to which patients medicating with cannabis reduce their use of prescription drugs. Sales of analgesics, antidepressants and other pharmaceuticals would plummet drastically if cannabis was readily available, and the manufacturers' stocks would follow suit. This is a scenario Wall St. wants to avoid.

Law enforcement, from the federal Drug Enforcement Administration to your local police and sheriff's department, has a financial incentive to uphold marijuana prohibition. So does the prison-industrial complex and the drug-treatment industry. So do the manufacturers of helicopters, drones, weapons, munitions, etc. used in eradication



campaigns. And does the Pentagon, the CIA, and myriad agencies that use the "war on drugs" as an excuse to build bases in foreign countries and conduct numerous operations the American people must pay for but are not allowed to know about.

What Can Cannabis Clinicians Achieve?

It has been 16 years since California voters legalized the medical use of cannabis by physician-authorized patients. In that time, perhaps a million Californians have gotten approvals. Because the drafters of Proposition 215 did not want the state government to compile a list of medical marijuana users —who would be committing a federal crime— they did not create a registry of patients. Although individual physicians and several physician chains have kept adequate records, no epidemiologist has tried to shed light on the health outcomes of medical marijuana users in California and elsewhere.

We are sitting on a treasure chest of useful information.

Recently, given the opportunity to address a group of doctors who were new to the field of cannabis therapeutics *(See story on page 1),* I described the Society of Cannabis Clinicians' study of patients with Inflammatory Bowel Disease as an example of the research that can now be conducted legally under state law. SCC colleagues have studied the use of cannabis in treating alcoholism, anxiety, and insomnia. Clinicians interested in following or joining our research projects are encouraged to visit the SCC website, www.cannabisclinicians.org.

We are sitting on a treasure chest of useful information. We need to analyze it and publicize the results with various audiences in mind.

(1) Reports of cannabis-use outcomes might alert the medical establishment and the government to the need for larger, better-controlled studies. As explained by Donald Abrams, MD, elsewhere in this issue, a documented "signal" can challenge the decision-makers in Bethesda to conduct basic efficacy studies.

(2) Medical cannabis consumers could benefit immediately from studies suggesting optimal delivery systems and dosing schedules for treating various conditions. Cannabis clinicians are well suited to conduct such studies.

(3) Patients can participate in N-of-1 studies, evaluating their symptoms during periods of cannabis use and non-use. Being one's own control is a common-sense approach to confirming efficacy. A physician aggregating N-of-1 studies involving a given condition can transform "mere anecdotal evidence" into scientifically valid evidence.

Recently the journal *Epilepsy Behavior* published a study by Manu Hegde and colleagues at UCSF and the San Francisco Veterans Affairs Medical Center involving "two patients whose focal epilepsy was nearly controlled through regular outpatient marijuana use." According to the abstract, "Both stopped marijuana upon admission to our epilepsy monitoring unit (EMU) and developed a dramatic increase in seizure frequency documented by video-EEG telemetry. These seizures occurred in the absence of other provocative procedures, including changes to anticonvulsant medications."

Video-EEG telemetry can quantify the number, duration, and severity of seizures that begin after marijuana use is stopped. The caregiver of a person with epilepsy, making notes as per a clinician's instructions, could approximate the same results. One obstacle to such research is the reluctance of patients benefitting from marijuana to stop using it, especially for a serious condition. But people do from time to time stop using —because they're traveling, to see if they no longer need the medication, and for various other reasons. Cannabis clinicans can request input from patients who, for whatever reason, stop using cannabis for a period of time.

(4) We can reach out to specialists in other fields to confirm patterns we have observed —such as the effect of cannabis oil on skin lesions, or on the longterm survival rate of hepatitis C patients. Epidemiologists are just beginning to recognize the validity of cannabis as medicine, and are beginning to mine data from various bases. Consider this under-publicized study in the *British Medical Journal*:

Decreased prevalence of diabetes in marijuana users: cross-sectional data from the National Health and Nutrition Examination Survey (NHANES) III

Tripathi B Rajavashisth,[1,2] Magda Shaheen,[✉3] Keith C Norris,[3] Deyu Pan,[3] Satyesh K Sinha,[1] Juan Ortega,[1] and Theodore C Friedman[1]

Rajavashisth is based at UCLA. He and his co-workers looked at 10,896 responses by people age 20-59 to the Center for Disease Control's National Health and Nutrition Examination Survey. Those who reported never having used marijuana accounted for 61% of the sample. The marijuana users were divided into three groups: past users, light users (once a week or less), and heavy users (25 times a month or more). The authors noted that "self-report of illicit substances is often underestimated."

A total of 719 diabetes patients were identified by self-report or abnormal triglyceride levels. The unadjusted prevalence rate for diabetes among non-users of marijuana was found to be 6.3%; among past users, 2.9%; among light users, 1.9%; and among heavy users, 3.0%. "For subjects without diabetes (n=10,165) 46.4% were marijuana users... For subjects with diabetes (n=719), 26.9% were marijuana users." The association of marijuana use and diabetes was deemed "significant... even after adjusting for social variables (race/ethnicity, physical activity, alcohol use and body mass index), laboratory variables (total cholesterol and triglyceride), inflammatory marker (CRP) and the comorbidity variable (hypertension)."

(5) Cannabis clinicians can share what we have learned with other doctors and healthcare workers. A succinct Continuing Medical Education course taught by our colleague Deborah Malka, MD, at the Community Hospital of Monterey recently drew an audience of 50. The evaluations included many expressions of appreciation. There are indications that fear is receding, serious interest in cannabis as medicine is building.

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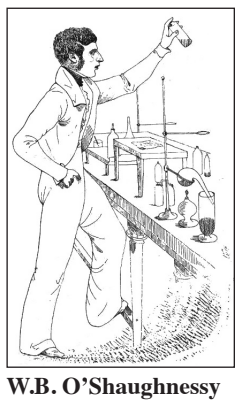

W.B. O'Shaughnessy "at the bench."

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