Abstract

CANNABIS MEDICINAL USES AT A "BUYERS'" CLUB

Mikuriya, T.H. Medicinal uses of cannabis at a buyers' club ___: _____ 1995

Background. A century ago, cannabis was regarded as the second most important analgesic after the opiates for the control of chronic pain. At the time of its removal from prescriptive availability in 1938 it was recognized as a sedative and antispasmodic.

Methods. 57 buyers of cannabis for self-medication were interviewed by the author at the Cannabis Buyers' Club of San Francisco utilizing a structured medical interview outline.

Results. 51 were male, 6 female, ranging in age from 18 to 69 with the median of 38 years. Race: 50 were white, 3 Hispanic, 2 Black, 1 Oriental, and 1 Samoan. Education ranged from 7th grade to post doctoral study. Medical characteristics of the population were 41 HIV+ and 16 Presumed HIV-. Time since HIV+ diagnosis ranged from 1 month to 10 years with a median of 40 months. Medicinal purposes reported were: anorexia/nausea/vomiting/diarrhea 39, anxiety/panic attacks/depression 39, AIDS related illness 35, arthritis and other pain 22, muscle spasm 19, harm reduction: alcohol substitution 12, opiod substitution 6, amphetamine substitution 1, followed by migraine/vascular headache 11, cancer/cancer chemotherapy 10, asthma/cough 9, itching/hiccough 8, epilepsy 5, glaucoma 4, drusen of the optic chiasm 1, psychiatric post traumatic stress disorder 1, and pre menstrual syndrome 1. Of the 19 who tried Marinol® none experienced equipotent effects, 7 experienced partial relief without adverse side effects, 5 experienced no effects, and 7 experienced adverse side effects.

Conclusions. Cannabis is not a new drug. Medicinal applications reported by self-medicating buyers would appear to reconfirm descriptions in clinical literature before the drug was removed from prescriptive availability. Further clinical study is warranted. Restoration of cannabis to prescriptive availability is indicated.

Key words: AIDS ANTIANXIETY ANTIDEPRESSANT ANTIINFLAMMATORY NSAID ANTISPASMODIC ANTICONVULSANT ANALGESIC ANTITUSSIVE ANTIPRURITIC ALCOHOL AND OPIOID SUBSTITUTE MARINOL PMS

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MEDICINAL USES OF CANNABIS AT A BUYERS' CLUB: A PILOT STUDY

by

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Background

From 1839 to 1938 cannabis was available by prescription and utilized for a variety of conditions before removal after the passage of the 1937 Marihuana Tax Act at which time it was an infrequently used sedative and antispasmodic[1]. Since then it has been legally defined as having no medicinal redeeming virtue having high potential for abuse by the Controlled Substances Act of 1970 as a Schedule I drug.

Recent History

Compassionate clinical investigative new drug (IND) applications for marijuana were suspended in 1991 by then chief of the Public Health Service James O. Mason, M.D.[2] [3]

Starting with a coalition of marijuana law reform and AIDS treatment/prevention activists in the San Francisco gay community a proposition was put on the ballot later that year to restore hemp medical preparations for prescribing.[4] The measure passed by a 4:1 margin that resulted in passage of a supportive resolution by the San Francisco Board of Supervisors that urged the District Attorney to allow a letter from a treating physician to be evidence of medical use.[5]

In December, 1993 the San Francisco Cannabis Buyers Club began to sell illicit cannabis to patients with a referral note from their physician or health facility.

Interviews at the site by the author with 57 of the buyers using a structured questionnaire (attached) provided the following data regarding medical conditions and drug use.

Setting. Several doors away from a busy street corner is a nondescript door with a peep lens. Pressing the doorbell between the hours of 10 AM to 7 PM weekdays, the door is opened by a doorman who asks to see the numbered club card. At the top of a short flight of stairs, a second hall person of hefty stature scrutinizes and greets the visitor. Entering

midway in a large old former dime-a-dance hall above the bar below, the room is well lit from clerestory windows. The ceiling is covered by a huge rainbow flag. The walls are covered with local artists' work and political posters. Two small rooms to the right are a kitchen with sink and refrigerator with access to the roof and an interview room. A sink and toilet are off the short hallway to the interview room.

The well ventilated rooms with open windows and a corner 15" exhaust fan left from the dance hall era are needed to cope with the clouds of cannabis (and some tobacco) smoke from the patrons. A large old dining room table dominates the center of the room, a semicircle of sofas at the left, and smaller tables against the wall on the right accommodate the buyers. Joints are rolled, pipes and water pipes are filled and shared from medium grade cannabis furnished by the house on small trays. The dealers measure out the cannabis from behind a "bar" where buyers inspect and purchase cannabis. Grades, types and prices are posted behind the bar on an erasable board with samples of each available for inspection and trial. Pipes, cigarette lighters, and rolling papers are also sold at the counter. In addition to smoked cannabis baked goods for oral use are sold. Cookies and brownies made from the lower grade cannabis are bioassayed by the bakers and staff with rough estimates of strength provided for each

batch. On the periphery, tables with diverse health and informational literature provides reading materials for the buyers. Stationary, postage, and lists of politicians provide other activities for buyers, staff, and visitors.

Demographics

There were 51 men and 6 women. Their ages ranged from 18 to 69, with the median of 38 years. Education was from 7th grade to post doctoral professionals. Racially, 50 were white, 3 hispanic, 2 black, 1 oriental, and 1 samoan.

Medical Characteristics

41 were HIV+ with 35 seeking treatment of AIDS related illness. The shortest time since diagnosis 1 month, the longest time was 10 years with 40 months the median, and 53.8 months the average.

The 16 presumed HIV- were 13 males and 3 females ages 23 to 69 years with a median of 36 with an average of 45.5 years of age. The racial composition was 13 white, 1 Hispanic 1 Black and 1 Oriental.

Symptoms and Conditions

Gastrointestinal and affective conditions were the most frequent with anorexia/nausea/vomiting/diarrhea, anxiety/panic attacks, and insomnia/depression (39 each). The second most numerous category was the musculoskeletal with Arthritis and other pain (22). The third most frequently mentioned target symptom was muscle spasm (19)

Harm reduction through substitution of cannabis for more toxic drugs: alcohol (12), sedative/opiates (6), amphetamine (1) was the fourth most mentioned category. Migraine/vascular headache (11) was the fifth largest category followed by: asthma/cough (9), Itching/hiccough (8) Epilepsy (5) Glaucoma (4) Post traumatic stress disorder (1) drusen of the optic chiasm (1)

Table 1

Conditions Treated With Self Administered Cannabis

Condition	HIV+	HIV-	Total
Anorexia/Nausea/Vomiting/Diarrhea	32	7	39
Insomnia/Depression	30	9	39
Anxiety/Panic Attacks	31	8	39
AIDS related illness	35	0	35
Arthritis/Other Pain	14	8	22
Muscle Spasm	16	3	19
Alcoholism/Alcohol Abuse	9	3	12
Migraine/vascular headache	10	1	11
Cancer/Cancer Chemotherapy	8	2	10
Asthma/Cough	8	1	9
Itching/Hiccough	8	1	9
Sedative/Opiate Dependence	6	0	6
Epilepsy	4	1	5
Glaucoma	2	2	4
Amphetamine Dependence	0	1	1
Post traumatic Stress Disorder	1	0	1
Drusen of Optic Nerve	0	1	1
Allergic rhinitis	0	1	1
Pre Menstrual Syndrome	0	1	1

Past experience with cannabis

All had used the drug recreationally prior to self medication. The shortest length of time since first use was 4 months, the longest was 48 years with the median of 14 years of using cannabis.

Dosage and Frequency of Use of Cannabis

The range of dose varied from two puffs on a pipe every two weeks to more than one cannabis cigarettes 6 times a day. The modal frequency was one or less cigarette or equivalent daily.

Route of Administration

Fifty smoked cannabis. Three ate cannabis only. The marijuana cigarette or "joint" was the most frequently used with 38, a pipe was second most popular with 27, water pipe third with 11.

Three inhaled but did not smoke. They utilized a vaporizer that permits delivery of cannabinoids at temperatures below the flash or burning point.[6]

Twenty three both ate and smoked the drug.

Of the three cases who only ate the drug, all had significant pulmonary pathology. One suffered recurrent fungal infections: aspergillosis and cryptococcus, one had pneumocystis carinii (PCP), and the third, recurrent bacterial pneumonitis and AIDS encephalopathy.

Marinol,[7] a legally available monocannabinoid, has been promoted as a viable alternative to crude polycannabinoids.

Of the 19 who described experience with Marinol, only 3 knew what dose they had taken. 5 experienced no effects or side effects, 7 felt it was somewhat helpful without adverse side effects.

The symptoms for which Marinol was somewhat helpful were: 5 Anorexia, nausea, and vomiting, 4 Depression and 1 with post traumatic injury pain. All of the dose levels were unknown.

Of the 7 who experienced adverse effects from Marinol, 5 complained of lethargy, tiredness and over sedation, 2 of confusion, (one with a 30 milligram dose, the other of an unknown dose), three described a worsening of the target symptoms of nausea (all at unknown dosage), one experienced a transient diploplia at an unknown dose, and one of a generalized headache from 10 milligrams.

Discussion

It would appear that naturally occurring polycannabinoid cannabis is superior to monocannabinoid dronabinol but that dronabinol gives partial relief for some. Supplementing Marinol with crude cannabis appears to decrease the intake of crude cannabis.

Cannabis has been described as having therapeutic properties in a variety of conditions in clinical literature prior to its removal from prescriptive availability in 1938.[8] Interviews with a status criminalized population of 57 individuals with serious illness self-medicating at a "medical speakeasy", confirm many of the pre prohibition therapeutic uses of cannabis.

The wide variety of conditions appear to have some common elements of affective, autonomic, and anti-inflammatory effects that warrant further systematic clinical study. Burstine suggests the inhibition of prostaglandin secretions modulated by eicosanoids, complex fatty acids, caused by certain tetrahydrocannabinols may be one of the mechanisms of action.[9] Indications of NSAID activity appear in the inhibition of marihuana effects by premedication with indomethacin.[10]

William B. O'Shaughnessy, M.D., who in 1839 introduced cannabis to western medicine, acknowledged its non-medical

use but was able to recognize and study its therapeutic potential despite the drug's adverse reputation.[11]While much has been learned scientifically of mechanisms of actions, adverse social attitudes continue to prevent clinical study for therapeutic potential.

The existence of this "buyers' club, per se, (some 2,000 members) appears to functionally contradict official pronouncements denying the therapeutic uses of cannabis and is a compensatory social excrescence of Prohibition as a public policy.

THM 12-4-94

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[6]delta 1,9 Tetrahydrocannabinol, one of the active principles of cannabis goes into a vapor phase at 155-157° centigrade (311-315° Fahrenheit)(The Merck Index 8th Ed Merck & Co. Rahway, NJ 1968 1713pp page 1026.

[7]A schedule II drug dronabinol; Delta 1,9 tetrahydrocannabinol dissolved in sesame oil. Supplied by Roxane in 2.5, 5.0, and 10 milligram gelatin capsules since 1986. PDR Medical Economics, Oradell NJ 2670 pp 1994: 2020.

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