

Clinicians ignored from previous page

cal Use of Drugs:

“In the end, the decisions in this field are very complex moral decisions based on a number of imponderables and competing values, and in many cases they involve a choice of the lesser of evils. There are few easy choices. There is no way that these kind of decisions can be passed over to experts. In the end, they will have to be handed back to [the public].”

Tod Mikuriya’s study of the pre-prohibition medical literature led him to conclude that marijuana was useful in treating a wide range of conditions. In the early 1990s his interviews with members of the San Francisco Cannabis Buyers Club confirmed this insight. He inferred that compounds in cannabis were affecting almost every physiological function. He wrote numerous case reports showing that cannabis can be used as a “harm reduction” substitute for alcohol, opioids, and other drugs with serious adverse side-effects.

For a few years after cannabis was legalized for medical use in California, Mikuriya was the only doctor known to readily issue approvals for less-than-grave conditions such as chronic pain and depression. As other doctors began specializing in treating cannabis users, Mikuriya organized the California Cannabis Research Medical Group, which became the Society of Cannabis Clinicians (SCC) when doctors from other states began joining.

Mikuriya saw the need for a journal in which cannabis clinicians could share their findings and observations. I helped him launch *O’Shaughnessy’s* in 2003. We published a number of case reports, some brief and some detailed.

Mikuriya’s own paper “Cannabis as a First-Line Treatment for Childhood Mental Disorders” (*O’Shaughnessy’s* Spring 2006) is a single, detailed case report.

“Cannabis as a Substitute for Alcohol” is based on 92 case histories, ran in

Three doctors who respected clinical evidence



GEOFFREY GUY, RAPHAEL MECHOULAM AND TOD MIKURIYA at the 1999 International Cannabinoid Research Society meeting in Acapulco. Guy’s GW Pharmaceuticals funded Notcutt’s study based on N-of-1 trials.

PHOTO BY FRED GARDNER



TOD MIKURIYA’S CASE REPORT on a 15-year old patient “who had been prescribed stimulants, antidepressants, analgesics, and antipsychotics that exacerbated his problems. Cannabis provided a benign, effective alternative.” The boy’s initial problem had been insomnia. Mikuriya generalized: “The first-line treatment for any condition, efficacy being equal, would be the drug or procedure least likely to cause harm. Given the benign side effect profile of cannabis, it should be the first line of treatment in a wide range of childhood mental disorders, including persistent insomnia.”



TEN YEARS AFTER CALIFORNIA VOTERS legalized cannabis for medical use, Mikuriya and colleagues in the Society of Cannabis Clinicians reported findings and observations in *O’Shaughnessy’s*. “A vast public-health experiment has been conducted in the nation’s most populous state. What have doctors learned about the medical efficacy and safety of cannabis?” The 2006 SCC survey documented patients reporting similar patterns of benefit (which may in time be confirmed by randomized placebo-controlled double-blinded clinical trials.)

O’Shaughnessy’s (Summer ‘03) and the *Journal of Cannabis Therapeutics*, 2004.) I doubt there will ever be a more insightful treatment of the subject.

In 2006, the 10-year point of legalization for medical use, Mikuriya surveyed his colleagues and published the results in a paper, “Medical Marijuana in California, 1996-2006” (*O’Shaughnessy’s*, Winter/Spring 2007).

All the SCC doctors reported in 2006 that pain patients were reducing opioid use —typically by 50%— by adding cannabis to their regimen.

noted in the SCC survey. To cite but one example, lowered resistance to graft implantation was reported in a case note by William Toy, MD:

“A 62-year-old man who had a heart transplant from the Stanford program 22 years ago. He apparently is the longest surviving transplant patient in the program. He has been using large doses of cannabis ever since he received the transplant. He is convinced that cannabis not only reduces the side-effects of his anti-rejection drugs, but that it has anti-rejection properties. He feels that he owes his star status in Dr. Shumway’s program to the modulation of his immune system by cannabis.”

The NAS decision to ignore cannabis clinicians’ case reports is blacklisting by algorithm. The findings of cannabis clinicians have been barred from “the literature.” Their “quality of evidence” is deemed inadequate. The word *published* simply does not apply to articles not indexed in PubMed Central.

The survey by Mikuriya et al may have been printed on electrobrite paper and distributed in 2007 (25,000 copies) by doctors and dispensary operators, but it was not “published.” Nor did you just read a citation to a case note by Dr. Toy, because only material published in “the literature” can be cited.

The language of Capital-S Science supersedes workaday English.

NAS Report from page 26

Abuse of other substances

“Cannabis use is likely to increase the risk for developing substance dependence (other than cannabis use disorder).

“There is SUBSTANTIAL evidence of a statistical association between cannabis use and:

- The development of schizophrenia or other psychoses, with the highest risk among the most frequent users. There is moderate evidence of a statistical association between cannabis use and:
- Better cognitive performance among individuals with psychotic disorders and a history of cannabis use.
- Increased symptoms of mania and hypomania in individuals diagnosed with bipolar disorders (regular cannabis use).
- A small increased risk for the development of depressive disorders.
- Increased incidence of suicidal ideation and suicide attempts with a higher incidence among heavier users.
- Increased incidence of suicide completion.
- Increased incidence of social anxiety disorder (regular cannabis use)

“There is MODERATE evidence of no statistical association between cannabis use and:

- Worsening of negative symptoms of schizophrenia (e.g., blunted affect) among individuals with psychotic disorders.

“There is LIMITED evidence of a statistical association between cannabis use and:

- An increase in positive symptoms of schizophrenia (e.g., hallucinations) among individuals with psychotic disorders.
- The likelihood of developing bipolar disorder, particularly among regular or daily users.
- The development of any type of anxiety disorder, except social anxiety disorder.
- Increased symptoms of anxiety (near daily cannabis use).
- Increased severity of post-traumatic stress disorder symptoms among individuals with post-traumatic stress disorder.

“There is NO EVIDENCE to support or refute a statistical association between cannabis use and:

- Changes in the course or symptoms of depressive disorders.
- The development of post-traumatic stress disorder.

“Heavy cannabis users are more likely to report thoughts of suicide than non-users.

“Regular cannabis use is likely to increase the risk for developing social anxiety disorder.”

And that, to quote a phrase, is “what the Science tells us” —about the health effects of cannabis and the cannabinoids.

Cannabis and lung cancer: NIDA’s dream dies hard

The expression “moving the goalposts back” refers to a situation in which you perform all the required tasks, only to be told that more tasks are required. It came to mind when I read in the NAS Report: “There is moderate evidence of no statistical association between cannabis use and:

- Incidence of lung cancer (cannabis smoking)
- Incidence of head and neck cancers.”

The findings announced by UCLA pulmonologist Donald Tashkin in 2005 were based on a clinical trial that was “gold standard” in every way. He intended the study to be definitive. There had been contradictory findings and he wanted to resolve the basic question: is there an association between marijuana use and lung cancer?

The study by Tashkin and colleagues from the UCLA School of Medicine was well funded by NIDA. The Los Angeles County Cancer Surveillance program provided the names of 1,209 L.A. residents aged 59 or younger with cancer (611 lung, 403 oral/pharyngeal, 90 laryngeal, 108 esophageal).

Interviewers collected extensive lifetime histories of marijuana, tobacco, alcohol and other drug use, and data on diet, occupational exposures, family history of cancer, and various “socio-demographic factors.”

Some 1100 controls were found based on age, gender and neighborhood. The researchers controlled for tobacco use and calculated the relative risk of marijuana use resulting in lung and upper airways cancers. Among marijuana-only users, Tashkin reported, “We found absolutely no suggestion of a dose response.”

Given the quality of Tashkin’s clinical trial, how did the NAS committee evaluating the link between cannabis and lung cancer decide that the evidence for “no association” was not conclusive, not substantial, but only “moderate?”

It turns out that the committee had been instructed not to consider individual studies, but to rely on the meta-analyses and systematic reviews published in the literature. Tashkin’s very clear findings had gotten blurred in the process —a meta-analysis had mushed it up with a Finnish study that didn’t control for alcohol use! A member of the committee reminds me not to be so negative: “‘Moderate evidence’ means there *is* evidence.”