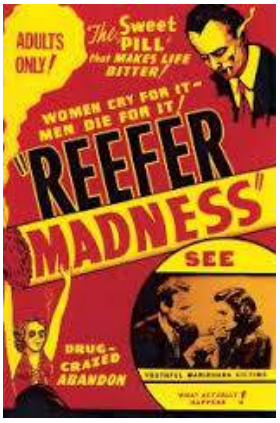
Reefer Madness from Cradle to Grave



Information on New Canadian Legislation for Comprehensive Care Family Physicians and Preliminary Guidance Document September 2014

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Dried_Cannabis_Prelim_Guidance

Conflict of Interest Declaration

for Preliminary Guidance Document and Workshop Participants

- **Lead Authors**: Sharon Cirone, Chair, Addiction Medicine Program Committee; Ruth E. Dubin, Chair, Chronic Pain Program Committee; Meldon Kahan, Member, Addiction Medicine Program Committee, Mark A. Ware, Consultant
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- **CFPC Staff**: Victor Ng and Roy Wyman Consulting Physicians, Programs and Practice Support; Jamie Meuser, Executive Director, Professional Development and Practice Support ; Lynn Schellenberg, Writer/editor
- **Financial disclosures:** Dr Ware has received research funding from Cannimed for clinical trials of vapourized cannabis for chronic pain disorders through the Mcgill University Health Centre Research Institute
- **Other competing interests:** none declared
- There is no commercial sponsorship of the guidance document or this workshop

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Learning Objectives

By the end of this workshop, participants will be able to:

1) describe the evidence for use of Marijuana (dried cannabis) in treatment of medical conditions

2) outline the risks of marijuana use for teens, young children, pregnant women and breastfeeding mothers

3) understand a harm reduction approach to patient education about safer marijuana use.

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Rationale for Preliminary Guidance Document

The Health Canada Marihuana for Medical Purposes Regulations (MMPR), which came into force on April 1, 2014, permit a physician to sign a medical document authorizing a patient's access to, and the dispensing of, a specified quantity of the dried cannabis plant from a licensed producer.

The medical document has a format and function similar to a prescription. Health Canada provides a sample medical document on its website.

However, dried cannabis differs from prescribed products in that Health Canada has not reviewed data on its safety or effectiveness and has not approved it for therapeutic use.

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Goals for the Guideline

The document was prepared by the SIFP groups to provide preliminary guidance on the authorizing of dried cannabis for chronic pain or anxiety.

The writing group chose chronic pain and anxiety as the clinical areas to highlight as they are the most common conditions for which a patient requests authorization for cannabis from a family physician.

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Development Strategy

Literature search and review of evidence with focus on cannabis effectiveness, safety, and adverse effects.

Recommendations:

Level I (based on well-conducted controlled trials or meta- analyses)

Level II (well-conducted observational studies)

Level III (expert opinion; for the purposes of this document - consensus among the committee members drafting this document on behalf of the CFPC).

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Terminology

- **Medical marijuana:** This term is in popular use but is imprecise, referring broadly to dried cannabis dispensed or otherwise obtained and used either for supervised medical purposes or for self-medication. In a scientific context we prefer to use the term "dried cannabis."
- **Dried cannabis/cannabis:** We use these terms interchangeably to refer to the substance or product that a patient may purchase through a licensed producer, under the MMPR, if he or she has a medical document authorizing its dispensing.
- **Pharmaceutical cannabinoids**: This term refers to the prescription drugs nabilone (Cesamet) and nabiximols (Sativex). Marinol (dronabinol) was previously available but has been removed from the Canadian market by the manufacturer.
- **Medical document:** Health Canada uses this term to denote the prescription-like form that physicians complete and sign to authorize patients' access to dried cannabis from licensed producers.

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Preliminary Guidance Document

15 Recommendations

- General principles (**1 to 6**)
- Misuse prevention and intervention (**7**)
- Assessment, monitoring, and cannabis discontinuation (**8 and 9**)
- Strategies to prevent harm from authorized cannabis (**10 and 11**)
- Communication with patients and consultants (**12 and 13**)
- Dosing (**14 and 15**)

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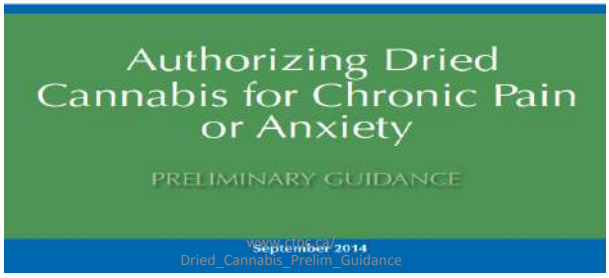
CFPC: Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance Document Sept 2014.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

http://www.cfpc.ca/Dried_Cannabis_Prelim_Guidance/
http://www.cfpc.ca/cannabis_orientation_preliminaire/



Case History- Mrs. Smith

- Mrs. Smith arrives in the office requesting an opportunity to ask questions about "medical marijuana" use by her husband.
- Mr. Smith has a chronic pain condition and was prescribed dried cannabis by a local pain expert .
- Mrs. Smith expresses concern that their 13 year old son has started to smoke marijuana and is using his father's supply.
- The Smith's daughter smokes marijuana recreationally and has just found out she is pregnant
- Mrs. Smith has asthma and is exposed to second hand marijuana smoke in the home and the car.

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Questions to Ponder

- How will you approach Mrs. Smith's concerns about her husband's use of dried cannabis?
- Do you have concerns about the teenage son using marijuana?
- Do you have concerns about a pregnant woman smoking marijuana?
- What are your next steps for this family?
- Is it safe for Mr. Smith to drive while smoking dried cannabis?

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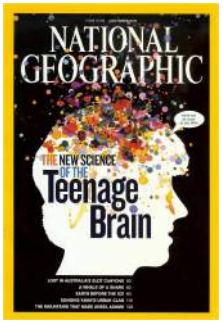
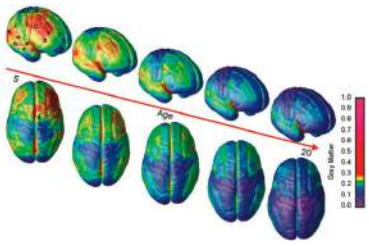
Teenage Brain Development and Vulnerability to Drug Use





Presented by Sharon Cirone

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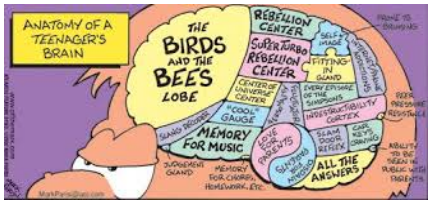
Neurocognitive Effects of Cannabis Use



- Decreased IQ
- Neurocognitive damage
- Risk of addiction

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The harm of youth cannabis use

- Increasing presentations of cannabis induced psychosis
- Exploring the link
- Increased access with new legislation?

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Message for youth and parents

"Regular cannabis use is not safe"

"Delay the onset of cannabis use past the sensitive period of significant neuromaturation"

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Mr. Smith – cannabis for neuropathic pain

presented by Ruth Dubin

- Mr. Smith: 57 y.o. labourer
- Traction injury at work L arm: Orthopedics: STI
- Reduced ROM/physio/NSAIDS/injections/Massage
- No improvement, pain restricting activities
- 6/12 later: severe burning pain L hand/ skin cool/ swollen, hair loss, hand clenched
- Pain MD: TCA's, duloxetine, pregabalin, topiramate, stellate ganglion blocks, high dose opiates, methadone : No relief
- Opioid Risk Tool Score: 4 (Dad-ETOH, depression)

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Diagnosis?

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Mr. Smith's friend gives him some cannabis to try

- Significant relief! Can sleep again, mood better, able to cut grass, go to hockey games, socialize,
- MMPR April 2014: Given Rx for 1.5 gm a day (Smoking < 1 joint tid)
- Educated re safe use: vapourizer, no driving for 4 hours, do not combine with other sedating drugs, alcohol, store in hidden lockbox
- Planning to retrain through workman's compensation

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Evidence for Cannabis in chronic pain

- Small studies support use in neuropathic pain conditions (e.g Peripheral neuropathy, M.S., post-surgical pain)
- No studies low back pain, fibromyalgia
- Canadian Rheumatology association does not support use of medical mj in FMA or osteoarthritis
- Some evidence for nabilone in FMA and other neuropathic pain conditions
- Nabiximols (SL drops) indication for M.S. $$$$

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THE BOTTOM LINE IN CHRONIC PAIN

- USE IN GENERAL ONLY WHEN OTHER RX HAS FAILED
- PHYSICIANS DEPEND ON PATIENT REPORTS OF SIGNIFICANT BENEFITS FOR MOST TREATMENTS
- PAIN SCORE CHANGES ALONE OF MUCH LESS VALUE THAN FUNCTIONAL IMPROVEMENTS
- ALSO REVIEW MOOD, SLEEP, QUALITY OF LIFE
- SCREEN FOR ABUSE RISK, SAFE USE

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MARIHUANA FOR MEDICAL PURPOSES REGULATIONS

http://laws-lois.justice.gc.ca/eng/regulations/SOR-2013-119/index.html

CANADA

CONSOLIDATION

Marihuana for Medical Purposes Regulations

SOR/2013-119

Current to May 27, 2014

Last amended on March 31, 2014

CODIFICATION

Règlement sur la marihuana à des fins médicales

DORS/2013-119

À jour au 27 mai 2014

Dernière modification le 31 mars 2014

Published by the Minister of Justice at the following address: http://laws-lois.justice.gc.ca

Publié par le ministre de la Justice à l'adresse suivante : http://lois-laws.justice.gc.ca

LET THE DEBATE BEGIN!

- "It is difficult to craft a logical argument as to why we should dismiss anecdotes about symptomatic improvement from cannabis while accepting them about, for example oxycodone or fentanyl" Juurlink CMAJ Sept 2 2014 186 (12)
- CFPC Medical Marijuana Position Statement http://www.cfpc.ca/ProjectAssets/Templates/Resource.aspx?id=5535&terms=marijuana
- See also Kahan and Srivastava CMAJ Sept 2 2014 186 (12) for more important information about cannabis

Smoking is a dangerous delivery system

Presented by Mel Kahan

- No other medication uses smoke as a delivery system
- Cannabis combustion produces hundreds of chemicals that are potentially toxic and carcinogenic
- Smoking produces a rapid rise and decline in serum THC levels
  - Even one or two inhalations can cause cognitive impairment
  - This is unacceptable for a long-term medication

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Evidence for effectiveness is extremely weak

- Far weaker than other medications
- 5 RCTs on smoked cannabis
- Total subjects = 180
- Duration range 3-15 days
- Subjects had severe neuropathic pain from MS or HIV or other causes
- Smoked cannabis compared to placebo, not to other treatments or to oral cannabis

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Cannabis has substantial evidence of serious harms

- Motor vehicle accidents
- Poor psychosocial performance, especially in youth
- Addiction
- Psychosis
- Reproductive effects
- Lung cancer

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Many patients requesting cannabis should not be prescribed it

- For many (most?) medical cannabis users, smoked cannabis not indicated, is contraindicated or precautions apply
  - Most medical cannabis smokers report using it for FM, MSK pain, H/A etc. – NOT for neuropathic pain
  - High prevalence of younger males with concurrent addiction and/or mental illness

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Rule out cannabis use disorder in patients requesting cannabis

- **Signs of possible cannabis use disorder:**
  - Current/past history of substance use
  - Concurrent anxiety, depression
  - Spends large amounts of time using cannabis
  - Poor social, work, or school function
  - Insists that 'nothing else works' for pain
  - Gets angry if physician reluctant to prescribe
  - No clear medical indication

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Self-report of benefit is not enough to prescribe

- All drugs of abuse temporarily relieve anxiety, pain
  - Alcohol, opioids, cocaine, benzodiazepines
- How well is the patient functioning?
  - An effective analgesic/analgesic improves patients' psychosocial functioning
- How does the patient function immediately after smoking?
  - Intoxication vs pain relief
  - Analgesia improves immediate function, intoxication reduces it

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Be careful about medical cannabinoid clinics

- Don't refer to a cannabinoid clinic unless:
  - The clinic doesn't charge fees; CPSO and other colleges prohibit charging fees
  - The clinic provides comprehensive assessment and management
  - The clinic has explicit, prudent and evidence-based prescribing policies

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Always prescribe pharmaceutical cannabinoids before prescribing dried cannabis

- One trial compared smoked cannabis to dronabinol
  - dronabinol had a longer duration of analgesia
- Oral/buccal cannabinoids are safer, less expensive, and have stronger evidence of benefit
- They are better suited for chronic neuropathic pain than smoked cannabis

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Cost issues

- Cesamet (nabilone) is covered in Ontario
- Sativex(delta 9 THC and cannabidiol) costs $12/day, for 5 sprays (the average dose)
- Dried cannabis costs about $8/gram
- 100-700 mg/day dried cannabis (recommended dose) costs $1-$6/day
- Typical medical cannabis user smokes 1-3 grams/day
  - = $8-24 per day

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Don't prescribe more than 100-700 mg/day 9% THC

- Evidence suggests this dose will be effective for neuropathic pain
- Doses >9% THC have not been studied
- Cognitive impairment related to cannabis dose and THC concentration
- **Maximum script should state:**
  - Dried cannabis 700 mg/day, 9% THC maximum, 21 grams x 30 days

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Don't believe the cannabis industry or their spokespersons

Industry uses cynical marketing strategies:

- Imply health benefits for which there is no evidence
- Branding strains with names, descriptions that emphasize their euphoric effects
- Developing very potent strains (20+% THC)
- **Legal marijuana is now more dangerous than street marijuana!**

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With anecdotal evidence, ask yourself:

- Who is presenting the anecdote?
  - Industry spokespersons, journalists are not objective
  - Cannabis clinics must demonstrate that their prescribing is prudent and evidence-based
- Is the anecdotal case typical of patients seen in my practice?
  - Most medical cannabis users do not have severe neuropathic pain
  - Many are at risk for cannabis-related harms
- Is the anecdote cherry-picked?
  - Addiction experts know of dozens of patients whose lives have been destroyed by cannabis

Base your practice on evidence, not sales pitches!

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How to Decline Prescribing Dried Cannabis

- • **Dried cannabis is not a good treatment for you**, even if you experience less anxiety or pain right after use. Overall, it may be harming you. it can cause sedation and fatigue, depression, anxiety, or memory impairment. it can also interfere with your work, school, or social relationships.
- • Dried cannabis has some serious risks and there is little evidence of benefit.
- • neither Health Canada nor any national medical organization has endorsed dried cannabis as a medicine. As a doctor i am bound to comply with the standards of my profession.
- • We will work together to come up with an individualized treatment plan for you. Safe and effective treatments are available for your condition.
- • **If the patient is at high risk for cannabis-related harms, eg, is young or has a concurrent anxiety or substance use disorder**: As your doctor i cannot prescribe any treatment that may harm you.

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How to Decline (cont)

- • **If the patient refuses a trial of oral cannabinoids prior to any consideration of dried cannabis, explore the possibility that the patient is using dried cannabis for its effects on mood:** if these drugs are not helping with pain relief or function, is it possible that you are getting a high from cannabis that makes it seem like it is helping pain for a while? if that's so, the trouble is that the high can also impair your thinking and perception, which can create bigger problems for you.
- • **If the patient remains dissatisfied**: i can't authorize the use of an untested therapy when we have other, carefully studied and effective treatments that are safer and subject to strict quality control. i won't authorize dried cannabis for you. i can refer you to a doctor who is a pain specialist, who can advise you on the risks and benefits of dried cannabis for your condition.

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How to Decline (cont)

- • **If you suspect a cannabis use disorder**: in my opinion, your use of cannabis could be causing you harm. We need to talk about ways to reduce or stop your cannabis use.
- • **If the patient says that your refusal forces him or her to purchase cannabis illegally**: i advise you not to buy cannabis or any other drug from the street. in my opinion, using street cannabis is not benefiting your health, and it could be causing you harm.

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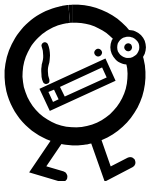
Effects of Prenatal exposure to Cannabis

Presented by Roxanne MacKnight

- Newborns show increased startles and tremors and altered sleep patterns
- Increased risk of motor, social and cognitive disturbances
- Reduction in long and short term memory retrieval and retention
- Lower academic acheivement, deficits in problem solving skills and visual-motor coordination
- Hyperactivity and impulsivity



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Recommendations for Pregnancy/Breastfeeding

- Abstinence is encouraged prenatally and while breastfeeding
- Dependence is managed by encouraging decrease in amount used if unable to abstain from marijuana use
- (Harm reduction model)

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Breastfeeding and Cannabis

- THC is excreted into breast milk
- Lethargy, sedation,less frequent feeding and poor sucking
- May show signs of decreased motor development and reduced muscular tone
- Infants will test positive in urine screens
- Studies are limited

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Marijuana Use in Epilepsy

- 1890 JR Reynolds reported the role of Cannabis in the therapy of epilepsy.
- **AUTHORS' CONCLUSIONS: The Cochrane Collaboration**
- No reliable conclusions can be drawn at present regarding the efficacy of cannabinoids as a treatment for epilepsy. The dose of 200 to 300 mg daily of cannabidiol was safely administered to small numbers of patients, for generally short periods of time, and so the safety of long term cannabidiol treatment cannot be reliably assessed.

- CBD-enriched hemp-oil concentrate used in children instead of dried cannabis
- Colorado has the secret recipe that is used by parents of children with epilepsy http://youtu.be/oxrKyjeClTk

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Marijuana Use in Epilepsy(cont)

- Good evidence from multiple animal models of epilepsy that CBD and other cannabinoids have antiseizure effect.
- Limited and low-quality evidence of antiseizure effect in humans
- Appears to be well tolerated and no reports of paradoxical effect (proconvulsant)
- Children with epileptic encephalopathy due to mutated sodium channel gene may be particularly responsive to CBD??????

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Respiratory effects of Cannabis

presented by Alan Kaplan

- **Symptoms:**
  The respiratory symptoms associated with dried cannabis use include wheezing apart from colds, exercise-induced shortness of breath, nocturnal wakening with chest tightness, and early morning sputum production.
- **Lung function:**
  Use of smoked cannabinoids has been found to increase the risk of airflow obstruction and hyperinflation but has been less associated with macroscopic emphysema.
  Heavy cannabis smoking may be an independent risk factor for impaired respiratory function and chronic obstructive pulmonary disease.
- **Risk of Cancer**:
  Cannabis use was associated with increased risk of lung and head and neck cancer.
  The depth of inhalation and the length of time the breath is held are usually **greater** when smoking marijuana than when smoking cigarettes.
  This means **exposure to the chemicals** in the smoke is greater for cannabis than for tobacco cigarettes, even though the frequency of smoking may be less.

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SMOKING

Effects of cannabis on pulmonary structure, function and symptoms

Aldington, Mathew Williams, Mike Nowitz, Mark Weatherall, Alison Pritchard, Amanda
ffrey Robinson, Richard Beasley

Thorax 2007;62:1058–1063. doi: 10.1136/thx.2006.077081

Background: lung worldwide. Long-term use of cannabis is known to cause chronic bronchitis a ce of macroscopic emphysema, the dose-response relationship and the dose t not been determined.
Methods: A convenience sample of adults fro recruited into four smoking groups: cannabis only, tobacco only, combined c of either substance. Their respiratory status was assessed using high-resolution function tests and a respiratory and smoking questionnaire. Associations betwe cannabis use were examined by analysis of covariance and logistic regression.
Results: 339 subjects were recruited into the four groups. A dose-response relationship was found betwe cannabis smoking and reduced forced expiratory volume in 1 s to forced vital capacity ratio and specific airways conductance, and increased total lung capacity. For measures of airflow obstruction, one cannabis joint had a similar effect to 2.5–5 tobacco cigarettes. Cannabis smoking was associated with decreased lung density on HRCT scans. Macroscopic emphysema was detected in 1/75 (1.3%), 15/92 (16.3%), 17/91 (18.9%) and 0/81 subjects in the cannabis only, combined cannabis and tobacco, tobacco alone and non-smoking groups, respectively.
Conclusions: 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 1:2.5–5 dose equivalence between cannabis joints and tobacco cigarettes for adverse effects on lung function is of major public health significance.

See end of article for authors' affiliations

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Received 28 December 2006
Accepted 6 June 2007

One cannabis joint smoked = 5 cigarettes in lung effects!

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Published in final edited form as:
Eur Respir J. 2008 February ; 31(2): 280–286. doi:10.1183/09031936.00065707.

C… AND RISK OF LUNG CANCER: A CASE-

… Mark Weatherall[3], Lutz Beckert[1], Anna … Richard Beasley[1,5] On behalf of the

[1]Me… Adam Cancer Epidemio… of Medicine & Health Sciences, … University of Southampton, Sou…

Abstract

Aim: To determine the risk of lung cancer …

Methods: A case-control study of lung cancer in adu… district health boards in New Zealand. Cases were identified … Registry and hospital databases. Controls were randomly selected … frequency matching to cases in 5-year age groups and district health boards … administered questionnaires were used to assess possible risk factors including … relative risk of lung cancer associated with cannabis smoking was estimated by logistic…

Results: There were 79 cases of lung cancer and 324 controls. The risk of lung cancer increased … 8% (95% CI 2% to 15%) for each joint-year of cannabis smoking, after adjustment for confounding variables including cigarette smoking, and 7% (95% CI 5% to 9%) for each pack-year of cigarette smoking, after adjustment for confounding variables including cannabis smoking. The highest tertile of cannabis use was associated with an increased risk of lung cancer RR=5.7 (95% CI 1.5 to 21.6), after adjustment for confounding variables including cigarette smoking.

Conclusions: Long term cannabis use increases the risk of lung cancer in young adults.

- Risk of lung cancer increased 8% for each joint-year of cannabis smoked! (cf. 7% for each pack year of cigarettes)

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Vaporizing versus Smoking?

- A vaporizer functions by heating the cannabinoids to their boiling temperature which dehydrates the buds and causes them to release their yield without ever catching fire.
- When smoking, the chemicals which burn do not necessarily arise from the plant itself; carcinogens can be found emanating from something as harmless as a campfire, and includes the paper that they are rolled in!

Estimates:

- When one smokes a joint, 88% of the combusted smoke gases contain non-cannabinoid elements.
- With vaping: they are inhaling approximately 95% cannabinoids.

Study:

- no difference in plasma concentration of THC, but CO levels reduced with Vaping

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Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study. . DI Abrams, HP Vizoso, SB Shade, C Jay, ME Kelly, and NL Benowitz. Clin Pharmacol Ther. 2007 Apr 11; [Electronic publication ahead of print].

Driving risks

- It is important to ensure that patients understand that potential side effects of cannabis, such as sedation or cognitive impairment, can impact their safety. As noted in **Recommendation 10**, Health Canada has stated that driving, operating heavy equipment, or other activities involving alertness and coordination may be unsafe for up to 24 hours following a single consumption, depending on the dosage, delivery route, and patient's age and other health factors. It is important to discuss with patients that their reactions to the substance and to different formulations are individual, and that it is important to go slowly with the treatment until a stable, effective dose is reached.

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Harm Reduction

- **Table 5. Advice for patients about safety and harm reduction**
- • Use the lowest dose necessary.
- • Do not "breath hold" or take more cannabis than the dose your doctor has specified.
- **• We recommend you ingest (that is, eat) your cannabis or take it using a vaporizer instead of smoking it, to reduce your risk of exposure to toxins that result from burning the cannabis in a cigarette. This is important to help protect you from heart or lung disease.**
- • Do not use dried cannabis with alcohol or other sedating drugs.
- • If you are smoking cannabis, do not mix tobacco into the cigarette.
- **• Do not give or sell your cannabis to others—it is both dangerous and illegal.**

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Harm Reduction (cont)

- **Table 5. Advice for patients about safety and harm reduction (cont)**
- • Store your dried cannabis in a locked container, out of reach of children and hidden from visitors and from adolescents at home.
- **• Avoid smoking cannabis in your house, to limit exposure of family members to second-hand smoke.**
- • Do not drive for at least four hours after any use by any route, and for at least six hours after oral ingestion. Do not drive for at least eight hours after using cannabis if you experience euphoria when you use it.
- **• Do not use cannabis of any kind if you are pregnant or plan to become pregnant, or if you are breastfeeding.**

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Next Steps

The CFPC released the Marijuana Guidance

Document to its full membership in September 2014

Media Launch accompanied dissemination

Feedback from other organizations and members gathered by CFPC Staff

Next draft of the Guidance Document to commence in Winter 2015

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Conclusion

- CFPC developed this guidance document in response to a clearly expressed need from members for assistance in navigating an extraordinary practice situation. They have been caught between their desire and obligation to provide evidence-informed care for their patients and a law that appears, to patients at least, to compel them to deal with dried cannabis as if it were a medicine.

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Recommendation 1

- There is no research evidence to support the authorization of dried cannabis as a treatment for pain conditions commonly seen in primary care, such as fibromyalgia or low back pain (**Level III**). Authorizations for dried cannabis should only be considered for patients with neuropathic pain that has failed to respond to standard treatments (**Level I**).

Recommendation 2

- If considering authorizing dried cannabis for treatment of neuropathic pain, the physician should first consider a) adequate trials of other pharmacologic and nonpharmacologic therapies and b) an adequate trial of pharmaceutical cannabinoids (**Level I**).

Recommendation 3

- Dried cannabis is not an appropriate therapy for anxiety or insomnia (**Level II**).

Recommendation 4

Dried cannabis is not appropriate for patients who:

- a) Are under the age of 25 (**Level II**)
- b) Have a personal history or strong family history of psychosis (**Level II**)
- c) Have a current or past cannabis use disorder (**Level III**)
- d) Have an active substance use disorder (**Level III**)
- e) Have cardiovascular disease (angina, peripheral vascular disease,cerebrovascular disease, arrhythmias) (**Level III**)
- f) Have respiratory disease (**Level III**) or
- g) Are pregnant, planning to become pregnant, or breastfeeding (**Level II**)

Recommendation 5

- Dried cannabis should be authorized with caution in those patients who:
- a) Have a concurrent active mood or anxiety disorder (**Level II**)
- b) Smoke tobacco (**Level II**)
- c) Have risk factors for cardiovascular disease (**Level III**) or
- d) Are heavy users of alcohol or taking high doses of opioids or benzodiazepines or other sedating medications prescribed or available over the counter (**Level III**)

Recommendation 6

- **Physicians should follow the regulations of their provincial medical regulators when authorizing dried cannabis (Level III).**
- Several provinces require physicians to:

State the patient's medical condition on the medical document Register with the regulator as a cannabis authorizer

Send the regulator a copy of the medical document, and/ or keep the medical documents on a separate record for possible inspection

Recommendation 7

- **Physicians should assess and monitor all patients on cannabis therapy for potential misuse or abuse (Level III).**
- If the patient does not use substances problematically and begins cannabis treatment, the physician should ask the patient at each office visit about cognitive and mood-altering effects, as well as compliance with the dosing recommendations and use of any other substances. Periodic urine drug screens are advised.

Recommendation 8

- Before signing a medical document authorizing dried cannabis for pain, the physician should do all of the following:
- a) Conduct a pain assessment (**Level II**)
- b) Assess the patient for anxiety and mood disorders (**Level II**)
- c) Screen and assess the patient for substance use disorders (**Level II**)

Recommendation 9

- The physician should regularly monitor the patient's response to treatment with dried cannabis, considering the patient's function and quality of life in addition to pain relief (**Level III**). The physician should discontinue authorization if the therapy is not clearly effective or is causing the patient harm (**Level III**).

Recommendation 10

- Patients taking dried cannabis should be advised not to drive for at least:
- a) Four hours after inhalation (**Level II**)
- b) Six hours after oral ingestion (**Level II**)
- c) Eight hours after inhalation or oral ingestion if the patient experiences euphoria (**Level II**)

Recommendation 11

- When authorizing dried cannabis therapy for a patient, the physician should advise the patient of harm reduction strategies (**Level III**).

Recommendation 12

- **The physician should manage disagreements with patients about decisions around authorization, dosing, or other issues with unambiguous, evidence-based statements (Level III).**
- The main messages for the patient who requests cannabis are that
- a) cannabis is not an approved medicine and
- b) the medical literature to date reports little evidence of benefit and considerable risk of harm with its use

Recommendation 13

- The physician who is authorizing cannabis for a particular clinical indication must be primarily responsible for managing the care for that condition and following up with the patient regularly (**Level III**). Physicians seeking a second opinion on the potential clinical use of cannabis for their patient should only refer to facilities that meet standards for quality of care typically applied to specialized pain clinics (**Level III**). In both instances, it is essential that the authorizing physician, if not the patient's most responsible health care provider, communicate regularly with the family physician providing ongoing comprehensive care for the patient (**Level III**).

Recommendation 14

- **Given the weak evidence for benefit and the known risks of using cannabis, the only sensible advice for physicians involved with authorizing dried cannabis is the maxim "Start low, and go slow" (Level III).**
- The optimal dose should improve pain relief and function, while causing minimal euphoria or cognitive impairment. Gradual dose titration is needed to establish the dose's effectiveness and safety. This is of critical importance because, as Health Canada has stated, even low doses of low-THC cannabis can cause cognitive impairment lasting as long as 24 hours in some individuals.

Recommendation 15

- Although it is not required by the MMPR, physicians should specify the percentage of THC on all medical documents authorizing dried cannabis, just as they would specify dosing when prescribing any other analgesic (**Level III**).

CFPC: Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance Document Sept 2014.

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http://www.cfpc.ca/Dried_Cannabis_Prelim_Guidance/
http://www.cfpc.ca/cannabis_orientation_preliminaire/