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THE CLARION

"CALLING FOR AN END TO CANNABIS PROHIBITION"

Nearly Half Of MS Patients Using Medicinal Pot, Study Says

Three Out Of Four Say Marijuana Alleviates Their Spasms

San Diego, CA: Forty-five percent of British multiple sclerosis (MS) patients are using marijuana therapeutically, according to the results of a survey presented this week at the 10th World Congress on Pain in San Diego. The survey's author, neurologist M. Sam Chong of King's College Hospital in London, said that the percentage was much higher than investigators anticipated, and noted that about half of the marijuana-using respondents said they only began using pot after they were diagnosed with MS. According to the study's findings, among those using marijuana, 74 percent said pot eliminated or controlled their spasms. Fifty-four percent reported that they used marijuana primarily for pain relief. Chong said that patients who suffered from the most severe symptoms were most likely to be using marijuana therapeutically.

More than 250 patients participated in the survey. A previous 1997 survey of British and American MS patients published in the journal European Neurology found that between 30 and 97 percent of respondents experienced symptomatic relief from cannabis, depending on specific symptoms. A 1998 report by the House of Lords Science and Technology Committee called for the legalization of marijuana for MS patients, but Parliament rejected their recommendation.

Presently, a number of clinical Phase III patient trials are ongoing in the United Kingdom to identify which strains of cannabis provide the most effective relief for symptoms of MS. A separate short-term trial on the impact of cannabis-therapy on MS is scheduled to begin in the U.S. at the Center for Medicinal Cannabis Research (CMCR) at San Diego later this year. For more information, please contact Paul Armentano, NORML Director of Publications and Research, at (202) 483-5500. Patients interested in participating in ongoing medicinal marijuana research studies should visit:

http://www.cmcr.ucsd.edu/partinfo/index.htm.

This article is now on the AAMC website at:

http://www.letfreedomgrow.com/news.htm

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SMOKE OUT THE POLITICIANS

Last week, the same day that Health Minister Anne McLellan suggested shelving medical marijuana, I was at the World Pain Congress in San Diego, Calif., listening to the first plenary session on pain and cannabinoids (the molecules that count in cannabis). There were about 5,000 pain scientists in one very large room, most of whom were familiar with the evidence that cannabis can relieve pain. Old news.

But what I also learned might shock our squabbling politicians. When it comes to the cannabinoids, we are already growing our own -- inside the body. How do we regulate that?

The same substance in cannabis that can help people with multiple sclerosis deal with muscle spasms, or cancer patients deal with nausea, is also present in human breast milk. Endogeneous cannabinoids, as they're known, are part of the body's own pain-killing resources -- cousins to more familiar ones, such as endorphins. Receptors for cannabinoids, in the brain, spine and peripheral nerves, have just been discovered in the past decade.

This is the science end of things. But we have a tendency to think about drugs superstitiously, dividing them into "natural" versus "synthetic," or heroic (anticancer drugs) versus sinister (narcotics and cannabis). The fact is that most drugs, regardless of the reassuring bubble packs we buy them in, are synthesized from plants or pods or pretty flowers. Drugs are not alien invaders; they often mimic or amplify perfectly natural mechanisms in the body. And the reason that opiates and marijuana work against pain (in quite distinct ways) is that they match substances that the body already creates. Strictly speaking, we all use dope.

Some scientists even believe that cannabis could be more useful for certain difficult kinds of neurological pain than opiates. This was the opinion of Andrew Rice, senior lecturer in pain research from Imperial College in London, England, when he gave his plenary address in San Diego. Dr. Rice began by pointing out that cannabis has been used for pain relief for centuries. Evidence of smoked marijuana was found beside the body of a woman who died in childbirth more than two centuries ago. Queen Victoria used cannabis for her menstrual cramps (she was a big fan of ether for childbirth, too). <continued next page>

<continued from previous page> In studies that use synthetic cannabinoids, very small doses have been shown to offer pain relief. Dr. Rice reported that "We are just beginning to discover the importance of the endocannabinoids [the home-grown stuff]."

The aim now is to develop a synthetic version that would divorce the analgesia from the high, because not everybody in pain wants that -- it tends to increase the Dorito intake, for one thing; besides, inhaling smoke has its health risks too.

Dr. Rice concluded that although there was lots of laboratory data to support the use of cannabis for pain relief, its clinical use was premature. Why? "This is probably much more of a political question than a medical matter," he said.

It's a question of access, in other words.

When Ms. McLellan says Canada should shelve the use of medical marijuana until further studies, she is depriving science of one very good avenue of research -- the experience of people in pain who are already using marijuana and benefiting from it.

Mark Ware, associate professor of anesthesia at McGill University and a pain physician, has done work on the therapeutic potential of cannabis. In a study presented at the congress (one of 16 papers on the subject), Prof. Ware followed a group of chronic pain patients who used marijuana. They all reported decreased pain, and most found it helped them relax and get to sleep. "What was interesting was how effective a low dose of marijuana could be," he pointed out. "The doses were variable but some got relief from as little as two or three puffs a day."

The amount of cannabis useful for pain relief, in other words, doesn't resemble the Cheech and Chong quantities that its opponents imagine. Nor does everyone want the high; their aim is to reduce suffering and get on with life.

Because these drugs are so promising in terms of health and economic benefits, it's important not to slow down research on them. Besides, cannabis can even lead to decreased drug use in patients. "One great advantage of using cannabinoids for pain relief," says Dr. Jim Henry, director of the Canadian Pain Consortium and another researcher in this area, "is that when you combine them with opiates, patients can lower their dosage of these drugs."

So why has Ms. McLellan chickened out on the marijuana front? Dr. Harold Merskey, an internationally recognized pain researcher in London, Ont., told me: "I suspect our politicians don't want to be ahead of America in this matter, because it raises a sensitive border issue." Namely, the fear of Americans flocking across the border to avail themselves of high-grade, government-issue cannabis.

But if Canada puts this sort of fear ahead of the therapeutic potential to ease suffering, we will be headed toward a mini-version of America's War on Drugs -- a campaign that has been a ruinous and costly failure in addressing the serious issue of addiction and drug abuse. It's ironic: Canada has the legal framework in place, lots of impressive research on hand -- but we're going to sit on it. Meanwhile, people with cancer, AIDS, MS, or severe arthritis, who could benefit from a puff or two a day, and who may not have the luxury of worrying about long-term effects, have been deprived of a cheap painkiller that has not caused a single fatality (unlike anti-inflammatories, which were linked with 20,000 deaths in the United States last year). Marijuana also looks quite nice growing in a window box.

Cannabis has risks, as all drugs do. We don't yet know its long-term effects on memory or the immune system. But hormone-replacement therapy has its proven dangers too, and the government hasn't bestirred itself to shelve premarin.

So let's do the clinical trials to measure long-term consequences. And by all means, let's develop a cannabinoid that cleanly targets pain without the high. (How Canadian: a drug that makes you feel normal.) Canadian cannabis has a nice brand-ish ring to it. If the maple leaf went on a diet, it might even resemble the leaf in question.

But in the meantime, let's not deprive ourselves of the one population that could offer us crucial evidence about the pros and cons of its use -- namely, the roughly 400,000 Canadians who already use marijuana for pain relief. For them, the main pain now is access.

Marni Jackson; author of Pain: The Fifth Vital Sign.
Details: http://www.mapinc.org/media/168

Symposium on Cannabinoids in Pain Management - Reno, Nevada - Sept 28

An all-day symposium on Cannabinoids in Pain Management will be presented on Saturday September 28, 2002 in Reno, NV as part of the annual American Academy of Pain management meeting. They have an excellent panel of international experts prepared to instruct us on the state of the art with cannabinoid therapeutics, both here and abroad: If you are a pain treatment specialist who lives in a state with a medical marijuana (clinical cannabis) law, a familiarity with the risks and benefits of cannabis therapeutics will be advantage in your patients management.

A Conference Announcement is available at:
http://www.aapainmanage.org/AAPM/Confrnce/conf2002.html
A Conference Brochure is available at:
http://www.aapainmanage.org/AAPM/Confrnce/Conf%202002%20Agenda.pdf