SOCIETY OF CANNABIS CLINICIANS AUSTRALIAN CHAPTER

ANZCCP
Australian & New Zealand College of Cannabinoid Practitioners

April 2nd, 2021

To whom it may concern,

This is a combined response by a collective of experienced Medical Cannabis prescribers in relation to the Newspaper article *("Medicinal Cannabis Backlisted by Australian pain specialists" March 23,2021 Story by Kate Aubusson Sydney Morning Herald)* by Dr Michael Vagg, Dean of the ANZCA and the choosing wisely guidance documents around the use of Medical Cannabis for chronic non-cancer pain (CNCP).

1. On close review of the articles referenced in the choosing wisely guidance documents, the results clearly show potential benefit of cannabis compared to placebo on CNCP and extensive preclinical evidence showing scientific basis for cannabinoids analgesic properties.
2. The main identified issue is low power of evidence or risk of bias being too high for conventional standards. This is true however emerging studies are building on this evidence base with very promising results. Lack of good quality evidence is not evidence that cannabinoids are ineffective.
3. The articles and guidance documents don't take into account the difficulties around doing clinical trials with a complex, often illegal, plant-based medicine with many variables that aren't encountered with conventional pharmaceutical agents.
4. The referenced systematic reviews and guidance documents allude to a high risk of harm when using cannabis medicines, but the side effects mentioned are mild and can be mitigated with correct dosage guidance and proper product selection. Also, many synthetic cannabinoids included in these literature reviews are known to have a very narrow therapeutic window with much higher side effect profile than carefully selected plant based cannabinoids.
5. There appears to be a pervasive fear around the use of cannabis leading to a similar situation as the opioid epidemic, something we all want to avoid; however this is unfounded. Cannabis in comparison to opioids has low addictive potential and extremely low chance of toxicity and overdose. There is also plenty of emerging evidence to show that cannabis can be an extremely helpful tool as an exit drug for patients suffering with opioid use disorder. California is a prime example of this with increasing availability of Cannabis leading to decreased opioid and benzodiazepine overdoses. We do however take this fear seriously, so we prescribe Medical Cannabis to appropriate patients and have updated healthcare record systems including Real-Time Prescription Monitoring to reduce drug diversion.
6. The Choosing Wisely position statement is in disagreement with the Australian TGA that cannabis has moderate evidence for CNCP. It also contradicts the Barnes review in the UK, Information for Healthcare Professionals – Cannabis and the Cannabinoids in Canada, and The Health Effects of Cannabis and Cannabinoids in the US, reviews all recognising that cannabis can have a place in chronic pain management.
7. The position statement and articles undermine hundreds of thousands of Australians who are using cannabis legally and illegally to treat their pain and continue to do so because of the benefit they receive.
8. In the Newspaper article it states the gold standard of treatment is a multi-disciplinary team (MDT) pain clinic. While this may be true waiting lists are over 2 years in many areas and many patient's symptoms are so severe and all-consuming that they require some relief to engage fully in the treatment program. Medical Cannabis works best alongside lifestyle and psychological support to improve health outcomes. They are mutually beneficial rather than exclusive.
9. The focus of these articles is on pain, however cannabinoids should be assessed on quality-of-life scores and functional outcomes. For most patient's chronic pain isn't just a physical problem. It affects all biopsychosocial aspects of well-being. Cannabis as well as helping pain for many patients,

can help restore sleep, improve mood, reduce stress etc. The multiple areas of potential benefit can significantly reduce the burden of polypharmacy often encountered in this patient population.

10. It needs to be mentioned that there is poor long term efficacy and expense related to procedures that many pain specialists provide to these same patients. As well as the pain and stress the actual procedures themselves can cause.
11. It also needs to be mentioned that the safety and tolerability as well as the risk/benefit ratio, makes cannabis a safe option to try vs pregabalin/opioids/benzodiazepines. All of which are often used in combination in these same patients. As well as being dangerous these more conventional medicines have poor efficacy for chronic pain.
12. Medical Cannabis was compared to alcohol which is destructive on so many levels and no medical purpose. This once again makes CNCP patients looking for relief who are using cannabis responsibly feel marginalised by a system that has often failed them.
13. Chronic non cancer pain being grouped as one condition is flawed in the first place as is mentioned in the IASP systematic review. There are many conditions that are clustered into CNCP with differing aetiology and varying responses to therapy, including Medical Cannabis.
14. In the articles and choosing wisely guidance cannabis is mistakenly viewed as a small class of medicines made up of CBD and THC. Plant based cannabis has hundreds of therapeutically active constituents often working in synergy to produce an "entourage effect". It is a broad class of medicines with millions of potential variations. This means certain products are going to be superior to others for pain conditions and it is difficult to class them under the same heading.

We are in agreeance that more research is needed and better methodologies for studying such a complex medicine need to be developed, however this is happening. In the meantime, cannabis is often a less harmful and potentially more effective option than other standard treatments for chronic non cancer pain.

Cannabis isn't a magic bullet or panacea for pain management, but it can be a great adjunct to more comprehensive lifestyle and psychological interventions to improve patient's quality of life. The fear mongering in these articles is doing patients a disservice. Prescribers do not take this decision lightly; it is an open, transparent discussion with patients after previous therapies have failed, and if appropriate, reached together through a mutual understanding of goals and expectations.

Kind regards,

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