

Oklahoma Pain Society Policy Statement on Medical Marijuana

The Oklahoma Pain Society continues to investigate and evaluate therapies that may bring relief to patients suffering from chronic pain, including the use of medical marijuana. Medical Marijuana is a scheduled therapy and should be treated with caution and education just as with any scheduled medication.

It is important for OPS members and all providers who treat chronic pain to be educated on the benefits and risks of using medical marijuana to treat chronic pain as a stand-alone remedy or in conjunction with other prescribed medicines such as opioids.

We encourage healthcare professionals to review the American Pain Society's Guidance on Medical Marijuana for Pain that can be found at:

<http://americanpainsociety.org/about-us/press-room/american-pain-society-offers-guidance-on-medical-marijuana-for-pain>

Instruction to Patients:

Medical Marijuana and Pain Management

- 1. Open up a conversation with your doctor, informing him/her of your interest in medical marijuana and whether or not s/he is willing to help you decide if it is beneficial for you.**
- 2. Discuss with your doctor your desire to reduce your opioid use and whether s/he would agree to let you try marijuana under a protocol where, if it is effective, you will reduce your opioids (see Pain Contract Rider: Medical Marijuana Trial).**
- 3. If your doctor is not willing to proceed, either negotiate (e.g. discuss relinquishing your MJ card if it doesn't help with pain) or ask that s/he refer you to another pain management doctor who is open to prescribing opioids to marijuana card holders. In a polite manner, remind your doctor that part of his/her duty of care is that s/he not medically abandon you and that there are pain management doctors in this state who are open to prescribing opioids to marijuana card holders.**
- 4. Lastly, do not be afraid to talk to your doctor about your personal beliefs: the importance of bodily autonomy, the need for social reform, your religious beliefs about medicinal plants, etc.. Do so with respect, and with the goal of helping your doctor see you as a person with feelings, values, and hopes.**

PAIN CONTRACT RIDER: MEDICAL MARIJUANA TRIAL

Dear Dr. _____. I have been your patient for _____ years and currently rely upon opioids to manage my chronic pain. Under my current pain contract, I have agreed to not use any “illicit” drugs. However, with the legalization of medical marijuana in Oklahoma, I would like to begin a trial use of medical marijuana and ask that you allow this rider to our pain contract.

I currently take the following opioids _____ and am hoping that with the assistance of medical marijuana, I will be able to reduce my opioid use by at least 50% within 90 days.

To that end, I would like to explore marijuana products for an initial 30 day period. If I find it effective, I will begin to reduce my opioid use during this period. If I report back that I have found marijuana effective for pain, my hope is that you will reduce my opioids first by 25% and then by 50% at my appointment after that. Hence, this trial will have three stages:

1. An initial 30 day period where I can explore marijuana products to determine whether one or another is effective for my pain.
2. A second 30 day period where I will receive 25% lower opioid doses (e.g. fewer breakthrough pills and/or lower dosages)
3. A third 30 day period where I will receive 50% lower opioid doses (e.g. fewer breakthrough pills and/or lower dosages)

If, after the first, second, or third periods, I find marijuana to be ineffective for pain and/or cannot reduce my opioid doses, my urinalysis will then be negative for THC metabolites within 30 days after we determine that the endpoint/target has not been met.

Beginning medical marijuana trial _____ (date)

25% reduction of opioids begins _____ (date)

50% reduction of opioids begins _____ (date)

If unsuccessful, THC negative urinalysis by _____ (date)

Signed,

_____ (date)

Note: if you are not able to accept this protocol, please refer me to a pain management physician who does allow the concurrent use of opioids and marijuana.

SAFETY of MJ (Respiratory Effects and in Combination with Opioids)

- **Cannabis for the Management of Pain: Assessment of Safety Study (COMPASS).**

The Journal of Pain, 16(12), 1233-1242.

<https://www.ncbi.nlm.nih.gov/pubmed/26385201>

“The primary outcome consisted of serious adverse events and non-serious adverse events. Secondary safety outcomes included pulmonary and neurocognitive function and standard hematology, biochemistry, renal, liver, and endocrine function. Secondary efficacy parameters included pain and other symptoms, mood, and quality of life. Two hundred and fifteen individuals with chronic pain were recruited to the cannabis group (141 current users and 58 ex-users) and 216 controls (chronic pain but no current cannabis use) from 7 clinics across Canada.”

- **Cannabis as an adjunct to or substitute for opiates in the treatment of chronic pain.**

J Psychoactive Drugs. 2012 Apr-Jun;44(2):125-33.

<https://www.ncbi.nlm.nih.gov/pubmed/22880540>

“When used in conjunction with opiates, cannabinoids lead to a greater cumulative relief of pain, resulting in a reduction in the use of opiates (and associated side-effects) by patients in a clinical setting. Additionally, cannabinoids can prevent the development of tolerance to and withdrawal from opiates, and can even rekindle opiate analgesia after a prior dosage has become ineffective”

- **Single-Dose Effect of Marijuana Smoke — Bronchial Dynamics and Respiratory-Center Sensitivity in Normal Subjects**

N Engl J Med 1973; 288:985-989

www.nejm.org/doi/full/10.1056/NEJM197305102881902

"Physiologic variables were monitored before and for 20 minutes after smoking. In the high-dose group the heart rate increased 28 per cent. Concomitantly, airway resistance, measured in a body plethysmograph, fell 38 per cent; the functional residual capacity remained unchanged (\pm 50 ml) throughout, and specific airway conductance increased 44 per cent. Flow-volume loops showed a 45 per cent increase in flow rate at 25 per cent of vital capacity. The low-dose group showed no increase in heart rate but significant, if lesser changes, in airways dynamics. Carbon dioxide sensitivity, measured by rebreathing remained unchanged in both groups. Marijuana smoke, unlike cigarette smoke, causes bronchodilatation rather than bronchoconstriction and, unlike opiates, does not cause central respiratory depression."

- **The effects of smoked marijuana on metabolism and respiratory control**

Am Rev Respir Dis. 1978 Nov;118(5):885-91
<https://www.ncbi.nlm.nih.gov/pubmed/367234>

“In a placebo-controlled study of 8 subjects, smoking marijuana significantly increased ventilation and hypercapnic ventilatory response. Peak effects occurred 15 min after smoking, when ventilation increased from 7.4 +/- 0.39 (mean +/- SE) to 10.4 +/- 1.41 liter per min (P less than 0.01), whereas hypercapnic ventilatory response, measured as the slope of the relationship of ventilation to CO₂, increased from 2.7 +/- 0.28 to 5.4 +/- 1.02 liter per min per mm Hg (P less than 0.05). Blood pH, PCO₂, and ventilatory response to hypoxia were unchanged. Changes in ventilation usually parallel changes in metabolic rate. Smoked marijuana caused an increase in metabolic rate that also peaked after 15 min. Pretreatment with propranolol completely abolished the increase in hypercapnic ventilatory response, but did not affect the other changes. Thus, smoked marijuana had stimulatory effects on metabolic rate, ventilation, and the ventilatory response to CO₂. The latter appears to be mediated by the beta sympathetic nervous system.”

- **Ventilatory-depressant effects of opioids alone and in combination with cannabinoids in rhesus monkeys**

European Journal of Pharmacology Volume 833, 15 August 2018, Pages 94-99
<https://www.sciencedirect.com/science/article/pii/S0014299918303108>

“In summary, cannabinoid receptor agonists, which increase the potency of opioids to produce antinociception, did not increase their potency to depress ventilation. Thus, the therapeutic window is greater for opioids when they are combined with cannabinoid receptor agonists, indicating a possible advantage for these drug mixtures in treating pain.”

- **Pharmacotherapy of Apnea by Cannabimimetic Enhancement, the PACE Clinical Trial: Effects of Dronabinol in Obstructive Sleep Apnea**

Sleep, Volume 41, Issue 1, 1 January 2018, zsx184,
<https://academic.oup.com/sleep/article/41/1/zsx184/4600041>

“In comparison to placebo, dronabinol dose-dependently reduced AHI by 10.7 ± 4.4 ($p = .02$) and 12.9 ± 4.3 ($p = .003$) events/hour at doses of 2.5 and 10 mg/day, respectively. Dronabinol at 10 mg/day reduced ESS score by -3.8 ± 0.8 points from baseline ($p < .0001$) and by -2.3 ± 1.2 points in comparison to placebo ($p = .05$).”

Summary:

Marijuana not only allows patients to take fewer pills and lower doses, but as it is a mild respiratory stimulant and bronchodilator, it increases the therapeutic window of opioids. In short: MARIJUANA LOWERS THE RISK OF OPIOID OVERDOSES.

Marijuana and Opioid Reduction

- **Cannabis Use Is Associated With Decreased Opiate Medication Use in a Retrospective Cross-Sectional Survey of Patients With Chronic Pain**

J. Pain Jun 2016; 17(6):739-44.

<http://www.ncbi.nlm.nih.gov/pubmed/27001005>

“Survey of 244 chronic pain patients found medical cannabis use associated with a 64% decrease in opioid use, decreased number and side effects of medications, and an improved quality of life.”

- **Cannabinoid-opioid interaction in chronic pain**

Clin Pharmacol Ther. 2011 Dec;90(6):844-51

<https://www.ncbi.nlm.nih.gov/pubmed/22048225>

“Cannabinoids and opioids share several pharmacologic properties and may act synergistically. The potential pharmacokinetics and the safety of the combination in humans are unknown. We therefore undertook a study to answer these questions. Twenty-one individuals with chronic pain, on a regimen of twice-daily doses of sustained-release morphine or oxycodone were enrolled in the study and admitted for a 5-day inpatient stay. Participants were asked to inhale vaporized cannabis in the evening of day 1, three times a day on days 2-4, and in the morning of day 5. Blood sampling was performed at 12-h intervals on days 1 and 5. The extent of chronic pain was also assessed daily. Pharmacokinetic investigations revealed no significant change in the area under the plasma concentration-time curves for either morphine or oxycodone after exposure to cannabis. Pain was significantly decreased (average 27%, 95% confidence interval (CI) 9, 46) after the addition of vaporized cannabis. We therefore concluded that vaporized cannabis augments the analgesic effects of opioids without significantly altering plasma opioid levels. The combination may allow for opioid treatment at lower doses with fewer side effects.”

- **The Effect of Medicinal Cannabis on Pain and Quality-of-Life Outcomes in Chronic Pain: A Prospective Open-label Study**

Clin J Pain. 2016 Dec;32(12):1036-1043

<https://www.ncbi.nlm.nih.gov/pubmed/26889611>

“A total of 274 participants were approved for treatment; complete baseline data were available for 206 (intent-to-treat), and complete follow-up data for 176 participants. At follow-up, the pain symptom score improved from median 83.3 (95% confidence interval [CI], 79.2-87.5) to 75.0 (95% CI, 70.8-79.2) (P<0.001). The pain severity score (7.50 [95% CI, 6.75-7.75] to 6.25 [95% CI, 5.75-6.75]) and the pain interference score (8.14 [95% CI, 7.28-8.43] to 6.71 [95% CI, 6.14-7.14]) improved (both P<0.001), together with most social and emotional disability scores. Opioid consumption at follow-up decreased by 44% (P<0.001). Serious adverse effects led to treatment discontinuation in 2 participants.”

Appendix: Marijuana's History and Current Legal Status

- historical records show that marijuana has been used medicinally for at least 5000 years.
 - from Japan to the Middle East, it was used for thousands of years, and entered Europe and the United States in the 1850s, as the result of British expansion into India (where it is routinely used still).
 - It was prescribed by U.S. physicians until 1937, when it was banned by Congress due to stories such as racial intermingling in southern jazz clubs. The AMA's testified before Congress, strongly opposing the decision.
 - It was then made Schedule I in the CSA, despite the commission set up to schedule drugs recommending that it not be scheduled.
 - Hence, its legal history is the result not of medical science but of politics and racism.
- From the 1970s to 1990s, the federal government sponsored more than fifty billion dollars of research to demonstrate the dangers of marijuana, and funding was dependent on confirming what was expected. At the same time, the NIH sponsored research in other countries, most notably in Israel, on its medical benefits. As a result, Israel legalized medical marijuana in 1992 (note that marijuana has a long history of use in Judaism, both medicinally and as part of religious activities, ranging from orthodox approaches to the prescribed mitzvah of tikkun olam to contemporary celebrations of Purim).
- California legalized medical marijuana in 1996, as did another 7 states as well as Canada by 2000. By 2010, 16 states legalized, and now we are at 31 states (plus D.C.) plus twenty-five other countries. In fact, along with ten other states, recreational marijuana is legal in our nation's capitol.
- Oklahoma legalized medical marijuana June 26th, 2018 and began to issue medical marijuana patient licenses August 25th. More than 5000 licenses have been issued as of September 15th and following national averages, we will have roughly 100,000 licenses issued over the next eighteen to twenty-four months.

With regard to the legality of prescribing opioids to card holders:

- 1) you do not need to sign a patient medical marijuana recommendation form. Patients can have their primary care provider or another doctor sign it.
- 2) there is no state or federal law against recommending marijuana. Physicians are constitutionally protected when they issue these recommendations (as established by Conat v. Walters 2002).
- 3) the OBN has stated that they have no objection to physicians prescribing opioids to marijuana card holders.
- 4) SB 1446 (Effective November 1st) requires pain management physicians to pursue strategies to help patients reduce their opioid doses. The epidemiological data overwhelmingly supports that marijuana legalization reduces opioid use; and likewise, the medical literature provides significant evidence of safety and efficacy. SB 1446 thus offers pain management physicians a reason for allowing their patients to use MJ in order to reduce their dosages.