Conflicting recommendations

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LETTER TO THE EDITOR

Conflicting recommendations: A labyrinth for the clinician and patients: A comment to Eisenberg's et al. "medical cannabis for chronic pain"

The recent publication: "Medicinal cannabis for chronic pain: The Bermuda triangle of low-quality studies, countless meta-analyses and conflicting recommendations." (Eisenberg et al., 2022) states that medicinal cannabis (MC) should be considered a third-line therapy for chronic neuropathic pain syndromes, whereas, for all other chronic pain conditions, the use of MC should be regarded as an individual therapeutic trial. This statement refers to the EFIC position paper (Häuser et al., 2018) and is more liberal than the IASP recommendation stating that due to a lack of evidence from high-quality preclinical and clinical studies the efficacy of cannabis and cannabinoids for pain relief cannot be endorsed. (IASP, 2021).

The difficulty in the assessment of the efficacy of MC relies mainly on the fact that selected studies conform with standard inclusion criteria reports on different types of pain, different products, and different administration forms. (Fisher et al., 2021).

The IASP presidential task force warns of the potential harms, especially with high doses and/or long-duration use, which is often the case in chronic pain treatment. Besides the safety concerns, the high cost of high doses of cannabidiol (CBD) as required for the treatment of epilepsy, anxiety, psychosis, and addiction may lead to the use of sub-optimal doses. This can become problematic resulting in inadequate treatment of the underlying disease (Manthey, 2019).

Cannabis may not be as addictive as opioids but, although reports that cannabis use remained stable in Europe in recent years, the number of users seeking treatment for cannabis problems increased by 76% over the years. This can be attributed to the regular use of cannabis or the potency levels, both major issues with MC.

The health effects of regularly using cannabis products of increased potency are unknown but of primary concern. (Manthey, 2019) The cannabis *potency levels*, with a higher concentration of THC than CBD, have been positively associated with treatment admission rates. There are no official data on the incidence of cannabis use disorders and clinical treatment statistics and the outline pathways suggesting an increase in the prevalence of cannabis use disorders are in sharp contrast.

We can conclude that we do not fully understand the long-term implications of taking cannabinoids, cannabis, and cannabis based medicine. Evidence is emerging on the negative long-term effects of cannabis, in particular cannabis with high THC content; but data for longer-term use of cannabinoids, cannabis, and cannabis based medicine in a medicinal context are lacking at present. (Eisenberg et al., 2022).

While in certain countries prescription of MC is legally supported under strict conditions, in other countries recreative use of cannabis is tolerated. The latter may result in patients using illicit cannabis for pain management, thus overriding medical control on dose, efficacy and safety.

The EFIC task force issued detailed recommendations for different types of pain. The general conclusion is in-line with the IASP recommendation stating that there is insufficient evidence for the use of cannabis in Europe (Häuser et al., 2018). The commentary paper tend to weaken the recommendations what does not improve clinicians' and patient understanding of the potential benefits and risks of MC. Moreover, in a period where information is widely spread, the recommendation for MC to be the third-line therapy for chronic neuropathic pain syndromes may stimulate patients to rely on less expensive illicit cannabis. The absence of medical supervision, in this case, may lead to dose escalation, interaction with other medication and risk for accidents.

The opioid crisis costed the life of hundred thousands of people. Hindsight, we realize that the aggressive marketing of pharmaceutical companies led to the use of increasing doses for a long period. The created addiction stimulated the use of illegal drugs such as heroin. It is documented that some countries legalized cannabis to stimulate economic growth. (Bell & Kalso, 2021).

If patients with pain do not respond to medication, should we not better focus on the biopsychosocial component of pain, with a much better risk/benefit ratio and a firm scientific base?

The IASP recommendation seems much more reasonable, physicians prescribing MC, should be aware of the lack of evidence, the problems with varying doses and the risks. Cannabis should be used under strict control after thorough multidisciplinary and specialized evaluation. Physicians carry the responsibility to care for patients and provide the correct information, weighing potential benefits and risks.

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CONFLICT OF INTEREST

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