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CURRENT CONTROVERSIES - RIGHT OF REPLY

'Cannabis use in gynaecology: A bad idea'

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The opposing piece penned by Kent highlights the common conflation of illicit and medicinal cannabis use.[1] Indeed, cannabis is one of the most widely used illicit drugs world-wide, and a great deal of research has focused on the harms associated with such use; however, applying this same logic to medicinal cannabis is like comparing street-sourced heroin to that of pharmaceutical opioids. The composition, dose, intent, safety, and medical oversight all fundamentally differ between illicit and medicinal consumers.

It is important to remember that medicinal cannabis is not just delta9-tetrahydrocannabinol (THC), and like other pharmaceutical drugs, product composition and dose are important variables to be considered. Most people who utilise illicit cannabis recreationally do so for its mind-altering properties (commonly referred to as being 'high'), which is due to significant levels of THC, and which is why illicit cannabis has been bred for the last 50 years to contain high concentrations of THC, the main intoxicating cannabinoid, with little to no attention paid to other cannabinoids. Most, if not all, illicit cannabis consumed in Australia and New Zealand is unlikely to have any accurate indication of the level of THC, and the lack of any quality control precludes any consistency between 'batches', thus making consistent dosing impossible. Conversely, medicinal cannabis undergoes rigorous testing procedures that are required across all dosage forms in Australia, including microbial limits, cannabinoid standardisation, detection of foreign matter, aflatoxins, ochratoxin A, pesticide and solvent residues, and the presence of heavy metals as outlined in the Therapeutic Goods Order 93 (*Standard for Medicinal Cannabis*).[2]

Medicinal cannabis, like any other prescription medication, is prescribed under the supervision of a medical practitioner. Given the pharmacokinetic and pharmacodynamic interactions observed with cannabis,[3] medicinal cannabis when prescribed by a doctor can reduce side-effects and drug interactions when compared to illicit usage. The fundamental difference with medicinal cannabis patients compared to recreational users is that they are primarily seeking symptom amelioration for predominantly chronic conditions, with many patients viewing feeling 'high' as an unwanted side-effect rather than a desired outcome.[4] Therefore, while medicinal cannabis products can and do include THC, high-potency THC-only products are rarely used by clinicians, especially as a first line treatment. Legal medicinal products have also been standardised so that the exact ratio of various cannabinoids is known, allowing for accurate dosing, and medicinal options include products such as cannabidiol (CBD) isolates that contain no THC at all, and which lacks any intoxicating effects. Unwanted impairment can also be managed by careful dose titration of THC-containing products,[5] as can the choice of products containing other cannabinoids in addition to, or instead of THC, such as CBD. This provides doctors a range of options to tailor treatment to individual patient symptoms and preferences.

We appreciate that Kent has given us an opportunity to address these misconceptions so clinicians in the future can undertake informed clinical decision making with accurate information, rather than rehashing safety concerns rooted in the era of Reefer Madness.

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CONFLICT OF INTEREST STATEMENT

MA and JS: MA has previously received funding from Canopy related to medicinal cannabis and primary dysmenorrhea, outside the submitted work. JS is employed as the chief scientific officer for Australian Natural Therapeutics Group. JS also sits on the board of the Australian Medicinal Cannabis Association, advisory group for the Society of Cannabis Clinicians (Australian Chapter) and the scientific advisory board for United in Compassion, all in a pro bono capacity.

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