# The Intersection of RX Opioids & Medical Marijuana

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# It starts with Pain



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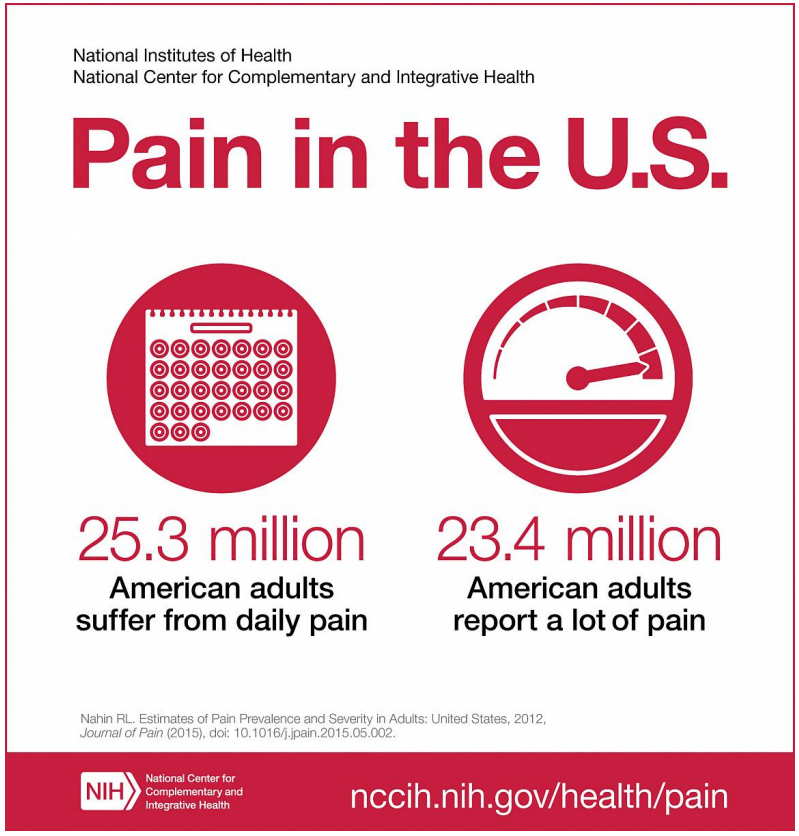
# It's Everywhere



# Pain is in the Brain

- Pain is real
- Emotions are real
- All are regulated (interpreted) by the brain
- But your filters are applied

https://www.psychologytoday.com/us/blog/day-without-pain/201301/chronic-pain-it-is-all-in-your-head-and-it-s-real

# Pain <> Suffering

- Pain is part of the human condition
  - Physical, emotional, social
- Suffering can be a choice
  - How pain is interpreted

- A quote from Dr. Mel Pohl …

  "When I ask patients about their pain, eight out of ten words they use to describe their experience are emotional. The three most frequently used terms are anxiety, fear, and anger, but there's also depression, helplessness, loss of purpose, frustration, guilt, and shame. "

# What if drugs aren't the answer?

- #BioPsychoSocialSpiritual
  - Cognitive Behavioral Therapy (CBT), biofeedback
  - Physical therapy, chiropractic treatment, massage therapy
  - Acupuncture, dry needling
  - Yoga, Tai Chi, stretching exercises
  - Mindfulness, deep diaphragmatic breathing
  - Guided imagery, virtual reality, hypnotherapy
  - Music therapy, pet therapy, aromatherapy
  - Wellness apps like calm.com and curablehealth.com
  - An active lifestyle, 7-8 hours of nightly sleep
  - Anti-inflammatory nutritious diet, proper hydration
  - ***Engaged, resilient patient***
  - ***Individualized self-management***

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# Treating Pain … Opioids



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# Opioid Use

- International Association for the Study of Pain
  - https://www.iasp-pain.org/Advocacy/Content.aspx?ItemNumber=7194
  - Acute
    - *"IASP strongly advocates for access to opioids for the humane treatment of severe short-lived pain, using reasonable precautions to avoid misuse, diversion, and other adverse outcomes."*
  - Chronic
    - *"There may be a role for medium-term, low-dose opioid therapy in carefully selected patients with chronic pain who can be managed in a monitored setting. However, with continuous longer-term use, tolerance, dependence, and other neuroadaptations compromise both efficacy and safety. Chronic pain treatment strategies that focus on improving the quality of life, especially those integrating behavioral and physical treatments, are preferred."*

# CDC Guidelines

https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf

## DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

**1 OPIOIDS ARE NOT FIRST-LINE THERAPY**

**Nonpharmacologic therapy** and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

**2 ESTABLISH GOALS FOR PAIN AND FUNCTION**

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

**Nonpharmacologic therapies and nonopioid medications include:**

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

**3 DISCUSS RISKS AND BENEFITS**

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.



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# CDC Guidelines

https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf

## OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

**4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING**

When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

**5 USE THE LOWEST EFFECTIVE DOSE**

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 **morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

**6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN**

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

**Immediate-release opioids:** faster acting medication with a shorter duration of pain-relieving action

**Extended release opioids:** slower acting medication with a longer duration of pain-relieving action

**Morphine milligram equivalents (MME)/day:** the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

**7 EVALUATE BENEFITS AND HARMS FREQUENTLY**

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

# So the goal is …

"Appropriate, Not Zero, Opioids"

https://www.linkedin.com/pulse/appropriate-zero-opioids-mark-rxprofessor-pew/



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# Treating Pain … Alternative Rx



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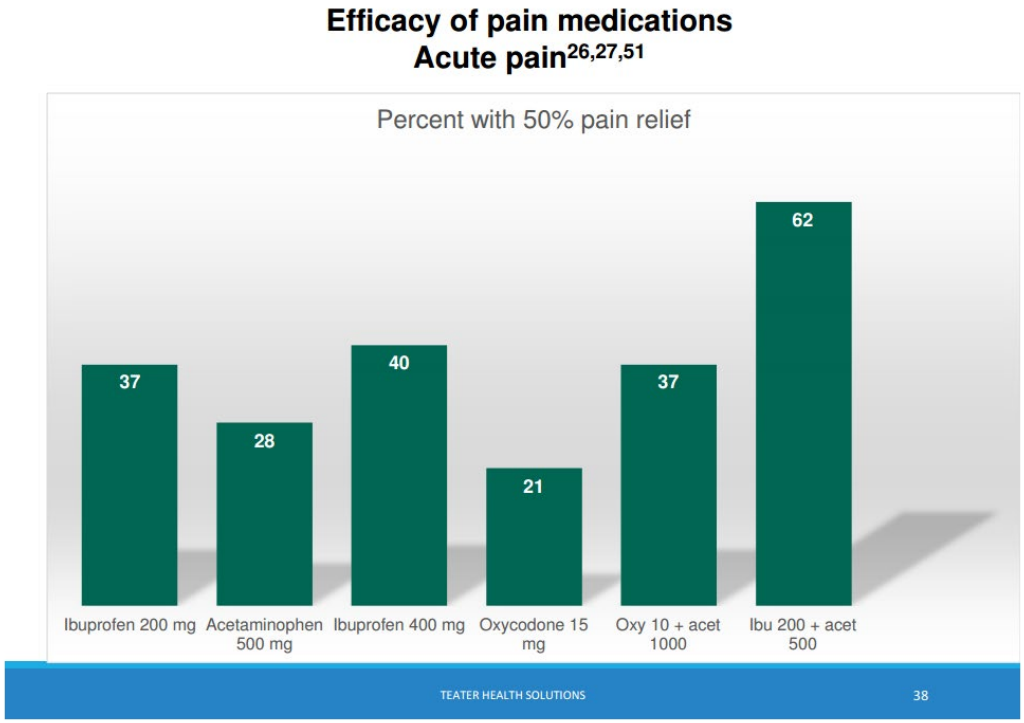
# The “Good Stuff” …




http://bit.ly/2yKMbQQ



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# Other drugs

- Anti-epileptic
  - Most common: Gabapentin (Neurontin), Pregabalin (Lyrica)
  - But they can be dangerous
- Benzodiazepine
  - Most common: Diazepam (Valium), Alprazolam (Xanax)
  - Highly addictive and more difficult to wean than opioids
- Muscle relaxant
  - (used to be) Most common: Carisoprodol (Soma)
  - Highly addictive
- Antidepressant
  - Most common: Duloxetine (Cymbalta)
  - FDA approved for depression & pain

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# Treating Pain … Cannabis



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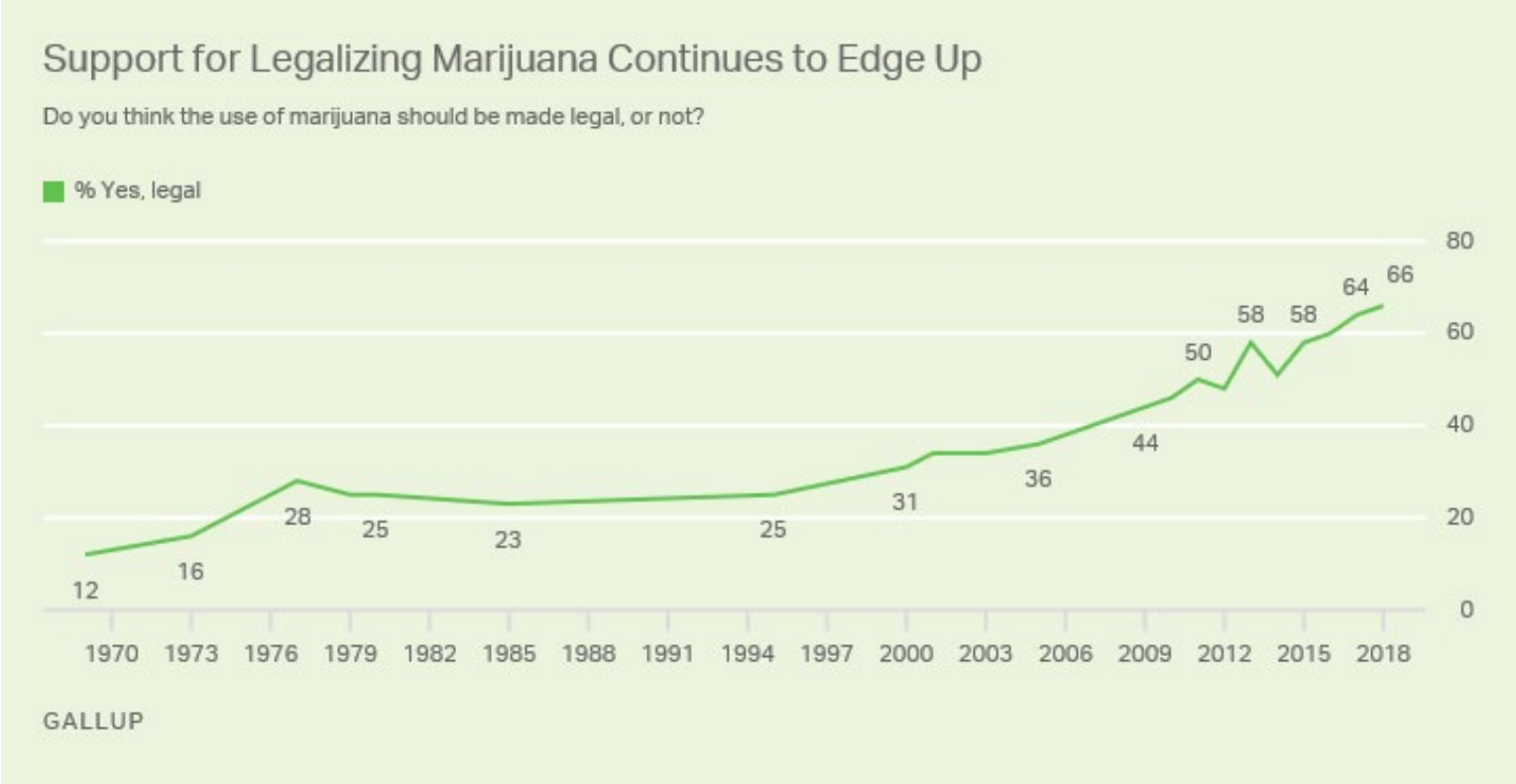
# Marijuana legalization




https://news.gallup.com/poll/243908/two-three-americans-support-legalizing-marijuana.aspx



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# Medical marijuana legalization

**Quinnipiac University Poll**

Do you support or oppose allowing adults to legally use marijuana for medical purposes if their doctor prescribes it?

| Poll Date | Support | Oppose | DK / NA |
|---|---|---|---|
| April 26, 2018 | 93% | 5% | 1% |
| Jan 11, 2018 | 91% | 6% | 2% |
| April 3, 2017 | 94% | 4% | 1% |
| April 20, 2017 | 94% | 5% | 1% |
| Feb 23, 2017 | 93% | 6% | 1% |
| June 6, 2016 | 89% | 9% | 2% |

https://poll.qu.edu/national/release-detail?ReleaseID=2539



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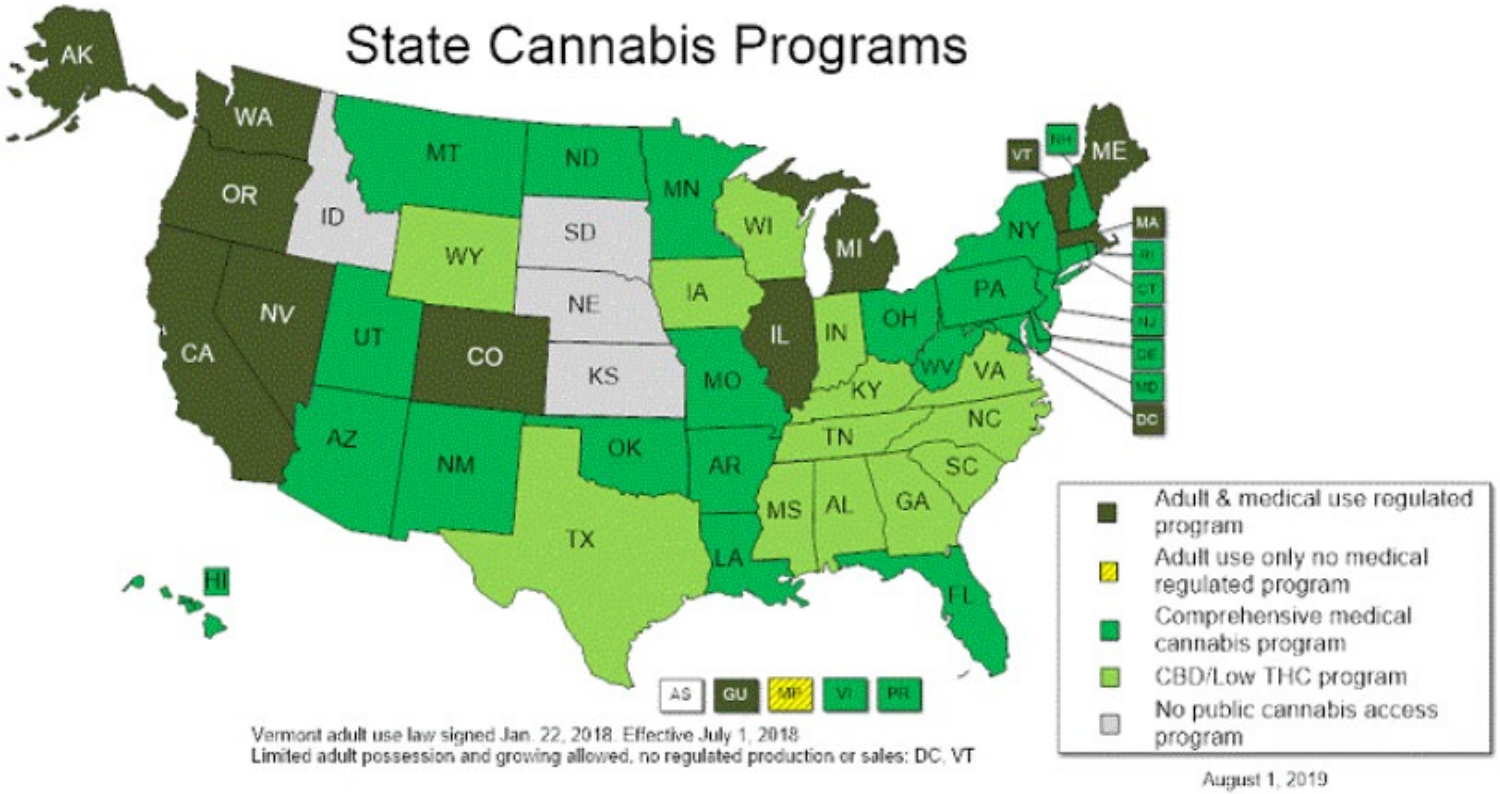
# Momentum




http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx



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# In 2016 …

- Marijuana science still half-baked (?)
  - *"The HHS concluded that marijuana has a high potential for abuse, has no accepted medical use in the United States, and lacks an acceptable level of safety for use even under medical supervision. Therefore, the HHS recommended that marijuana remain in Schedule I."*
  - www.linkedin.com/pulse/marijuana-science-still-half-baked-mark-rxprofessor-pew/

# In 2018 …

- Epidiolex (cannabidiol)
  - Purified drug substance derived from marijuana
  - Schedule V
  - On-label: Lennox-Gastaut syndrome or Dravet syndrome
  - www.fda.gov/newsevents/newsroom/pressannouncements/ucm611046.htm
- December 2018 Farm Bill
  - Legalized hemp (cannabidiol, < .03% THC)
  - www.brookings.edu/blog/fixgov/2018/12/14/the-farm-bill-hemp-and-cbd-explainer/#cancel

# In 2019 …

- *"Surgeon General Believes It's High Time To Think About Science-Driven Policy For Cannabis Research"*
  - China has 600 cannabis-related patents
  - Israel has 110 clinical studies
  - Canada is driving innovation
- FOMO

https://www.forbes.com/sites/nicolefisher/2019/01/07/surgeon-general-believes-its-high-time-for-marijuana-reclassification/#46fddaa35686



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# The Primary Driver?

- It's changed over time …
- Marijuana can solve our opioid epidemic
- And, now, social justice

# Connecting opioids and cannabis

# A 2014 study

- *"Medical cannabis laws are associated with significantly lower state-level opioid overdose mortality rates"*
  - **24.8%** lower mean annual opioid overdose mortality rate
  - JAMA Internal Medicine (October 2014)
  - https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1898878

- *"In 2010 alone, states with legalized medical marijuana saw approximately **1,700** fewer opiate-related overdose deaths"*
  - https://drugabuse.com/legalizing-marijuana-decreases-fatal-opiate-overdoses/



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# A 2018 study

- *"Counties with (medical cannabis) dispensaries experience **6% to 8%** fewer opioid-related deaths among non-Hispanic white men, while mortality due to heroin overdose declines by **more than 10%**"*
  - October 2018
  - https://mpra.ub.uni-muenchen.de/89613/1/MPRA_paper_89613.pdf

Cause and Effect?

# My conversations

- ⅓ to ½ of my audiences say it is medicine
  - Because they know somebody
- CBD Treatment Regimen Pilot in NV & CA
  - 75 patients
  - Average of 50% reduction in use of Rx opioids within 60 days
  - 78% eliminated Rx opioids and NSAIDS
- 500 patients in GA
  - 90% reduced their Rx opioids

# Connected to Rx opioids

- **5** states have explicitly tied the two substances together
  - CO, IL, NJ, NY, PA
- **6** more appear to have an "open door" to the connection
  - DC, LA, MA, MO, OK, VA
- **11** more could be included if OUD is considered a "chronic or debilitating disease / medical condition"
  - AK, AR, AZ, DE, HI, MI, NH, ND, RI, VT, WA

- **The MSM has made the connection for the public**
  - **And regulators are codifying the connection**

- For more context read "Marijuana & Opioids" at https://www.linkedin.com/pulse/marijuana-opioids-mark-rxprofessor-pew/

# Illinois

- Compassionate Use of Medical Cannabis Act in 2013
- Opioid Alternative Pilot Program (OAPP) in 2018
  - Licensed physicians must certify the qualifying patients has a medical condition for which an opioid has been or could be prescribed based on generally accepted standards of care.
  - Registered patients are eligible to purchase 2.5 ounces of medical cannabis every 14 days.
  - Physician certifications are valid for 90 days but can be renewed to allow patients to continue accessing medical cannabis.
  - www.dph.illinois.gov/topics-services/prevention-wellness/medical-cannabis/opioid-alternative-pilot-program
- January 1 – Legal weed

# Bottom Line

Unless something cataclysmic happens

Cannabis is here to stay

What is your risk management plan?

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## Who is Mark Pew?

www.legalnetinc.com/2017/02/09/thursday-thought-leader-mark-pew



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