Medical Cannabis and CBD: a view from the professional bodies

Published 1 October 2020

With cost and safety issues looming large, moving forward will require a range of different approaches - from alternatives to traditional trials, to the involvement of the pharmaceutical industry.

When clinicians talk about evidence and safety, the shadow of Thalidomide looms large. Thalidomide was widely prescribed in the 1950s and '60s to treat nausea in pregnancy. But in the '60s it became apparent that it caused severe birth defects in thousands of children around the world.

Dr Barry Miller, a full-time NHS consultant in pain medicine, says there are legitimate concerns. "We don't know if in twenty years down the line people will develop some unusual disease or cancer," he says. "These things are not uncommon – look at Thalidomide and Vioxx [which caused heart attacks and strokes]. Maybe medical cannabis will turn out to be a valuable addition to pain medicine therapeutics, but until we have solid evidence of safety, there are real concerns."

Dr Miller is the former Dean of the Faculty of Pain Medicine at the Royal College of Anaesthetists and now is chair of the Medicines Advisory Group at the Faculty. He feels that regulators and Royal Colleges are right to be cautious in their prescribing guidelines.

Hannah Deacon says doctors who want to prescribe responsibly have been given some reassurance by their professional regulator, the General Medical Council (GMC).

"Professor Mike Barnes [from the Medical Cannabis Clinicians Society, or MCCS] wrote to the GMC to ask what would happen to a doctor who had done their research and prescribed within their competencies. The chief executive wrote back saying it would have no grounds to institute any action. What we must see is NICE and the GMC translating that support directly to doctors and trusts so doctors understand that they are supported if they make the clinical decision to prescribe."

Prescribing guidelines

With that in mind Dr Barron, who along with Professor Barnes is a co-founder of the MCCS, has drawn up prescribing guidelines to counterbalance what he sees as relatively restrictive official guidelines from NICE which limit use to a small number of patient groups with specific conditions or for prescription as a special medicine.

Dr Miller isn't convinced: "The idea of asking doctors to prescribe unlicensed substances on a large scale for chronic pain is unique. We need to know if we are going to be doing harm to the developing brain in young people, or a developing foetus unexpectedly exposed, particularly if they are using it for pain," he says.

The Royal College of Psychiatrists' position paper called for more high-quality RCTs. It backs calls by the research community for the MDA to be amended so that clinical trials of all types of cannabis can be carried out without a Home Office licence, of which the College says "that is costly and time-intensive to obtain".

Given what it calls the "global precedent" of CBMPs being sanctioned without trials, the College wants Government and patients' groups to pressure pharmaceutical companies to invest in research "or the evidence for the efficacy of CBMPs won't allow for a change in current practice around prescribing".

It also wants the potential adverse consequences of the mass-prescription of products containing THC to be explored, and says countries that have already allowed mass prescribing should share their clinical findings.

Taking the lead on research

If CBMPs are to become widespread, the College says clinicians need guidance on how to prescribe them effectively and safely, and any change in prescribing must be accompanied by a public education campaign where people are "informed of the potential health risks of cannabis use and discouraged from self-medication".

Eoin Keenan agrees there is a need to have a medical consensus on the effectiveness of CBMPs "and increased trials and data is the best way to get to that point".

"The head of Public Health England [Duncan Selbie] has suggested that private companies take the lead on establishing the

research on cannabis. If pharmaceutical companies can come in, help to fund more studies and standardise processes, then it's beneficial for patients and the industry as a whole," he says.

Long lead time

Given the long lead time for RCTs and the fact that patients are using illegal cannabis, TWENTY21 was launched in November 2019 by independent scientific body Drug Science. The organisation is led by the controversial former Government drugs policy adviser Professor David Nutt, who was sacked after publicly stating that ecstasy and LSD were less dangerous than alcohol.

By 2021 the project hopes to enrol 20,000 patients with a range of conditions to create the largest body of evidence for the effectiveness and tolerability of medical cannabis. "We hope that the findings will make a powerful case for NHS funding, by proving the favourable risk/benefit ratio of medical cannabis in seven key identified conditions," Drug Science said in a launch statement.

Given that projected global profits from CBMPs run into billions, Dr Miller was concerned at the urgency to extend prescribing and use. "I am a little concerned that this is a push to try to get something into a market without proper regulation or scrutiny. Clearly there is also the issue that a lot of people argue that medical cannabis is a lot better than opioids – again, it might be, but the evidence is very weak – we need to be careful about it."

He does not think that other countries have a better handle on cannabis medicines. While doctors are freer to prescribe in Holland, Germany, Denmark and Canada, he says this doesn't equate to evidence that it works and is safe.
"I have seen papers from across the world but very little of it is good quality evidence that would get licences."

Need for caution

Prof Goddard says that for very challenging conditions, such as childhood epilepsies, alternatives to RCTs are "not unreasonable." But he adds: "When it comes to common conditions such as chronic pain, where there are a large number of patients who can be tested on a large scale, RCTs should be done – particularly where the benefits are small and you need a clear answer."

In time Prof Goddard feels CBMPs will form part of the GP formulary. But he reiterates the need for caution. "Just because it is exciting and so many companies want to do it doesn't mean we should run before we can walk. People seem to think that as cannabis is a plant, it must be safe. But taxol, which we use to treat some cancers, is from the Pacific yew tree, and aspirin, which comes from willow bark, is perfectly capable of killing. We have to learn the lessons from previous drugs we thought were safe – like Thalidomide.

Click here to download 'Medical Cannabis and CBD: Challenges and opportunities' in full.

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