Integrating Medical Cannabis Into Palliative Care

A commentary on Briscoe J, et al. Top ten tips palliative care clinicians should know about medical cannabis. *J Palliat Med.* 2019;22(3):319-325.

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As the silver tsunami approaches and palliative care experts prepare for the rise in older patients, cannabis is poised to play a larger role in end-of-life care. With a growing number of states recently enacting medical marijuana and adult-use cannabis legislation, many patients entering palliative care may already be using cannabis or may request use of cannabis for symptom management.

The review article by Briscoe et al. presents an excellent overview of current evidence on the benefits and risks of cannabis use in the palliative care population, as well as the unknowns.[1]

Barriers to Medical Cannabis

The authors begin the review by discussing the legal issues surrounding cannabis, which is a primary concern regarding cannabis expressed by health care providers.[2-5] It is important to know state law as a first step before integrating cannabis use in clinical practice.

Whether I am educating a hospital practice, fellows, or a concierge group, the first barrier to medical cannabis use always is legality. Physicians are reluctant to sign their name recommending medical cannabis because of its Schedule I designation.

Perhaps, the second most common barrier for physicians is lack of knowledge about efficacy, data, research, potency/dosage information, titration, allergic reactions, adverse drug reactions, and potential drug–drug interactions.[2,6,7] However, medical literature is available to guide decisions on each of these topics.

In the palliative care setting, as well as in long-term care facilities and hospitals, providers are concerned about policy, storage, diversion, delivery systems, and cannabis disposal.[8] Additionally, in sick populations receiving palliative care, it is important to consider the impact of cannabis use on blood sugar in patients with diabetes and on blood pressure in patients with hypertension. Antidiabetic agents and antihypertensives may need to be re-dosed in patients initiating cannabis. Increased monitoring is recommended in these cases.

Benefits of Cannabis in Palliative Care

I have seen a number of advantages of cannabis use in patients with cancer in the palliative care setting. From personal experience these benefits seem to include reduced side effects of chemotherapy (eg, vomiting and pain), reduced need to increase chemotherapy dosing, improvements in physical/mental stress, as well as reduced anxiety or stress levels, particularly before chemotherapy sessions.[9-12] For example, a patient scheduled for chemotherapy on Friday may begin to feel anxious on Tuesday or Wednesday in anticipation of the side effects of treatment. Thus, by lessening this anxiety, cannabis use can change a patient's approach to the disease.

In addition to chemotherapy-induced nausea and vomiting, evidence also supports efficacy of cannabis use in neuropathic pain and anorexia associated with AIDS, according to Briscoe et al.[1] More research is needed on the efficacy of cannabis in the treatment of psychological conditions (such as anxiety and depression) and cancer-associated cachexia and anorexia. Clinically focused research in these areas could make medical cannabis products more reliable and predictable when used in the palliative care setting.

Importantly, cannabis patches and suppositories are available and may be a beneficial form of administration in the palliative care setting, particularly when used in cancer patients for pain management. For example, properly formulated suppositories bypass the first round of metabolism in the liver, helping to avoid potential drug–drug interactions, and exert systemic effects when entering the rectal mucosa. The result is greater bioavailability compared with oral administration as healing compounds spread quickly through nearby organs and into the bloodstream.[13] Additionally, suppositories that are formulated properly could be an effective way of potentially bypassing the "head high" psychoactive effects of delta-9-tetrahydrocannabinol (THC).

Policy Considerations at Long-Term Care Facilities

Patients whose symptoms are stable on cannabis and are receiving palliative care in the home setting, may have issues continuing their treatment when entering a long-term care facility or hospital that does not have a cannabis policy. Even if a physician at an inpatient facility is pro-cannabis, nurses may not want to sign off on dispensing cannabis because it is a Schedule I agent.[1]

Thus, it is important to find a palliative care group in which the entire care team has received training and education on cannabis and its uses, as well as the legal status of various products. All members of the interdisciplinary team must be educated on cannabis,

including the side effects, dosing, and delivery systems. Caregivers also play an important role in obtaining cannabis for the patient, as well as keeping a diary documenting which cannabis varieties and products were or were not effective, route of administration, and doses given to better individualize treatment decisions.

Palliative care providers seeking to integrate cannabis use into practice should work with their legal department to establish a written policy regarding cannabis use that includes information regarding storage, tracking, dispensing, and discarding of cannabis to prevent diversion. Also, facilities need to consider finding a cannabis-friendly hospital that also has a cannabis policy in case patients require a hospital transfer.

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—Luba Andrus, RPh, MJ

I ran into policy issues when conducting a small study on medical cannabis use at a memory care unit, where nurses initially refused to give cannabis to the patients. Fortunately, the director of nursing took full responsibility of the cannabis product at the facility, and kept the product locked in her office. Policy and procedure regarding cannabis use was written for staff, and cannabis products were given to patients by the director of nursing and nurses who volunteered to be a part of the study. The product could not be kept in a medication cart or in the patients' rooms freely.

Conclusion

The review article by Briscoe and colleagues presents a concise overview of medical cannabis as part of symptom-directed treatment regimens in the palliative care setting. Limitations of the review include a lack of information on the effects of cannabis on the cytochrome P450 system and avoiding drug–drug interactions in patients taking cannabis. While a recent review of drug–drug interactions was published by Cox et al, it may lack actionable information for many health care professionals.[14] Additionally, the review does not present information on cannabis patches or suppositories as alternative routes of administration in the palliative care population.

HELPFUL TIPS

Tips on Cannabis Use in Palliative Care[1]

1. Check with local laws and regulations regarding medical cannabis
2. Ask about cannabis use when conducting a comprehensive pain assessment
3. Medical cannabis may be useful to treat
   - Neuropathic pain
   - Chemotherapy-induced nausea and vomiting
   - Anorexia associated with AIDS
4. Evidence on cannabis use is limited and/or varied for
   - Psychiatric conditions
   - Cancer-associated cachexia and anorexia
5. Smoking medical cannabis is not linked to lung cancer or chronic lung disease risk, but may have side effects
6. Evidence supporting use of cannabis for treating seizures is growing, particularly in pediatric epilepsy
7. Driving under the influence of cannabis is linked to increased risk for motor vehicle collisions
   - Whether this risk extends to medical cannabis is unclear
   - Check state laws on what legally constitutes impairment (eg, presence of THC or THC metabolite)
   - It is unclear how long to wait to drive after taking medical cannabis; a period of at least several hours may be warranted

Source: Briscoe J, et al. *J Palliat Med.* 2019;22(3):319-325.

References

1. Briscoe J, Kamal AH, Casarett DJ. Top ten tips palliative care clinicians should know about medical cannabis. *J Palliat Med.* 2019.22(3)319-325.
2. Hewa-Gamage D, Blaschke S, Drosdowsky A, Koproski T, Braun A, Ellen S. A cross-sectional survey of health professionals' attitudes toward medicinal cannabis use as part of cancer management. *J Law Medicine.* 2019;26(4):815-824.
3. Kaplan L, Klein T, Wilson M, Graves J. Knowledge, practices, and attitudes of Washington state health care professionals regarding medical cannabis. *Cannabis Cannabinoid Res.* 2019. doi:10.1089/can.2019.0051
4. Rosenberg J, Loflin M, Hurd YL, Bonn-Miller MO. Prescribing health care providers' attitudes, experiences, and practices surrounding cannabis use in patients with anxiety disorders and post-traumatic stress disorder. *Cannabis Cannabinoid Res.* 2019;4(2):124-130. doi:10.1089/can.2018.0008
5. Reece S, Holle L, Mukherjee K. Survey of pharmacists' knowledge of Connecticut's medical cannabis program. *Cannabis Cannabinoid Res.* 2019. doi:10.1089/can.2019.0013
6. Philpot LM, Ebbert JO, Hurt RT. A survey of the attitudes, beliefs and knowledge about medical cannabis among primary care providers. *BMC Fam Pract.* 2019;20(1):17.
7. Takakuwa KM, Mistretta A, Pazdernik VK, Sulak D. Education, knowledge, and practice characteristics of cannabis physicians: a survey of the society of cannabis clinicians. *Cannabis Cannabinoid Res.* 2019. http://doi.org/10.1089/can.2019.0025
8. Palace ZJ, Reingold DA. Medical cannabis in the skilled nursing facility: a novel approach to improving symptom management and quality of life. *J Am Med Dir Assoc.* 2019;20(1):94-98.
9. Mortimer T, Mabin T, Engelbrecht A-M. Cannabinoids: the lows and the highs of chemotherapy-induced nausea and vomiting. *Future Oncol.* 2019;15(9):1035-1049.
10. Portman D, Donovan KA. Age-related differences in cannabis use by cancer patients referred for supportive care. *J Clin Oncol.* 2019;37(suppl 31):104-104.
11. Donovan KA, Chang YD, Oberoi-Jassal R, et al. Relationship of cannabis use to patient-reported symptoms in cancer patients seeking supportive/palliative care. *J Palliat Med.* 2019;22(10):1191-1195.
12. Kleckner AS, Kleckner IR, Kamen CS, et al. Opportunities for cannabis in supportive care in cancer. *Ther Adv Med Oncol.* 2019;11:175883591986636.
13. Grotenhermen F. Cannabinoids for therapeutic use. *Am J Drug Deliv.* 2004;2(4):229-240.
14. Cox EJ, Maharao N, Patilea-Vrana G, et al. A marijuana-drug interaction primer: precipitants, pharmacology, and pharmacokinetics. *Pharmacol Ther.* 2019;201:25-38.

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