A painful lesson: Are we repeating previous mistakes in pain management?

The idea that cannabis could be an alternative to opioids in the treatment of pain is clearly attractive and one that is gaining attention. The United States has witnessed a significant rise in opioid related deaths over the last decade, where restricting the use of prescribed opioids has resulted in many people sourcing these opioids elsewhere including the illicit market 1. For many patients their journey to opioid dependency started when they were introduced to these drugs as a result of surgery or as a way of managing acute and chronic pain 2.

There is clearly an incentive to find an alternative drug that has a lower risk of overdose or developing a dependency. But could cannabis or the group of compounds known as cannabinoids be a safer and more effective alternative?

The answer according to Campbell and colleagues3 seems straightforward: cannabis did not reduce pain for the patients included in their prospective cohort study. Nor did it reduce their use of opioid medication. However, there are of course limitations to these observational findings. Although participants were asked about how many days they used cannabis we don’t know if some people used once in a day or more than once. Any proof of concept, pharmaceutical trial or licencing approval for a drug would need this detail to establish how often a drug should be taken. Likewise we don’t know what type of cannabis the participants used in this study. This matters as cannabis varies in strength 4 and as with any analgesia the dose needs to be matched to the severity of pain experienced. The lack of information about the type and strength of cannabis is a common problem across all cannabis research 5. This could be improved by a standard assessment instrument based on an agreed measure of cannabis strength, in the same way that alcohol by volume (ABV) is used to measure and describe the strength of alcohol.

The World Health Organisation recently reviewed the therapeutic potential of one particular cannabinoid - cannabidiol 6.Although this review appears to focus on the potential benefits in relation to epilepsy there is a brief mention of analgesia, however the evidence they suggest is ‘considerably less advanced’ than for epilepsy. In part the WHO review is in response to the increasing number of countries permitting access to cannabis for medicinal use. This regulatory change in itself can raise the expectations and hope for patients that cannabis is an effective treatment for their health problems including pain. We shouldn’t repeat the problems we now face with opioid prescribing, which originated from weak evidence that these drugs are effective in the management of chronic pain 7. One way forward would be to conduct a randomised controlled trial which investigates cannabis and its ability to control pain. Controlling and measuring the dose and type of cannabis used in such an experiment would be critical for any comparison study and for applying the findings in practice. Unless we learn from the history of opioids and their use, we run the risk of replicating a non-evidence based approach to pain, which will ultimately let down patients in need.

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