



ARTHRITIS **AND** **MEDICAL** **CANNABIS**



AmericansFor
SafeAccess

Advancing Legal Medical Marijuana Therapeutics and Research

A Note from Americans for Safe Access

We are committed to ensuring safe, legal availability of marijuana for medical uses. This brochure is intended to help doctors, patients and policymakers better understand how marijuana—or "cannabis" as it is more properly called—may be used as a treatment for people with serious medical conditions. This booklet contains information about using cannabis as medicine. In it you'll find information on:

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We recognize that information about using cannabis as medicine has been difficult to obtain. The federal prohibition on cannabis has meant that modern clinical research has been limited, to the detriment of medical science and the wellness of patients. But the documented history of the safe, medical use of cannabis dates to 2700 B.C. Cannabis was part of the American pharmacopoeia until 1942 and is currently available by prescription in the Netherlands and Canada.

Testimonials from both doctors and patients reveal valuable information on the use of cannabis therapies, and supporting statements from professional health organizations and leading medical journals support its legitimacy as a medicine. In the last few years, clinical trials in Great Britain, Canada, Spain, Israel, and elsewhere have shown great promise for new medical applications.

This brochure is intended to be a starting point for the consideration of applying cannabis therapies to specific conditions; it is not intended to replace the training and expertise of physicians with regard to medicine, or attorneys with regard to the law. But as patients, doctors and advocates who have been working intimately with these issues for many years, Americans for Safe Access has seen firsthand how helpful cannabis can be for a wide variety of indications. We know doctors want the freedom to practice medicine and patients the freedom to make decisions about their healthcare.

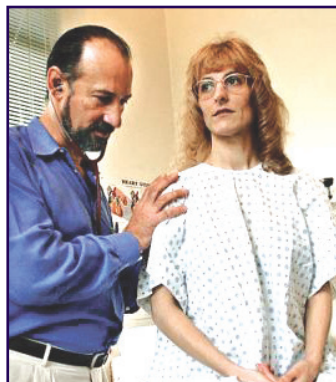
For more information about ASA and the work we do, please see our website at **AmericansForSafeAccess.org** or call **1-888-929-4367**.

Is Cannabis Legal to Recommend?

In 2004, the United States Supreme Court upheld earlier federal court decisions that doctors have a fundamental Constitutional right to recommend cannabis to their patients.

The history. Within weeks of California voters legalizing medical cannabis in 1996, federal officials had threatened to revoke the prescribing privileges of any physicians who recommended cannabis to their patients for medical use.¹ In response, a group of doctors and patients led by AIDS specialist Dr. Marcus Conant filed suit against the government, contending that such a policy violates the First Amendment.² The federal courts agreed at first the district level,³ then all the way through appeals to the Ninth Circuit and then the Supreme Court.

What doctors may and may not do. In *Conant v. Walters*,⁴ the Ninth Circuit Court of Appeals held that the federal government could neither punish nor threaten a doctor merely for recommending the use of cannabis to a patient.⁵ But it remains illegal for a doctor to "aid and abet" a patient in obtaining cannabis.⁶ This means a physician may discuss the pros and cons of medical cannabis with any patient, and issue a written or oral recommendation to use cannabis without fear of legal reprisal.⁷ This is true regardless of whether the physician anticipates that the patient will, in turn, use this recommendation to obtain cannabis.⁸ What physicians may not do is actually prescribe or dispense cannabis to a patient⁹ or tell patients how to use a written recommendation to procure it from a cannabis club or dispensary.¹⁰ Doctors can tell patients they may be helped by cannabis. They can put that in writing. They just can't help patients obtain the cannabis itself.



Angel Raich & Dr. Frank Lucido

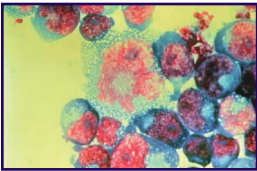
Patients protected under state, not federal, law. In June 2005, the U.S. Supreme Court overturned the *Raich v. Ashcroft* Ninth Circuit Court of Appeals decision. In reversing the lower court's ruling, *Gonzales v. Raich* established that it is legal under federal law to prosecute patients who possess, grow, or consume medical cannabis in medical cannabis states. However, this Supreme Court decision does not overturn or supersede the laws in states with medical cannabis programs.

For assistance with determining how best to write a legal recommendation for cannabis, please contact ASA at 1-888-929-4367.

Scientific Research Supports Medical Cannabis

Between 1840 and 1900, European and American medical journals published more than 100 articles on the therapeutic use of the drug known then as Cannabis Indica (or Indian hemp) and now simply as cannabis. Today, new studies are being published in peer-reviewed journals that demonstrate cannabis has medical value in treating patients with serious illnesses such as AIDS, glaucoma, cancer, multiple sclerosis, epilepsy, and chronic pain.

The safety of the drug has been attested to by numerous studies and reports, including the LaGuardia Report of 1944, the Schafer Commission Report of 1972, a 1997 study conducted by the British House of Lords, the Institutes of Medicine report of 1999, research sponsored by Health Canada, and numerous studies conducted in the Netherlands, where cannabis has been quasi-legal since 1976 and is currently available from pharmacies by prescription.



T cells

Recent published research on CD4 immunity in AIDS patients found no compromise to the immune systems of patients undergoing cannabis therapy in clinical trials.¹¹

The use of medical cannabis has been endorsed by numerous professional organizations, including the American Academy of Family Physicians, the American Public Health Association, and the American Nurses Association. Its use is supported by such leading medical publications as The New England Journal of Medicine and The Lancet.

Recent Research Advances

While research has until recently been sharply limited by federal prohibition, the last few years have seen rapid change. The International Cannabinoid Research Society was formally incorporated as a scientific research organization in 1991. Membership in the Society has more than tripled from about 50 members in the first year to over 500 in 2010. The International Association for Cannabis as Medicine (IACM) was founded in March 2000. It publishes a bi-weekly newsletter and the IACM-Bulletin, and holds a bi-annual symposium to highlight emerging research in cannabis therapeutics. In 2001, the State of California established the Center for Medicinal Cannabis Research to coordinate an \$8.7-million research effort at University of California campuses. As of 2010, the CMCR had completed six of 14 approved studies. Of those, five published double-blind, placebo-controlled studies studied pain relief; each showed cannabis to be effective.

In the United Kingdom, GW Pharmaceuticals has been conducting clinical trials with its cannabis-based medicine for the past decade. GW's Phase II

and Phase III trials of cannabis-based medicine show positive results for the relief of neurological pain related to: multiple sclerosis (MS), spinal cord injury, peripheral nerve injury (including peripheral neuropathy secondary to diabetes mellitus or AIDS), central nervous system damage, neuroinvasive cancer, dystonias, cerebral vascular accident, and spina bifida. They have also shown cannabinoids to be effective in clinical trials for the relief of pain and inflammation in rheumatoid arthritis and also pain relief in brachial plexus injury.

As of December 2010, the company has obtained regulatory approval in Spain, New Zealand, and the UK for Sativex®

Oromucosal Spray, a controlled-dose whole-plant extract. Sativex® was approved in Canada for symptomatic relief of neuropathic pain in 2005, in 2007 for patients with advanced cancer whose pain is not fully alleviated by opioids, and in 2010 for spasticity related to multiple sclerosis. Sativex has been made available either for named patient prescription use or for clinical trials purposes in a total of 22 countries. In the US, GW was granted an import license for Sativex® by the DEA following meetings in 2005 with the FDA, DEA, the Office for National Drug Control Policy, and the National Institute for Drug Abuse. Sativex® is currently an investigational drug in FDA-approved clinical trials as an adjunctive analgesic treatment for patients with advanced cancer whose pain is not relieved by strong opioids.

INSTITUTE OF MEDICINE

"Nausea, appetite loss, pain and anxiety . . . all can be mitigated by marijuana.... For patients, such as those with AIDS or undergoing chemotherapy, who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad spectrum relief not found in any other single medication."

**Marijuana and Medicine:
Assessing the Science Base, 1999**

CANNABIS AND ARTHRITIS

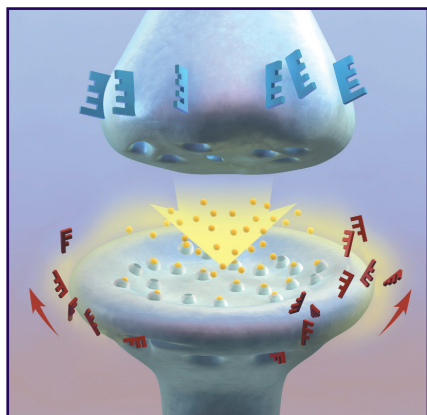
More than 31 million Americans suffer from arthritis. There are two main types of arthritis: rheumatoid arthritis and osteoarthritis. Both affect the joints, causing pain and swelling, and limiting movement.

Rheumatoid arthritis (RA) is caused by a malfunction of the immune system. Instead of fighting off intruders such as bacteria or viruses, the body attacks the synovial membranes, which facilitate the movement of joints, eventually destroying cartilage and eroding bones. Rheumatoid arthritis is most common among the aged, whose immune systems are no longer as robust or efficient as they were when younger.

Osteoarthritis (OA), or arthritis of the bones, is also found primarily among the elderly, where cartilage has been worn away through many years of use. Arthritis may also manifest as chronic inflammation of the joints as the

result of injuries. OA is the most common form of arthritis, affecting more than 10 million people worldwide. Currently, no drugs are available to treat or modify this disease, and treatment is primarily focused around the use of pain killers, which often have limited benefits and hazardous side effects.

An important aspect of arthritis pathology relates to maintaining healthy bone. As people age, bones undergo extensive remodelling, which can lead to destruction or functional degradation of synovial joints. Drugs which can not only modulate pain from arthritis but also protect bones are of great importance.



CB1 receptor

Cannabis and cannabinoids represent a promising treatment which can reduce arthritic pain and inflammation and positively modulate bone growth and maintenance. It has already been demonstrated that cannabinoids can effectively treat some types of arthritic pain, but recent evidence suggests that the cannabinoids are also important for bone growth and maintenance throughout life.¹²⁻¹⁷

The importance of cannabinoids in bone health has been established in transgenic mice that are missing either the CB1 or CB2 receptor. These mice develop osteoporosis much more quickly than normal or wild mice. Research has recently shown that mice missing both cannabinoid receptors have extremely weak bones, a condition that underlies osteoporosis and osteoarthritis pathology.¹⁸⁻²⁰

Based on genetic screening techniques, a correlation between cannabinoids and bone is emerging in humans as well. Three studies in three distinct ethnic groups have demonstrated that mutations in the type 2 cannabinoid receptor correlate to bone diseases. One study even showed that hand bone strength weakness is very well correlated with dysfunctional/mutant CB2 receptors.

Arthritis of any type can be an extremely painful and debilitating condition that presents challenges for pain management. The use of cannabis as a treatment for musculo-skeletal pain in western medicine dates to the 1700s.²¹⁻²² Evidence from recent research suggests that cannabis-based therapies are effective in the treatment of arthritis and the other rheumatic and degenerative hip, joint and connective tissue disorders. Since these are frequently extremely painful conditions, the well-documented analgesic properties of cannabis make it useful in treating the pain associated with arthritis, both

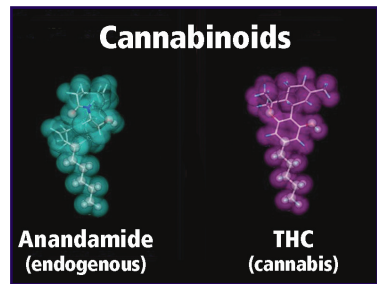
on its own and as an adjunct therapy that substantially enhances the efficacy of opioid painkillers.

Cannabis has also been shown to have powerful immune-modulation and anti-inflammatory properties,²³⁻²⁶ suggesting that it could play a role not just in symptom management but treatment of arthritis. In fact, one of the earliest records of medical use of cannabis, a Chinese text dating from ca. 2000 BC, notes that cannabis "undoes rheumatism," suggesting its anti-inflammatory and immune modulating effects were known even then.²⁷

Modern research on cannabidiol (CBD), one of the non-psychoactive cannabinoid components of cannabis, has found that it suppresses the immune response in mice and rats that is responsible for a disease resembling arthritis, protecting them from severe damage to their joints and markedly improving their condition.²⁸⁻²⁹

Human studies have repeatedly shown cannabis to be an effective treatment for rheumatoid arthritis, and it is one of the enumerated conditions for which many states allow legal medical use. Cannabis has a demonstrated ability to improve mobility and reduce morning stiffness and inflammation. Research has also shown that patients are able to reduce their usage of potentially harmful Non-Steroidal Anti-Inflammatory drugs (NSAIDs) when using cannabis as an adjunct therapy.³⁰⁻³¹

Medical researchers at Hebrew University in Jerusalem found that when cannabidiol is metabolized, one result is the creation of a compound with potent anti-inflammatory action comparable to the drug indomethacin, but without the considerable gastrointestinal side effects associated with that drug.³²

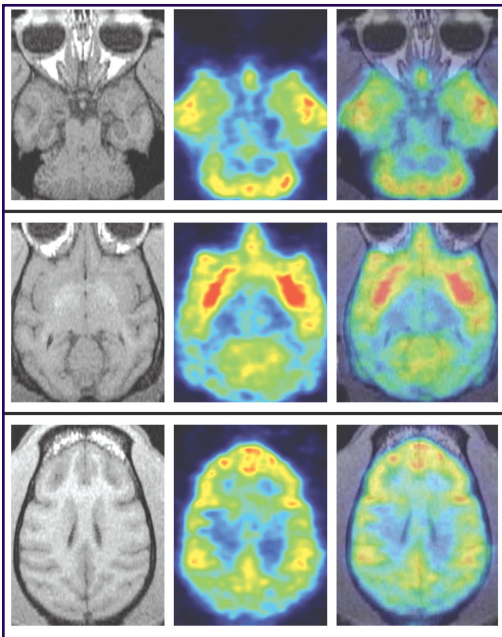


In addition, when the body metabolizes tetrahydrocannabinol (THC), one of the primary cannabinoid components of cannabis, it produces a number of related chemicals. At least one of these metabolites has anti-inflammatory and pain-relieving effects. By modifying this metabolite, researchers have produced a synthetic carboxylic acid known as CT-3 (also called dimethylheptyl-THC-11 oic acid or DMH-11C), which is more powerful than the natural metabolite itself, and thus can be given in smaller doses. Animal tests found CT-3 effective against both chronic and acute inflammation, and it also prevented destruction of joint tissue from chronic inflammation.

The remarkable 5,000-year safety record of cannabis—there has never been a recorded death from an overdose—and the fact that a metabolite with the desired anti-inflammatory effect is produced in the body when cannabis

is used, indicates that the development of targeted, safe, and effective anti-inflammatory drugs in this class are possible.³³ CT3 has also demonstrated considerable analgesic effects in animals. In some cases, the dose-dependent effect of THC was equivalent to morphine, but with a much greater duration of action and far less toxicity.³⁴⁻³⁵

In contrast to the NSAIDs commonly prescribed arthritis sufferers, CT3 did not cause ulcers at therapeutically effective doses. Moreover, it does not depress respiration, produce dependence, induce body weight loss, or cause



Cannabinoid receptors in the brain

mutations, as many commonly prescribed drugs do. Studies on its mechanism of action are currently underway, with cytokine synthesis one of the pathways being studied.³⁶

Cannabis may also help combat rheumatoid arthritis through its well-recognized immune-modulation properties.³⁷ Rheumatoid arthritis is characterized by dysregulation of the immune system in response to an initial infection or trauma. Over-activity of the immune system's B-cells causes antibodies to attack and destroy the synovial tissues located in the joint.

The immuno-modulatory properties of a group of fats found in cannabis, known as sterols and sterolins, have been used as natural

alternatives to conventional rheumatoid arthritis treatments that employ highly toxic drugs to either suppress the entire immune response of the body or to palliate pain and the inflammatory process without correcting the underlying immune dysfunction.

Cytokines play a role in either fuelling or suppressing the inflammation that causes damage in rheumatoid arthritis and some other diseases. The release of selected cytokines is impaired by cannabis, but the findings differ by cell type, experimental conditions, and especially the concentration of the cannabinoids examined.³⁸⁻⁴¹ A sterol/sterolin combination has been experimentally demonstrated to reduce the secretion of the pro-inflammatory cytokines controlled by the TH2 helper cells and to increase the number of TH helper cells that regulate the secretion of antibodies from the B cells. This selective activation and inhibition of the immune system results in an

effective control of the dysfunctional auto-immune response.

Similarly, ajulemic acid (another non-psychoactive cannabinoid) has been found to reduce joint tissue damage in rats with adjuvant arthritis.⁴² Tests on human tissue done in vitro showed a 50% suppression of one of the body's chemicals (interleukin-1beta) central to the progression of inflammation and joint tissue injury in patients with rheumatoid arthritis.⁴³

Conventional Arthritis Medications

Over 100 medications are listed by the Arthritis Foundation website for use with arthritis or other related conditions, such as fibromyalgia, psoriasis, osteoporosis and gout. These medicines include aspirin, ibuprofen and other oral and topical analgesics that dull pain. The most commonly used analgesic, **acetaminophen** (aspirin-free Anacin, Excedrin, Panadol, Tylenol) is usually not associated with side effects, though long-term use of acetaminophen is thought to be one of the common causes of end-stage renal disease.. To effectively control arthritis, **aspirin** must be taken in large, continuous doses (1000-5400 mg daily), which can cause stomach pain or damage; it is believed to cause more than 1,000 deaths annually in the United States. For that reason, some doctors prescribe one of several chemical variations referred to as **nonacetylated salicylates**, such as CMT, Tricosal, and Trilisate, which can cause deafness or ringing in the ears in large doses.



Much stronger analgesics are also prescribed for arthritis, sometimes along with acetaminophen.

These are: **codeine** (Dolacet, Hydrocet, Lorcet, Lortab); morphine (Avinza, Oramorph); **oxycodone** (Vicodin, Oxycontin, Roxicodone); **propoxyphene** (Percocet, Darvon, Darvocet) and **tramadol** (Ultram, Ultracet). These medicines can cause psychological and physical dependence, as well as constipation, dizziness, lightheadedness, mood changes, nausea, sedation, shortness of breath and vomiting. Taking high doses or mixing with alcohol can slow down breathing, a potentially fatal condition.

Analgesics don't treat the inflammation that can cause severe arthritis pain. For inflammation, steroids, NSAIDs and newer COX-2 inhibitors are prescribed. **Corticosteroids** (Cortisone), **prednisone** and related medications can cause bruising, cataracts, elevated blood sugar, hypertension, increased appetite, indigestion, insomnia, mood swings, muscle weakness, nervousness or restlessness, osteoporosis, susceptibility to infection and thin skin.

Twenty NSAIDs are available with a doctor's prescription, with three of those also available over the counter. They are **diclofenac** (Arthrotec, Cataflam, Voltaren); **diflunisal** (Dolobid); **etodolac** (Lodine); **fenoprofen calcium** (Nalfon); **flurbiprofen** (Ansaid); **ibuprofen** (Advil, Motrin IB, Nuprin);

indomethacin (Indocin); **ketoprofen** (Orudis); **meclufenamate sodium** (Meclomen); **mefenamic acid** (Ponstel); **meloxicam** (Mobic); **nabumetone** (Relafen); **naproxen** (Naprosyn, Naprelan); **naproxen sodium** (Anaprox, Aleve); **oxaprozin** (Daypro); **piroxicam** (Feldene); **sulindac** (Clinoril); and **olmetin sodium** (Tolectin).

Side effects of NSAIDs include abdominal or stomach cramps, edema (swelling of the feet), pain or discomfort, diarrhea, dizziness, drowsiness or lightheadedness, headache, heartburn or indigestion, nausea or vomiting, gastric ulcers, stomach irritation, bleeding, fluid retention, and decreased kidney function. This is because NSAIDs act on arthritis by inhibiting

prostaglandins, which protect the stomach lining, promote clotting of the blood, regulate salt and fluid balance, and maintain blood flow to the kidneys. The gastrointestinal complications of NSAIDs are the most commonly reported serious adverse drug reaction, though NSAIDs are reported to cause more than 7,600 deaths and 0,000 hospitalizations annually.

FEDERATION OF AMERICAN SCIENTISTS

"Based on much evidence, from patients and doctors alike, on the superior effectiveness and safety of whole cannabis compared to other medications,... the President should instruct the NIH and the FDA to make efforts to enroll seriously ill patients whose physicians believe that whole cannabis would be helpful to their conditions in clinical trials"

FAS Petition on Medical Marijuana, 1994

The newer group of arthritis drugs is known as cyclo-oxygenase-2 inhibitors (COX-2), which include **Celebrex**, **Bextra** and **Vioxx**. These medications have the same side effects as NSAIDs, except they are less likely to cause bleeding stomach ulcers and increase susceptibility to bruising or bleeding.

Non-selective NSAIDs have been associated with an increased risk of congestive heart failure. Less is known or has been concluded about the cardiovascular effects of COX-2 inhibitors, though a retrospective analysis of the risk of hospital admission for heart failure done by the Institute for Clinical Evaluative Sciences in Toronto, Canada suggests some may have serious side effects. The study of 130,000 older patients found that those using Vioxx had an 80% increased risk of hospital admission for congestive heart failure. Those using non-selective NSAIDs had a 40% increased risk, and those using Celebrex had the same rate of heart failure as people who had never used NSAIDs.

Antipyretic and anti-inflammatory effects of NSAIDs can mask the signs and symptoms of infection. Their use can interfere with the pharmacologic control of hypertension and cardiac failure in patients who take beta-adrenergic antagonists, angiotensin-converting enzyme inhibitors, or diuretics. Long-term use may damage chondrocyte (cartilage) function.

About 60% of patients will respond to any single NSAID. Approximately 10% of rheumatoid arthritis patients will not respond to any NSAID. Biologic response modifiers such as **adalimumab** (Humira); **etanercept** (Enbrel); **infliximab** (Remicade), and **anakinra** (Kineret) are prescribed to either inhibit or supplement the immune system components called cytokines. Rare reports of lupus (with such symptoms as rash, fever and pleurisy) have been linked to treatment with adalimumab, etanercept and infliximab. Lupus symptoms resolve when the medication is stopped. Multiple sclerosis has rarely developed in patients receiving biologic response modifiers. Seizures have been reported with etanercept.

Cannabis: By comparison, the side effects associated with cannabis are typically mild and are classified as "low risk." Euphoric mood changes are among the most frequent side effects. Cannabinoids can exacerbate schizophrenic psychosis in predisposed persons. Cannabinoids impede cognitive and psychomotor performance, resulting in temporary impairment. Chronic use can lead to the development of tolerance. Tachycardia and hypotension are frequently documented as adverse events in the cardiovascular system. A few cases of myocardial ischemia have been reported in young and previously healthy patients. Inhaling the smoke of cannabis cigarettes induces side effects on the respiratory system. Cannabinoids are contraindicated for patients with a history of cardiac ischemias. In summary, a low risk profile is evident from the literature available. Serious complications are very rare and are not usually reported during the use of cannabinoids for medical indications.

Is cannabis safe to recommend?

"The smoking of cannabis, even long term, is not harmful to health...." So began a 1995 editorial statement of Great Britain's leading medical journal, *The Lancet*. The long history of human use of cannabis also attests to its safety—nearly 5,000 years of documented use without a single death. In the same year as the *Lancet* editorial, Dr. Lester Grinspoon, a professor emeritus at Harvard Medical School who has published many influential books and articles on medical use of cannabis, had this to say in an article in the *Journal of the American Medical Association* (1995):

"One of marijuana's greatest advantages as a medicine is its remarkable safety. It has little effect on major physiological functions. There is no known case of a lethal overdose; on the basis of animal models, the ratio of lethal to effective dose is estimated as 40,000 to 1. By comparison, the ratio is between 3 and 50 to 1 for secobarbital and between 4 and 10 to 1 for ethanol. Marijuana is also far less addictive and far less subject to abuse than many drugs now used as muscle relaxants, hypnotics, and analgesics. The chief legitimate concern is the effect of smoking on the lungs. Cannabis smoke carries even more tars and other particulate matter than tobacco smoke. But the amount smoked

is much less, especially in medical use, and once marijuana is an openly recognized medicine, solutions may be found; ultimately a technology for the inhalation of cannabinoid vapors could be developed."

The technology Dr. Grinspoon imagined in 1995 now exists in the form of "vaporizers," (which are widely available through stores and by mail-order) and recent research attests to their efficacy and safety. 44 Additionally, pharmaceutical companies have developed sublingual sprays and tablet forms of the drug. Patients and doctors have found other ways to avoid the potential problems associated with smoking, though long-term studies of even the heaviest users in Jamaica, Turkey and the U.S. have not found



Angel Raich using a vaporizer in the hospital

increased incidence of lung disease or other respiratory problems. A decade-long study of 65,000 Kaiser-Permanente patients comparing cancer rates among non-smokers, tobacco smokers, and cannabis smokers found that those who used only cannabis had a slightly lower risk of lung and other cancers as compared to non-smokers.⁴⁵ Similarly, a study comparing 1,200 patients with lung, head and neck cancers to a matched group with

no cancer found that even those cannabis smokers who had consumed in excess of 20,000 joints had no increased risk of cancer.⁴⁶

As Dr. Grinspoon notes, "the greatest danger in medical use of marijuana is its illegality, which imposes much anxiety and expense on suffering people, forces them to bargain with illicit drug dealers, and exposes them to the threat of criminal prosecution." This was the conclusion reached by the House of Lords, which recommended rescheduling and decriminalization.

Cannabis or Marinol?

Those committed to the prohibition on cannabis frequently cite Marinol, a Schedule III drug, as the legal means to obtain the benefits of cannabis. However, Marinol, which is a synthetic form of THC, does not deliver the same therapeutic benefits as the natural herb, which contains at least another 60 cannabinoids in addition to THC. Recent research conducted by GW Pharmaceuticals in Great Britain has shown that Marinol is simply not as effective for pain management as the whole plant; a balance of cannabinoids, specifically CBC and CBD with THC, is what helps patients most. In fact, Marinol is not labeled for pain, only appetite stimulation and nausea control. But studies have found that many severely nauseated patients expe-

rience difficulty in getting and keeping a pill down, a problem avoided by use of inhaled cannabis.

Clinical research on Marinol vs. cannabis has been limited by federal restrictions, but a review of state clinical trials conducted in the 70's and 80's published in 2001 reports that "...the data reviewed here suggested that the inhalation of THC appears to be more effective than the oral route... Patients who smoked marijuana experienced 70-100% relief from nausea and vomiting, while those who used THC capsules experienced 76-88% relief."⁴⁷ Additionally, patients frequently have difficulty getting the right dose with Marinol, while inhaled cannabis allows for easier titration and avoids the negative side effects many report with Marinol. As the U.K. House of Lords report states, "Some users of both find cannabis itself more effective."

THE EXPERIENCE OF PATIENTS

Dorothy Gibbs

In 1911, at the age of one, I contracted the polio virus.... The early onset of polio caused permanent damage in my legs, spine, and back, resulting in significant weakness and atrophy in my legs. As a result, I have never been able to walk without the assistance of crutches and braces or a wheelchair. Approximately 30 years ago, my condition began to deteriorate. I began to suffer from increasing levels of pain and weakness in my legs and back as well as severe osteoarthritis in my hands, arms, and joints. Over time, my deteriorating medical condition has been exacerbated by my pain, leaving me increasingly immobilized....

By May, 1996, my physician [Dr. Arnold Leff, M.D.] had tried various prescription medications to relieve my pain, including: Tylenol #3, Ultram, Daypro, Tegretol, Soma, Valium, steroid injections into the trigger point, Dilantin, Duragesic, Zofran and Comapazine for the nausea caused by the opioid pain relievers, and Doloboid and Lodine as nonsteroids. Nothing seemed to work, and the pain persisted. I was growing increasingly depressed by the inability of anything to relieve my pain....

During this period it was clear to me, my caretaker and my physician that nothing was working to combat my pain. My caretaker, Pat, had heard of the success some people experience with the medicinal use of marijuana for pain management. Sometime during the end of 1997, she obtained a sample for me. Although I had never used marijuana in my previous eighty-seven years of life, I was willing to try anything that could alleviate even part of the pain.

The relief I experienced from medical marijuana was almost immediate. I was so pleased with the result that I wrote to Dr. Leff about my use of med-

ical marijuana and we talked about the benefits of the medicine. Dr. Leff examined me and noted that medical marijuana helped me experience less chronic pain and nausea, leading him to recommend medical marijuana as part of my daily pain care regimen....

Ever since trying medical marijuana, my life has drastically improved. Although chronic pain, related to my post-polio syndrome will always be a part of my life, medical marijuana had helped me manage this pain by providing fast and effective relief for my muscle spasms, acute pains, and arthritis....

Since I began using medical marijuana, my pain is no longer persistent or debilitating. When I do suffer from pain, I am usually able to "get ahead of it" by using medical marijuana and make it manageable....

Margaret

I am a 45-year-old granny, and I smoke marijuana for medicinal reasons. I was 25 when I was diagnosed with rheumatoid arthritis. The doctor told me it was a painful, crippling disease and I would end up in a wheel chair. He gave me prescriptions for the arthritis and pain and sleeping pills.

Some of the pills had side effects and I would have to change to different ones. My arthritis was getting worse and I was depressed all the time. I started taking anti-depressants. For years I abused codeine, anti-depressants and sleeping pills. I don't smoke tobacco or drink alcohol. My friends smoked marijuana but it didn't interest me to try it.

I smoked my first joint when I was 30. One night I was in a lot of pain and feeling terribly uncomfortable. My friend Ed was with me and said he had heard marijuana helps relieve pain. I was willing to try anything and had a few tokes. After a few minutes I was relaxed and the pain seemed to have dulled. I was also more limber with my joints. I had a very restful sleep that night. I have been smoking marijuana every day since then. I have also been happier and no longer need anti-depressants. I now control my pain with marijuana.

Alfred

I'm a 23-year-old male currently employed as an accounting assistant. This fall I began work on my Master's Degree. I am afflicted with Gout, a hereditary form of arthritis, which I have had for 6 years. When an attack arises the pain is in the main joint of my left foot and on the side of my big toe. When these attacks happen it is virtually impossible for me to walk.

I take Vicodin for the pain. I'm also given steroid shots for the pain in the doctor's office. In addition, I take Allopurinol, this helps my body to get rid

of the uric acid build up which leads to the pain of Gout. The reason that I have uric acid build up is because my kidneys do not function properly and rid my body of the uric acid.

The main side effects of Vicodin and Allopurinol are drowsiness, which are very bad if you are a full time college student and also employed. But, I have to have some kind of pain medicine to be able to walk, I have learned that marijuana helps a great deal with the pain, and I have found that I am able to walk and also function much better on marijuana than Vicodin. Allopurinol takes a terrible toll on my stomach. I would say 73% of the time I puke the medication up. I tried using marijuana in combination with the Allopurinol and I've found that this has helped drop the number of times that I throw the medication up. Now, I puke it up around 18% of the time, which is a big deal to me.

AMERICAN NURSES ASSOCIATION

In 2003 the American Nurses Association passed a resolution that supports those health care providers who recommend medicinal use, recognizes "the right of patients to have safe access to therapeutic marijuana/cannabis," and calls for more research and education, as well as a rescheduling of marijuana for medical use.

Matt Glandorf

I have arthritis in both hands and my chest, but here is the real kicker-- I am severely allergic to aspirin. I can't even take a Motrin without breaking out into a rash. I was born with a chest deformity called pectus excavatum (funnel chest and encaved chest are a couple other names for it.) I had corrective surgery in 1976 to try to make my rib cage bigger. In that surgery they break all the ribs and actually break the sternum in half, remove it, flip it over, and put it back together after removing most of the cartilage and muscle. Now I have arthritis along with lung problems and asthma. I usually spend two to three weeks a year in the hospital with lung infections and make numerous visits to the doctor for chest pain.

Needless to say, I have eaten a lot of pain killers and tried nerve blocks and so on. All have had little success and make me so stoned that I can't even drive a car. So I started using pot and went from four Vicodin a day to one, and with watching my activities and a healthy diet I can go with no doctor's meds for weeks on end.

Bob Burrill

I am a Canadian medical marijuana advocate. Osteoarthritis of the cervical spine is my problem. I have constant severe pain from many large bone spurs, compressed discs, and so on. Many narcotic and other types of pain

reduction prescriptions have been tried with limited success. I have self-medicated with marihuana for the past 7 or 8 months, under my doctor's care, with great success. My doctor and I have applied to the Canadian government to obtain a written ministerial exemption from prosecution so that I can cultivate and consume marijuana for a medical purpose.

Without medical marihuana, I have no life. I am restricted to bed or the couch and stuck inside the house. It's about time governments and the public alike awakened to the fact that this is not "Cheech and Chong medicine" but one of the safest and user-friendly herbs on the planet. I only wish I had tried it a lot sooner. I can't say enough about the merits and benefits of medical marijuana

THE EXPERIENCE OF DOCTORS

Ethan Russo, M.D.

Patients have long told us that cannabis has been helpful to them in the treatment of their arthritic conditions. Science has now demonstrated that the THC component of cannabis is a very effective analgesic (pain killer), and that the CBD (cannabidiol) component has unique immunomodulatory benefits as an antagonist of tumor necrosis factor-alpha, supporting benefits in treatment of rheumatoid arthritis, as well as Crohn's disease and psoriasis. It appears that cannabis-based medicines will likely be an important component of arthritis treatment in the 21st century.

Ethan Russo, MD, is a board-certified child and adult neurologist in Missoula, MT, and researcher in migraine, ethnobotany, medicinal plants, cannabis and cannabinoids in pain management. Dr. Russo currently serves in a consultancy position as Senior Medical Advisor to the Cannabinoid Research Institute, the division of GW Pharmaceuticals established to promote exploratory research. He holds faculty positions as adjunct associate professor in the Department of Pharmaceutical Sciences of the University of Montana, and clinical associate professor in the Department of Medicine of the University of Washington. He has published numerous articles in scientific journals and is co-editor of Cannabis and Cannabinoids: Pharmacology, Toxicology and Therapeutic Potential. Dr. Russo is the founding editor of Journal of Cannabis Therapeutics.

Arnold S. Leff, M.D.

I currently treat at least 20 patients for whom I believe marijuana is medically appropriate in responding to treatment-induced nausea or for appetite stimulation. In my medical judgment, in some cases medical marijuana may be the only effective medicine.

Two of my patients, Hal Margolin and Dorothy Gibbs, have benefited tremendously from [medical cannabis]. Both suffer from chronic pain. Ms. Gibbs, who is 93 years old and who had not previously tried marijuana until joining WAMM, has found marijuana to be a highly effective analgesic for treating acute and chronic pain associated with post-polio syndrome and complications arising there from [including arthritis].

Ms. Gibbs turned to marijuana only after trying a wide range of conventional prescription pharmaceuticals and therapies prescribed by me, but to little or no avail. These treatments, including powerful and highly addictive opioid analgesics, either did not work, gradually lost their efficacy, or caused such debilitating side effects (particularly nausea and dizziness) that Ms. Gibbs found intolerable.

Ms. Gibbs is a good example of a patient who experiences episodic acute pain for which Marinol is too slow-acting and who, when stricken with acute pain, often requires the faster analgesic and antiemetic effects produced by smoked marijuana. I have been pleasantly surprised at the degree to which marijuana has afforded Ms. Gibbs relief from the agony that she suffered.

NEW ENGLAND JOURNAL OF MEDICINE

"A federal policy that prohibits physicians from alleviating suffering by prescribing marijuana to seriously ill patients is misguided, heavy-handed, and inhumane.... It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to prescribe morphine and meperidine to relieve extreme dyspnea and pain...there is no risk of death from smoking marijuana.... To demand evidence of therapeutic efficacy is equally hypocritical"

**Jerome P. Kassirer, MD, editor
N Engl J Med 336:366-367, 1997**

Dr. Leff has been an advisor on national drug control policy and public health to the administrations of Presidents Nixon, Ford and Carter. He has worked with the Department of Defense and State Department developing drug abuse programs in foreign countries and for U.S. military troops, and has consulted with local law enforcement officials on drug treatment. He served as Director of Health Services for Contra Costa County, California and has held teaching positions on the medical school faculties of the University of Cincinnati and the University of California.

Harvey L. Rose, M.D.

Both my research and my many years as a clinician have convinced me that marijuana can serve at least two important roles in safe and effective pain management. Ample anecdotal evidence and clinical observations, as well as significant research findings, strongly indicate that marijuana, for whatever reason, is often effective in relieving pain. This is true across a range of patient populations, including the elderly, the terminally ill seeking comfort

in their final days, young adults stricken with life-threatening conditions, and cancer patients unable to tolerate the devastating effects of potentially life-saving therapies. Marijuana is also widely recognized as an antiemetic that reduces the nausea and vomiting often induced by powerful opioid analgesics prescribed for chronic, severe pain, as well as the nausea, vomiting and dizziness which often accompany severe and/or prolonged pain. I

AMERICAN ACADEMY OF FAMILY PHYSICIANS

"The American Academy of Family Physicians [supports] the use of marijuana ... under medical supervision and control for specific medical indications."

1996-1997 AAFP Reference Manual

have had the benefit of consultations on this subject over many years with a range of treatment providers, including physicians, oncologists, pharmacologists, family practitioners, hospice workers, and pain specialists....

Specifically, I have found that cannabis can have an important opioid-sparing effect for pain patients. That is to say, that patients who are prescribed high doses of opioid analgesics can significantly reduce their reliance on these medications and improve their daily functioning by incorporating cannabis into their pain care regimen.

Marijuana not only has important analgesic properties but it also is an effective and important adjuvant therapy for patients suffering acute and/or chronic pain. No experienced and respected physician will deny that for such patients opioid therapy is central to palliative care. By the same token, the same experienced physicians will readily acknowledge that opioids often induce nausea and vomiting. For a number of pain patients, standard prescription antiemetics (e.g., Compazine, Zofran and Reglan) simply do not substantially reduce their nausea. For many, those medications are substantially less effective, or produce more debilitating side effects, than marijuana....

Quite simply, marijuana can serve much the same function for pain patients undergoing opiate therapy that it does for cancer patients undergoing chemotherapy: it suppresses the nausea and vomiting associated with treatment, and reduces the pain associated with prolonged nausea and retching, thereby increasing the chances that the patient will remain compliant with the primary treatment. With both chemotherapy and long-term pain management, failure to obtain and continue proper palliative and adjuvant care can have dire, even fatal, consequences....

Finally, it is important to note that in my clinical experience observing patients who ingest cannabis for relief from pain and nausea and/or to stimulate appetite, I have witnessed no adverse complications. By contrast, many of the first-line pharmaceuticals used to combat cancer, HIV/AIDS, and pain associated with these and other illnesses can induce a variety of iatrogenic

effects, including, in some instances, death. While patients may face serious legal implications related to their use of medical marijuana, as a physician I have yet to encounter a medical downside to their cannabinoid therapy...

[A]gainst the backdrop of a growing body of scientific research, the reports of myriad pain patients, and the burgeoning clinical experience of physicians like myself, it is my considered opinion that cannabis can constitute an acceptable and sometimes necessary medicine to alleviate the immediate suffering of certain patients.

Dr. Rose served as a medical officer in the Air Force before entering private practice. During his 40-year career, he has taught at UC Davis School of Medicine and consulted with state legislative bodies.

THE HISTORY OF CANNABIS AS MEDICINE

The history of the medical use of cannabis dates back to 2700 B.C. in the pharmacopoeia of Shen Nung, one of the fathers of Chinese medicine. In the west, it has been recognized as a valued, therapeutic herb for centuries. In 1823, Queen Victoria's personal physician, Sir Russell Reynolds, not only prescribed it to her for menstrual cramps but wrote in the first issue of *The Lancet*, "When pure and administered carefully, [it is] one of the of the most valuable medicines we possess."⁶¹

The American Medical Association opposed the first federal law against cannabis with an article in its leading journal.⁶² Their representative, Dr. William C. Woodward, testified to Congress that "The American Medical Association knows of no evidence that marihuana is a dangerous drug," and that any prohibition "loses sight of the fact that future investigation may show that there are substantial medical uses for Cannabis." Cannabis remained part of the American pharmacopoeia until 1942 and is currently available by prescription in the Netherlands and Canada.

Federal Policy is Contradictory

Federal policy on medical cannabis is filled with contradictions. Cannabis was widely prescribed until the turn of the century. Now cannabis is a Schedule I drug, classified as having no medicinal value and a high potential for abuse, yet its most psychoactive component, THC, is legally available as Marinol and is classified as Schedule III. But the U.S. federal government also grows and provides cannabis for a small number of patients today.

In 1976 the federal government created the Investigational New Drug (IND) compassionate access research program to allow patients to receive medical cannabis from the government. The application process was extremely complicated, and few physicians became involved. In the first twelve years the government accepted about a half dozen patients. The federal government

approved the distribution of up to nine pounds of cannabis a year to these patients, all of whom report being helped by it substantially.

In 1989 the FDA was deluged with new applications from people with AIDS, and 34 patients were approved within a year. In June 1991, the Public Health Service announced that the program would be suspended because it undercut the administration's opposition to the use of illegal drugs. The program was discontinued in March 1992 and the remaining patients had to sue the federal government on the basis of "medical necessity" to retain access to their medicine. Today, a few surviving patients still receive medical cannabis from the federal government, grown under a doctor's supervision at the University of Mississippi and paid for by federal tax dollars.

Despite this successful medical program and centuries of documented safe use, cannabis is still classified in America as a Schedule I substance. Healthcare advocates have tried to resolve this contradiction through legal and administrative channels. In 1972, a petition was submitted to reschedule cannabis so that it could be prescribed to patients.

The DEA stalled hearings for 16 years, but in 1988 their chief administrative law judge, Francis L. Young, ruled that, "Marijuana, in its natural form, is one of the safest therapeutically active substances known... It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance." The DEA refused to implement this ruling based on a procedural technicality and continues to classify cannabis as a substance with no medical use.

Widespread public support; state laws passed

Public opinion is clearly in favor of ending the prohibition of medical cannabis and has been for some time. A CNN/Time poll in November 2002 found that 80% of Americans support medical cannabis. The AARP, the national association whose 35 million members are over the age of fifty, released a national poll in December 2004 showing that nearly two-thirds of older Americans support legal access to medical marijuana. Support in the West, where most states that allow legal access are located, was strongest, at 82%, but at least 2 out of 3 everywhere agreed that "adults should be allowed to legally use marijuana for medical purposes if a physician recommends it."

The refusal of the federal government to act on this support has meant that patients have had to turn to the states for action. Since 1996, 15 states have removed criminal penalties for their citizens who use cannabis on the advice of a physician. Voters have passed medical cannabis ballot initiatives in 10 states plus the District of Columbia, while the legislatures in Hawaii, Maryland, New Jersey, New Mexico, Rhode Island, and Vermont have

enacted similar bills. Approximately one third of the U.S. population resides in a state that permits medical use, and medical cannabis legislation is introduced in more states every year.

Currently, laws that effectively remove state-level criminal penalties for growing and/or possessing medical cannabis are in place in Alaska, Arizona, California, Colorado, Hawaii, Maine, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia. Maryland has reduced the criminal penalty for medical use to a maximum \$100 fine. Thirty-six states have symbolic medical cannabis laws (laws that support medical cannabis but do not provide patients with legal protection under state law).

2005 U.S. Supreme Court ruling

In June 2005, the U.S. Supreme Court overturned a decision by a U.S. appeals court (*Raich v. Ashcroft*) that had exempted medical cannabis from federal prohibition. The 2005 decision, now called *Gonzales v. Raich*, ruled that federal officials may prosecute medical cannabis patients for possessing, consuming, and cultivating medical cannabis. But according to numerous legal opinions, that ruling does not affect individual states' medical cannabis programs, and only applies to prosecution in federal, not state, court.

Petitions for legal prescriptions pending

The federal Department of Health and Human Services (HHS) and the FDA are currently reviewing two legal petitions with broad implications for medical marijuana. The first, brought by ASA under the Data Quality Act, says HHS must correct its statements that there is no medical use for marijuana to reflect the many studies which have found it helpful for many conditions. Acknowledging legitimate medical use would then force the agency to consider allowing the prescribing of marijuana as they do other drugs, based on its relative safety.

A separate petition, of which ASA is a co-signer, asks the Drug Enforcement Administration for a full, formal re-evaluation of marijuana's medical benefits, based on hundreds of recent medical research studies and two thousand years of documented human use.

Legal Citations

1. See "The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200" (Dec. 30, 1996).
2. See *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997).
3. See *id.*; *Conant v. McCaffrey*, 2000 WL 1281174 (N.D. Cal. 2000); *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002).
4. 309 F.3d 629 (9th Cir. 2002).
5. *Id.* at 634-36.
6. Criminal liability for aiding and abetting requires proof that the defendant "insome sort associate[d]

himself with the venture, that he participate[d] in it as something that he wishe[d] to bring about, that he [sought] by his action to make it succeed." *Conant v. McCaffrey*, 172 F.R.D. 681, 700 (N.D. Cal. 1997) (quotation omitted). A conspiracy to obtain cannabis requires an agreement between two or more persons to do this, with both persons knowing this illegal objective and intending to help accomplish it. *Id.* at 700-01.

7. 309 F.3d at 634 & 636.

8. *Conant v. McCaffrey*, 2000 WL 1281174, at *16 (N.D. Cal. 2000).

9. 309 F.3d at 634.

10. See *id.* at 635; *Conant v. McCaffrey*, 172 F.R.D. 681, 700-01 (N.D. Cal. 1997).

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PROFESSIONAL ORGANIZATION ENDORSEMENTS

AIDS Action Council	French Ministry of Health
Alaska Nurses Association	Hawaii Nurses Association
American Academy of Family Physicians	Health Canada
American Medical Student Association	Kaiser Permanente
American Nurses Association	Lymphoma Foundation of America
American Preventive Medical Association	Mississippi Nurses Association
American Public Health Association	Multiple Sclerosis Society (Canada)
American Society of Addiction Medicine	National Acad. of Sciences Inst. of Medicine
Arthritis Research Campaign (UK)	National Association for Public Health Policy
Australian Medical Association	National Nurses Society on Addictions
Australian National Task Force on Cannabis	Netherlands Ministry of Health
Belgian Ministry of Health	New Jersey State Nurses Association
British House of Lords Select Committee	New Mexico Medical Society
British Medical Association	New Mexico Nurses Association
California Academy of Family Physicians	New York State Nurses Association
California Nurses Association	North Carolina Nurses Association
California Pharmacists Association	San Francisco Mayor's Summit on AIDS
Colorado Nurses Association	San Francisco Medical Society
Federation of American Scientists	Virginia Nurses Association
Florida Governor's Red Ribbon Panel on AIDS	Whitman-Walker Clinic
Florida Medical Association	Wisconsin Nurses Association

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DEA CHIEF ADMINISTRATIVE LAW JUDGE

Marijuana, in its natural form, is one of the safest therapeutically active substances known... It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance.

The Honorable Francis L. Young,
Ruling on DEA rescheduling hearings, 1988

ADDITIONAL RESOURCES

Americans for Safe Access maintains a website with additional resources for doctors and patients. There you will find the latest information on legal and legislative developments, new medical research, and what you can do to help protect the rights of patients and doctors.

With more than 45,000 active members and chapters and affiliates in all 50 states, ASA is the largest national member-based organization of patients, medical professionals, scientists, and concerned citizens promoting safe and legal access to cannabis for therapeutic uses and research.



Advancing Legal Medical Marijuana Therapeutics and Research

888-929-4367 www.AmericansForSafeAccess.org
1322 Webster Street, Suite 402, Oakland, California 94612