MEDICAL MARIJUANA UPDATE

by Rick Doblin, MAPS President

MARIJUANA is a substance that has been used medically for thousands of years. Recent archeological evidence shows that in the 4th century hashish was used to ease labor pains in a 14 year old girl. History notwithstanding, marijuana is considered by our legal system to be a Schedule 1 drug with no currently accepted medical use, no accepted safety for use under medical supervision, and a high potential for abuse. For over twenty years, physicians, researchers, lawyers and political activists have been struggling with the Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) in hopes of getting marijuana reclassified as a prescription drug. Nevertheless, marijuana is still not available by prescription (see related story in MAPS newsletter Spring,1992).

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"Those who insist marijuana has medical uses would serve society better by promoting or sponsoring more legitimate scientific research, rather than throwing their time, money, and rhetoric into lobbying, public relations campaigns and perennial litigation," stated Mr. Bonner, the administrator of the DEA, in a March, 1992 Federal Register opinion which sought to justify his ruling to prohibit prescription access to marijuana. As president of MAPS, I took part of his advice to heart and intensified my search for physicans interested in conducting research into the medical use of marijuana, just like I sought out Dr. Charles Grob and offered whatever assistance he needed to help him design, secure approval for, and conduct MDMA research (see FDA-approved protocol on page 2-3). Unlike Mr. Bonner, however, I also see the neccessity of lobbying, public relations campaigns and perennial litigation (which by the way the DEA has *always* lost). Still, I think the most important step to make marijuana available by prescription is exactly what Mr. Bonner recommends, to conduct additional FDA-approved scientific research exploring marijuana's medical risks and benefits.

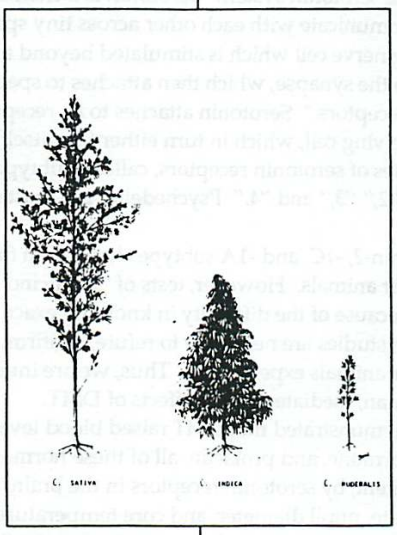
Finally my search has borne fruit, catalyzed by the arrest this summer of Mary Rathbun ("Brownie Mary") while she was baking 2 pounds of marijuana into brownies to give away free to AIDS and cancer patients. For many years, Mary had been a volunteer at San Francisco General Hospital's AIDS Ward. She had seen that marijuana brownies eased the nausea in cancer and AIDS patients and stimulated their appetites. Mary's arrest prompted me to call several doctors at San Francisco General to ask if any were willing to consider conducting research into the medical use of marijuana. One physician who knew "Brownie Mary", Dr. Donald Abrams, decided to consider getting involved. Dr. Abrams is one of the foremost AIDS reseachers in the country. He helps direct the Community Consortium, an association of Bay Area HIV Health Care Providers, and is on the faculty at the University of California, San Francisco.

FOR THE LAST several months, I have coordinated informal discussions between Dr. Abrams and FDA, NIDA, DEA and the White House Office of National Drug Control Policy concerning scientifically testing the medical use of marijuana in the treatment of HIV-related wasting syndrome. Concurrently, Dr. Abrams has secured approval to proceed with the study from the Consortium's Scientific Advisory Committee, Community Advisory Forum, and Executive Board.

The experiment he is considering will be a small pilot study lasting three months comparing weight gain and various safety and quality of life measures in about 20 patients who smoke marijuana and about 20 patients who receive oral THC pills

(Marinol). Previous research has already demonstrated that oral THC pills are effective in promoting weight gain in a significant number of patients. UNIMED, the company that markets Marinol, has successfully gotten the FDA to declare Marinol an Orphan Drug for the treatment of the wasting syndrome, triggering all sorts of financial incentives and FDA guidance.

Dr. Abrams expects to submit a protocol to the FDA within the next month or so, and a decision regarding permission is expected within 30 days thereafter. One main uncertainty at this time concerns securing a supply of high-THC content marijuana for the study so that the AIDS patients will need to inhale as little smoke as possible per unit of cannabanoids. For people whose immune systems are compromised, the less smoke the better. Marijuana, like all medicines, has side effects and it is wise to minimize them whenever possible. Unfortunately, the marijuana supplied to reseachers and patients by the National Institute on Drug Abuse (NIDA) from the government pot farm at the University of Mississippi is of poor quality with a low THC content of around 2-3%. The best NIDA can offer is a few kilos of 5% THC content marijuana.



YOU MAY HAVE HEARD the stories about today's marijuana being so much more powerful than that found twenty years ago (and therefore according to the goverment whatever you previously thought about pot is wrong). While there has always been high-THC content pot around, as well as hashish, it is not unheard of today for skilled growers to produce marijuana with a THC content in excess of 10% or more, with some buds containing 15% THC. Therefore, in the interests of the patients, I have requested that the DEA supply high-THC content marijuana for the experiment from seized supplies; I think my request is being taken seriously (although I would like to hear the discussions around the DEA water coolers about it!)

I have also begun a collaboration with Dale Gierenger of California NORML and Ed Rosenthal, national expert in marijuana cultivation and president of Quick Trading. We plan to study the constituents of marijuana smoke as it comes out of a waterpipe and also a vaporizer (THC vaporizes at about 180 degrees, less than it takes to burn marijuana). We are currently seeking scientific researchers interested in helping determine whether waterpipes and/or a vaporizor would reduce the particulate matter inhaled by the AIDS patients in the study. If successful, then we will have found a way to reduce what I suspect is the main health risk of marijuana, the effect of the smoke on the lungs. We estimate that this study will cost a mere $2,500. Ironically, for that tiny amount of money, we may generate more valuable information about minimizing the harms from smoking marijuana than has been generated in the entire last 25 years of the War on Drugs.

Securing the neccessary funding for the study is another remaining challenge. If you wish to help support this project, donations to MAPS may be earmarked for the medical marijuana study. ■

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