Cannabis and chronic pain

Brian Erickson, MD, has a perspective few, if any, physicians in Minnesota share regarding medical cannabis and pain. Erickson, medical director of Health East’s Pain Clinic in St. Paul, previously practiced in Vermont, where severe pain has been a qualifying condition for medical cannabis use since 2007. (Medical cannabis became legal in that state in 2004.)

Erickson saw patients at the University of Vermont’s pain clinic, where he certified some for medical cannabis use. With Minnesota’s Commissioner of Health recently adding intractable pain to the list of conditions for which patients will be able to obtain medical cannabis, Erickson shared his thoughts with Minnesota Medicine editor Kim Kiser.

You’re a psychiatrist. How did you get involved in treating patients with pain?

After medical school at the University of Minnesota and a psychiatry residency in Vermont, I practiced psychiatry in Duluth and worked with patients who had chronic pain and were taking antidepressants. We had a couple of psychologists in the group who did biofeedback and marriage and family therapy who also were working with patients who had chronic pain. It was something I wanted to learn more about because there is a lot of overlap between psychiatry and chronic pain. We set up a pretty involved chronic pain program at St. Mary’s Duluth Clinic in 1993.

About 14 years ago, I returned to Vermont to practice at the University of Vermont’s pain clinic. At the time, it was mostly anesthesiologists doing chronic pain treatment. I did a lot of medication management. During that time, I developed an interest in alternative and complementary therapies. A number of my patients had tried many different medications and found they weren’t satisfactory or helpful. I really wanted to have alternatives.

What was the sentiment in the medical community about medical cannabis when Vermont was considering legalizing it?

There was very little public discussion or input from medical providers compared with what I’ve experienced here in Minnesota. There was a feeling that if a person was on opioids, we didn’t want them to also be using marijuana. There was concern about addiction and misuse.

The law that ultimately passed in Vermont is a lot like Minnesota’s in that the cannabis became available in the form of a tincture that could be used under the tongue or be vaporized, and physicians had to certify that patients have one of the qualifying conditions, which included HIV, nausea, cancer, and later, chronic pain. One distinction was that the patient had to have a six-month relationship with the certifying doctor, so the doctor knew the patient and their condition.

Did your patients ask you about medical cannabis?

Some of my patients started reading about medical cannabis, doing their own research and asking about it. Many of them were very sheepish—middle-aged teachers who had never used marijuana in their life, people who didn’t want their kids knowing they were using it. These were people who were desperate and at the same time a little embarrassed. I ended up certifying between 60 and 80 pain patients for medical cannabis use during my time in Vermont.

Did it help their pain?

In my experience, patients ended up doing very well. Many of my patients were able to decrease or get off opioids entirely. One who was on 100 mg a day of methadone got off of it entirely. Another who was on 80 mg a day of oxycodone got off of it entirely. It was very helpful for patients with peripheral neuropathy, back pain and headaches, who weren't responding to other medications.

Were there problems with addiction? How did you monitor patients?

There was concern about addiction, especially for patients who were on suboxone. We didn’t want them using marijuana if they were in recovery with suboxone. But medical cannabis was different. The medical cannabis formulation used for chronic pain tends to be high CBD (cannabinoid) and low TCH (tetrahydrocannabinol). THC is the psychoactive part of the drug. The high CBD is thought to be helpful for pain and anxiety and nausea. So the formulation they were using wasn’t the sort...
of thing that would lead people to get high and have amotivational syndrome.

We would talk to patients’ family members, therapists and suboxone counselors and make sure we knew how they were doing. In general, their pain was better, their function was better and they were able to get off opioids. There wasn’t a problem with addiction, and I never heard from law enforcement about patients diverting it. The high-CBD, low-THC formulation wouldn’t have the street value a formulation with high THC would have.

**What are you hearing from your pain patients in Minnesota?**

My patients in Minnesota are very interested. Some have traveled to Colorado and California and used what’s available there. They found it helpful. I have a number of patients who, despite our best efforts with pharmacotherapy, acupuncture and physical therapy, don’t get the results they want. I do suspect they could get some benefit from medical cannabis.

**Have you shared your perspective with other clinicians? What were their thoughts?**

I talked about my experience at an MMA forum. A number of doctors were interested. Some had already certified their patients for other things. Others thought adding intractable pain was going to open doors to all kinds of problems and misuse. I can respect their opinions and concerns. Clearly, we should be concerned about adolescents and the developing brain, for example. Certainly, there is a risk for addiction to marijuana. But with the high-CBD, low-THC formulation, that risk should be relatively low. Some had concerns about patients using medical marijuana and driving. But we have those same concerns about patients who are on benzodiazepines and opioids.

**In Vermont, did they collect any data or do any studies about medical cannabis’ effect on pain?**

They weren’t doing any large-scale research on medical cannabis. So my information about the patients who got off opioids or decreased their opioid dose is anecdotal. However, a recent study from the University of Pennsylvania of 13 states that legalized medical cannabis reported a nearly 25 percent reduction in the annual opioid overdose mortality rate after the cannabis laws were enacted.

There’s a lot of fascinating work to be done with this. I think we’ll see some good work around medical cannabis and PTSD, and I think there are going to be some interesting immunological findings that come from this.

At the national level, those who talk about medical cannabis and chronic pain are really saying marijuana has to be changed from a Schedule 1 to a Schedule 2 drug so it can be appropriately studied and understood. I think that’s important, and it’s a far cry from legalizing it for recreational use.