

OREGON HEALTH DIVISION

ASSESSMENT WORKSHEET FOR EVALUATING PETITIONS TO EXPAND THE LIST OF "DEBILITATING MEDICAL CONDITIONS" UNDER THE OREGON MEDICAL MARIJUANA ACT

CONDITION _____ **DEPRESSION** _____
REVIEWED _____ **3/25/2000** _____

DATE

I. Consideration of Available Evidence

Description of Evidence Considered:

- Please note that the petition says "clinical depression" and anxiety but "anxiety condition" is addressed on a separate worksheet and only "depression condition" is addressed below.
- 1. Case Reports in books by psychiatrists Lester Grinspoon, MD [Marihuana: The Forbidden Medicine](#) (1997 Yale University Press) and Tod Mikuriya, MD [Marijuana Medical Handbook](#) (1997 Quick American Archives") and from patient interviews.
- 2. Toxicity issues come from several books in submitted bibliography from website http://www.teleport.com/~omr/omr_mmj_bibliography.html including [Marijuana Myths: Marijuana Facts: A Review of the Scientific Evidence](#) by Lynn Zimmer, PhD & John Morgan, MD (1997 The Lindesmith Center).
- 3. Historical Medical Literature from when Cannabis could be prescribed by American doctors (roughly 1840 to 1940) published in [Marijuana: Medical Papers 1839-1972](#) (1973 Medi-Comp Press) by psychiatrist Tod Mkuriya and also in the forthcoming [Handbook of Psychotropic Herbs](#) (2000 Haworth Press) by neurologist Ethan Russo.
- 4. Medline search, including "Do patients use marijuana as an antidepressant?" by Gruber et al from [Depression](#) 4(2): 77-80, 1996.
- 5. "Delta-9-Tetrahydrocannabinol in Depressed Patients" by Kotin et al from [Archives of General Psychiatry](#) 28: 345-348 (March 1973).

Clinical Effectiveness (and comparison with established alternatives):

Case reports, medical literature, and patient interviews indicate that cannabis is clinically effective for depression in some patients. Compared to an ideal antidepressant with 100% effectiveness and 0% side effect rate, cannabis would be a poor choice because of cannabis-related sedation and inconsistent benefits. Although cannabis may help, THC does not seem to benefit those with depression (very small study by Kotin). Since there is no treatment for depression that fulfills the ideal of 100% effective without side effects then one must be very reluctant to cast aside any potentially beneficial treatment in a disease like depression that has a natural history mortality rate around 15%.

Health Benefits and Risks:

Benefits seem to be improvement in the sadness, improvement in the appetite, improvement in sleep, decreased thoughts of worthlessness, and decreased obsession with suicidal thoughts in some patients. Risks of marijuana are primarily sedation and respiratory issues such as

bronchitis if large quantities are smoked chronically. However other dosage delivery systems such as vaporization and oral administration exist.

Factors Affecting Safety, Effectiveness, and Related Considerations for All Patients and for Specific Patient Types:

Sedating antidepressants are seldom preferred and this is one reason for the popularity of the new Selective Serotonin Reuptake Inhibitors (SSRI) class of antidepressants. Smoking is not a preferred delivery system and oral once daily agents are preferred. On the other hand, there are no antidepressants that are 100% effective or 100% side effect free. It would seem that cannabis would be an infrequently used option and very low on the list of choices and used only after other attempts have resulted in toxicity or therapeutic failure. However to total disregard for the option of cannabis could damage patients because the consequences of refractory depression are too often fatal.

Net Health and Overall Impact of Medical Marijuana Use for This Condition:

The net health and overall impact of medical marijuana for depression would be small because it would be used so infrequently and often temporarily while more standard antidepressants are administered. However for an individual patient with severe sadness, wasting, insomnia, and suicidal obsession with poor impulse control, a trial of cannabis may be life-saving.

Other Considerations:

The primary consideration in treating depression is to recognize that people die from this illness (natural history of death from suicide reported at ~ 15%). There are no documented cases of death from cannabis toxicity.

Access to health care and especially mental health care with counseling and prescription drug access is difficult for poor and nonurban patients. If cannabis works, it can be a very cheap option for those that would have no access to the full spectrum of modern psychiatric counseling and expensive pharmacology. Those who might otherwise remain untreated and possibly at risk of suicide might get some treatment that may prevent suicide.

II. Performance On Assessment Criteria

(1) **Quality and Sufficiency of Available Evidence:** *There is sufficient available evidence of sufficient quality to permit reaching a sound determination relating to the use of medical marijuana for the treatment of this condition.* Yes [] Possibly [] No [] NAD []

Comments:

Although the data is primarily historical and based on case reports, there are many sources over many years including recent case reports published by psychiatric experts. Moreover no one has been able to invalidate the efficacy of whole cannabis for small numbers of patients with depression.

(2) [A] **Clinical Effectiveness:** *The use of medical marijuana for this condition is clinically effective.* Yes [] Possibly [**x**] No [] NAD []

Comments:

The use of medical marijuana for depression has been clinically effective for a small number of select individuals with prior toxicity and/or therapeutic failure involving more conventional drug therapy.

[B] **Relative Clinical Effectiveness:** *The use of medical marijuana for this condition is clinically effective relative to established alternative treatments for this condition.*

Yes [] Possibly [] No [] NAD [**x**]

Comments:

There are no published clinical trials of placebo versus cannabis versus older polycyclic compounds (such as amitriptylline or imipramine) versus newer SSRIs (such as fluoxetine) in treatment of depression. Because of the marked sedating effects of cannabis, I doubt if it would fare well in comparisons, especially to newer agents. The clinical effectiveness would exist primarily for patients who have toxic responses to alternatives and possibly if other effects of cannabis such as pain relief and sedation are desired.

(3) **Health Benefit/Risk Ratio:** *The health benefits of medical marijuana use for this condition outweigh the health risks.* Yes [**x**] Possibly [] No [] NAD []

Comments:

This would be primarily related to the relatively high (~ 15%) mortality rate in refractory depression and the absence of a mortality rate from cannabis toxicity in humans or lab animals.

(4) **Net Health Impact:** *The use of medical marijuana for this condition improves net health outcomes (functional status and/or ability to perform activities of daily living) for those individuals with this condition who use medical marijuana.*

Yes [] Possibly [**x**] No [] NAD []

Comments:

Cannabis is not a "first or second-line treatment" for depression and will be used rarely. It will be used only when physicians have had difficulty treating depression with standard drugs alone. I suspect it will primarily be an adjunct for a patient who has had positive prior experiences with cannabis or used when patients have had significant side effects from standard agents. With

SSRI's and newer drugs, older drugs (including cannabis) should be less necessary but nevertheless valuable for some patients in special settings.

(5) **Net Overall Impact:** *The use of medical marijuana for this condition improves net overall outcomes (quality of life and/or perceived satisfaction with condition improvement) for those individuals with this condition who use medical marijuana.*

Yes [] Possibly [] No [] NAD []

Comments:

Improvement in symptoms in the syndrome of depression generally results in a marked improvement in "net overall impact", including quality of life measurements. Cannabis can improve depressive symptoms in some patients as reported in many patients' case histories. It also may provide an alternative for those who have problems with standard approaches.

(6) **Safety, Effectiveness, or Related Issues:** *There are no such compelling or overriding issues that alter any of the determinations regarding the use of medical marijuana for the treatment of this condition that would have been reached absent these issues.*

Yes [] Possibly [] No [] NAD []

Comments: *(If yes, what are these issues and how do they alter these determinations?)*

Depression kills Oregonians. Cannabis is not lethal in overdose settings. In my internal medicine practice I took care of many patients who nearly died or died from overdosing on polycyclic antidepressants. With the advent of SSRIs, there was a welcome decrease in this activity. Having an agent for depression that doesn't kill in overdose settings is very important.

Note: NAD = Not Able to Determine

III. Overall Findings and Recommendations

Summary of Findings

Many case reports from multiple sources are published showing that Cannabis alleviates symptoms of depression. Depression is a serious illness with a significant mortality rate. Cannabis is not harmless but does not kill in overdose. The newer antidepressants like SSRIs do not kill in overdose either and should be the preferred initial treatment in patients with depression who require drug therapy. However some patients do not respond to standard drug therapy or have toxic side effects. Cannabis offers an option for a small number of patients who have failed a more conventional and preferred approach. The benefits reported by users of Cannabis have not been reported with synthetic oral THC although the latter numbers are very small.

Access to health care and especially mental health care with counseling and prescription drug access is difficult for poor and nonurban patients. If cannabis works, it can be a very cheap option for those that would have no access to the full spectrum of modern psychiatric counseling and expensive pharmacology. Those who might otherwise remain untreated and possibly at risk of suicide might get some treatment that may prevent suicide.

Recommendation Regarding Adding this Condition to the List of “Debilitating Medical Conditions” for Purposes of the Oregon Medical Marijuana Act

- Add disease to list of disease conditions pursuant to ORS 475.302(2)(a) []
- Add symptom to list of symptom conditions pursuant to ORS 475.302(2)(b) [X]
- Do NOT add disease or symptom to list of debilitating medical conditions []

COMMENTS Re: this Recommendation:

If it were possible to add "severe depression" as a symptom with "severe" meaning that other treatment options have failed or have been toxic, this would be my preference. Another synonym for "severe" in this setting might be "refractory". "Severe depression with unfavorable response to conventional treatment" would also summarize my recommendation.

RATIONALE Re: this Recommendation:

Listing as a symptom is a softer recommendation than adding depression as a disease. Although published information consists of many compelling case reports from multiple sources and opinions from American psychiatrists most experienced with using cannabis in depression (Drs. Tod Mikuriya and Lester Grinspoon), there are no controlled trials. Depression is a VERY serious illness with a significant mortality rate and an imperfect conventional treatment. Newer agents for depression (particularly SSRIs) are available with lower general toxicity than a sedating agent such as cannabis, which is often smoked. Nevertheless, cannabis, an older herbal treatment for depression, should be available as a treatment option because of the benefit to risk ratio in some patients. Cannabis would be used rarely and used in those who failed conventional therapy and/or had significant toxicity, but it might save someone's life in this devastating illness.

Strength of this Recommendation:

As someone who practiced internal medicine, cared for depressed patients in Intensive Care Units with death resulting from drug overdoses, performed internal medicine consultation on locked inpatient psychiatric units, and a doctor who provided continuing education to other physicians in a "Diagnosis and Treatment of Depression in Primary Care" series of presentations, I feel strongly that cannabis should be available as an option for patients who fail and/or have toxicity with conventional approaches to depression, particularly if the patient is at risk for suicide.

Other Comments, Observations, Etc

Submitted By:

Signature

Print Name