

Comprehensive Review of Medicinal Marijuana, Cannabinoids, and Therapeutic Implications in Medicine and Headache: What a Long Strange Trip It's Been . . .

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Background.—The use of cannabis, or marijuana, for medicinal purposes is deeply rooted though history, dating back to ancient times. It once held a prominent position in the history of medicine, recommended by many eminent physicians for numerous diseases, particularly headache and migraine. Through the decades, this plant has taken a fascinating journey from a legal and frequently prescribed status to illegal, driven by political and social factors rather than by science. However, with an abundance of growing support for its multitude of medicinal uses, the misguided stigma of cannabis is fading, and there has been a dramatic push for legalizing medicinal cannabis and research. Almost half of the United States has now legalized medicinal cannabis, several states have legalized recreational use, and others have legalized cannabidiol-only use, which is one of many therapeutic cannabinoids extracted from cannabis. Physicians need to be educated on the history, pharmacology, clinical indications, and proper clinical use of cannabis, as patients will inevitably inquire about it for many diseases, including chronic pain and headache disorders for which there is some intriguing supportive evidence.

Objective.—To review the history of medicinal cannabis use, discuss the pharmacology and physiology of the endocannabinoid system and cannabis-derived cannabinoids, perform a comprehensive literature review of the clinical uses of medicinal cannabis and cannabinoids with a focus on migraine and other headache disorders, and outline general clinical practice guidelines.

Conclusion.—The literature suggests that the medicinal use of cannabis may have a therapeutic role for a multitude of diseases, particularly chronic pain disorders including headache. Supporting literature suggests a role for medicinal cannabis and cannabinoids in several types of headache disorders including migraine and cluster headache, although it is primarily limited to case based, anecdotal, or laboratory-based scientific research. Cannabis contains an extensive number of pharmacological and biochemical compounds, of which only a minority are understood, so many potential therapeutic uses likely remain undiscovered. Cannabinoids appear to modulate and interact at many pathways inherent to migraine, triptan mechanisms of

action, and opiate pathways, suggesting potential synergistic or similar benefits. Modulation of the endocannabinoid system through agonism or antagonism of its receptors, targeting its metabolic pathways, or combining cannabinoids with other analgesics for synergistic effects, may provide the foundation for many new classes of medications. Despite the limited evidence and research suggesting a role for cannabis and cannabinoids in some headache disorders, randomized clinical trials are lacking and necessary for confirmation and further evaluation.

Key words: cannabis, hemp, headache, medical marijuana, cannabinoids, cannabidiol, CBD, delta-9-tetrahydrocannabinol, THC

The plant genus *Cannabis* is a member of the plant family Cannabaceae, and there are 3 primary cannabis species which vary in their biochemical constituents: *Cannabis sativa*, *Cannabis indica*, and *Cannabis ruderalis*.¹ In general, cannabis that has high levels of the psychoactive cannabinoid, delta⁹-tetrahydrocannabinol (Δ^9 -THC), and low levels of the non/anti-psychoactive cannabinoid, cannabidiol (CBD), is referred to as “marijuana.” Cannabis that has high levels of CBD, and very low insignificant levels of Δ^9 -THC, is referred to as “industrial hemp,” or “hemp,” and has no psychoactive effects. The botanical origin of cannabis is suspected to be from Western and Central Asia. It has been cultivated since ancient times in Asia and Europe, and spread to the New World in post-Columbian times.² Carbon dating has confirmed the use of cannabis fibers in the form of hemp back to 4000 BC.^{3,4} Hemp has a long history of many past and current uses including textiles for clothing, industrial products, building materials (such as hempcrete), manufacturing, oil paints, solvents, fuel, paper, soaps, shampoos, cosmetics, food, and medicinal purposes, to name a few.

Historical records reveal that the use of cannabis once held a strong and prominent position in medicine. Various benefits of cannabis have been translated from Sanskrit and Hindi literature under many different names as early as 1400-2000 BC,^{5,6} although its medicinal use was more thoroughly described in Indian *Ayurvedic* medicine and the plant cultivated as early as 900 BC.² The Greek physicians Claudius Galen (131-201 AD) and Pedanius Dioscorides (40-90 AD) described medicinal indications for cannabis.⁷

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In 1839, Dr. William Brooke O'Shaughnessy introduced the Western world to the medicinal uses of *C. indica*, or "Indian hemp," after his time in Calcutta, India. He suggested its use in analgesia and as a muscle relaxant.⁸⁻¹⁰ He was a physician and scientist who graduated from the University of Edinburgh, and a professor of chemistry at the Medical College of Calcutta.^{11,12} Dr. Clendinning in London was one of the first Western physicians to treat migraine with cannabis in the 1840s,^{11,13} and another London physician, Dr. R. Greene, was recommending daily doses of cannabis for the prophylaxis of migraine in 1872.^{11,14}

The medicinal use of *C. indica* for both acute and preventive headache treatment was subsequently advocated by many prominent physicians through the 19th and early decades of the 20th centuries, including E.J. Waring, S. Weir Mitchell, Hobart Hare, Sir William Gowers, J.R. Reynolds, J.B. Mattison, and Sir William Osler.^{4,8,9,15} Cannabis was included in British and American pharmacopoeias for headache treatment during these early years.⁴

In 1887, Dr. S. Mackenzie published an article advocating for the use of marijuana twice daily for chronic daily headache, which was likely chronic migraine by description.^{11,16} Dr. J.W. Farlow described the use of marijuana suppositories as having "few equals in its power over nervous headaches" in 1889.^{11,17} In 1890, Sir John Russell Reynolds, the president of the British Medical Association and physician to the royal household, wrote a paper in *Lancet* reviewing 30 years of personal experience in prescribing cannabis to advocate for its legitimate medicinal uses for a wide variety of ailments, particularly migraine and neuralgia.^{11,18}

In 1915, the father of modern medicine, Sir William Osler, advocated for cannabis use in migraine, which he published in his textbook *The Principles and Practice of Medicine*.¹¹ He stated that when treating migraine, "*Cannabis indica* is probably the most satisfactory remedy. Seguin recommends a prolonged course."^{4,11,15}

Dr. E.C. Seguin, to whom Osler was referring, was a well-known neurologist and president of the New York Neurological Society, and a vocal proponent of cannabis for migraine at that time.¹¹ In 1916, Dr. Walter Ernest Dixon, who was a well-known professor of pharmacology at Kings' College and the University of Cambridge, described the therapeutic effects of smoked cannabis for headache treatment.⁴

The rising use of medicinal cannabis was eventually derailed by political factors in the United States (US) consisting of propaganda that cannabis was a drug of abuse used by minority and low-income communities, along with a campaign by Harry Anslinger and the Federal Bureau of Narcotics in the 1930s which attempted to associate psychosis, mental deterioration, addiction, and violent crimes to marijuana use. Other historians have stated that the purpose was to also reduce the size of the growing hemp industry, influenced by prominent businesspersons such as Andrew Mellon, and the Du Pont family, who were

involved and invested heavily in competing industry including synthetic fibers such as nylon.^{11,19-21} These claims and agenda led to the *Marihuana Tax Act of 1937*, despite the American Medical Association's strong opposition to this legislation.^{4,22,23} This law imposed a heavy tax on anyone associated with cannabis and hemp for medicinal or industrial uses, with prison and large fines for those failing to comply.¹¹ In response to this ruling, Dr. Robert Walton published a comprehensive review of cannabis in 1938, and stated that legislation should not prohibit medicinal use and scientific investigation, referencing 12 significant authorities on its efficacy for migraine.⁴

The protest from the medical community could not overcome the political powers pushing for banning cannabis and associating it as a drug of abuse. In 1941, cannabis preparations were taken off the *United States Pharmacopoeia and National Formulary*.⁴ Despite this removal, Dr. M. Fishbein, the editor of the *Journal of the American Medical Association*, still recommended oral preparations of cannabis over ergotamine tartrate for menstrual migraine in 1942.^{4,24} A resurgence of recreational marijuana use occurred during the anti-establishment cultural phenomenon that developed in the US between the early 1960s and the early 1970s. This counterculture and time period left a lasting impression in many aspects. Unfortunately, one of those lasting impressions and stigma has been the association between the psychedelic hippie counterculture movement of that era and recreational marijuana use, rather than the longer and deeper history of medicinal use that existed long prior to that time period.

In August 1970, the Assistant Secretary of Health, Dr. Roger O. Egeberg, wrote a letter recommending that marijuana be classified as a Schedule 1 substance, the same as heroin and lysergic acid diethylamide (LSD), and it has remained so since the passage of the Controlled Substances Act of 1970. His stated reasoning for this decision was:

"Since there is still a considerable void in our knowledge of the plant and effects of the active drug contained in it, our recommendation is that marijuana be retained within Schedule 1 at least until the completion of certain studies now underway to resolve the issue."²⁵

Therefore, marijuana was classified as a Schedule 1 substance, not because of scientific evidence, but due to a lack of existing scientific knowledge at that time.²⁵ The consequence of the Schedule 1 classification of cannabis has been detrimental to researching its benefits. This is because research on cannabis in the US remains illegal as a consequence of this classification. This has senselessly left the potential therapeutic applications of cannabis at a standstill for decades, despite possible benefits described through history with extensive anecdotal descriptions and scientific research, the fact that cannabis remained in the Western pharmacopoeia until 1941, and was prescribed for a multitude of symptoms including headache by many of the most prestigious physicians of those times.

The Drug Enforcement Agency (DEA) continues to refuse to take marijuana off the restricted “most dangerous” Schedule 1 classification, claiming it has “no accepted medicinal use,” a statement that has no evidence-based medicine to support it. More evidence exists disproving and refuting those claims. The Schedule 1 classification impedes US federal funding for research, or even the legal ability to proceed with research. This has been the primary hurdle in conducting the large-scale medical research that is needed to obtain that necessary evidence-based medicine on the potential benefits, or lack thereof, of cannabis.

Hypocritically, despite the insistence of the Schedule 1 classification, the US Government, as represented by the Department of Health and Human Services, in 2001 filed a patent (US Patent #6,630,507) for cannabinoids that was awarded in 2003 for “cannabinoids as antioxidants and neuroprotectants.”²⁶ This patent is a clear contradiction of the US Government’s own definition for classification of a Schedule 1 drug having no medicinal benefit.

Another glaring contradiction to the Schedule 1 status of marijuana is the fact that the US Federal Drug Administration (FDA) has approved synthetic versions of the cannabinoid Δ^9 -THC in the form of Dronabinol (Marinol[®]) and Nabilone (Cesamet[®]) for medicinal purposes. These observations further confirm that the cannabinoids found in cannabis are recognized by the government to be therapeutic with valid medicinal uses. However, the Schedule 1 status remains intact, stating that there is no accepted medical use of cannabis. Clearly, this Schedule 1 status needs to be reviewed and reclassified.

An attempt to reclassify marijuana to Schedule 2 failed in 1988, despite the DEA administrative law judge, Francis Young’s, recommendation that marijuana be removed from Schedule 1 and made available for physicians to prescribe.²⁷⁻³⁰ He reviewed evidence and testimonies from the scientific community and stated, “By any measure of rational analysis, marijuana can be safely used within a supervised routine of medical care,” and its use was suggested for spasticity, paraplegia, and multiple sclerosis (MS), and as an anti-emetic, while its use for glaucoma was considered “reasonable.”^{4,28} The FDA reviewed the scheduling of marijuana in both 2001 and 2006, both times recommending that it should remain in Schedule 1. A federal judge is again reviewing whether reclassification is warranted at the time of this writing.

The only access to legal marijuana has been through the FDA’s Investigational New Drug Program, which was closed by the Secretary of Health and Human Services in 1992, although the 13 patients in the program at that time were allowed to continue.^{31,32} The only federally approved source of research-grade cannabis for that program, and still remaining, has been from a farm at the University of Mississippi. It has had contracts with the federal government since 1968, and has provided medicinal marijuana to a few patients. The program initially started in 1976

when a glaucoma patient sued the government on grounds that the cannabis was preventing his vision loss, and won.³² Currently there are still 2 patients who receive monthly government supplied marijuana, one for multiple hereditary exostoses, a painful bone tumor disorder, and the other for glaucoma.³² The program is still controlled by the National Institute on Drug Abuse (NIDA).

In 1995, Richard Smith, the editor of *British Medical Journal*, called for some marijuana legalization and decriminalization,³³ and the *Journal of the American Medical Association* also published a commentary in support of medical marijuana.³⁴ In November 1995, the *American Journal of Public Health*, the journal for the oldest and largest organization of healthcare professionals in the world, issued a resolution urging lawmakers to make medical marijuana accessible for research as an investigational new drug, and to make marijuana a legally available medicine to ill patients.²⁷ They further stated that, “cannabis/marijuana was wrongfully placed on the Schedule 1 of the Controlled Substances depriving patients of its therapeutic potential,” and concluded that, “greater harm is caused by the legal consequences of its prohibition than possible risks of medicinal use.”²⁷ In 1997, the British Medical Association published a book called *Therapeutic Uses of Cannabis* describing the many potential medical benefits of cannabinoids, and also concluded that cannabinoids may have potential use for patients with spastic neurological disorders such as spinal cord injury and MS, which are not well controlled with available drugs.³⁵

Neurologist Dr. Ethan Russo received FDA support in conducting a study looking at the effects of smoked marijuana in the treatment of migraines in the late 1990s. However, his study was halted by the NIDA. He stated the following:

“My FDA-approved study on cannabis’ ability to reduce migraine was stone-walled because NIDA holds a monopoly on the legal supply of cannabis for research, and they refused to provide it for my study. As a doctor and a citizen, knowing that researchers in other countries are researching and confirming new medical uses for cannabis all the time, such as its ability to protect the brain after head trauma or stroke, I am dismayed by policies that prevent us from fully utilizing the healing potential of this plant and preventing people from using the best medicine for their condition.”³⁶

Many physicians are pushing for schedule reclassification of cannabis allowing medicinal cannabis for the treatment of a multitude of ailments, and allowing research. In a 2013 apology article retracting his previous anti-marijuana stance, Dr. Sanjay Gupta MD, CNN Chief Medical Correspondent, stated:

“Well, I am here to apologize. I apologize because I didn’t look hard enough, until now. I didn’t look far enough. I didn’t review papers from smaller labs in other countries doing some remarkable research, and I was too dismissive of the loud chorus of legitimate patients whose symptoms improved on cannabis. Instead, I lumped them with the high-visibility malingerers, just

*looking to get high. I mistakenly believed the Drug Enforcement Agency listed marijuana as a Schedule 1 substance because of sound scientific proof. Surely, they must have quality reasoning as to why marijuana is in the category of the most dangerous drugs that have “no accepted medicinal use and a high potential for abuse.” They didn’t have the science to support that claim, and I now know that when it comes to marijuana neither of those things are true. It doesn’t have a high potential for abuse, and there are very legitimate medical applications. In fact, sometimes marijuana is the only thing that works. We have been terribly and systematically misled for nearly 70 years in the United States, and I apologize for my own role in that.*²⁵

Dr. Gupta also noted that of more than 20,000 papers published in recent times, only 6% of the studies look at the potential benefits of cannabis, while all the rest investigate potential harm, leading to an inherent bias and a profoundly distorted view.²⁵

A poll by WebMD/Medscape revealed that the majority of 1544 physicians from more than 12 specialties and 48 states said that medicinal marijuana should be legalized nationally, and agreed that it should be an option for patients.³⁷ The rapidly increasing anecdotal reports about its benefits and subsequent exodus of families being forced to move to Colorado for legal use of a special strain of marijuana called *Charlotte’s Web*³⁸ to treat their children’s refractory seizure disorders seems cruel and senseless, and has led to stronger calls for legal research and availability.

The Epilepsy Foundation has asked the DEA to relax its marijuana restrictions to allow for medical research to proceed, and in April 2014, the American Academy of Neurology published a consensus statement on the use of medical marijuana in neurologic disorders.³⁹ It was based on a systematic review of studies involving marijuana or synthetic cannabinoid treatment for symptoms of only MS, epilepsy, and movement disorders between 1948 and November 2013. In that consensus, they concluded that certain forms of medical marijuana, cannabinoids, and synthetic formulations can effectively treat some symptoms of MS, including spasticity, painful spasms, central pain, and overactive bladder, although efficacy was uncertain for the other neurologic conditions evaluated. They recommended that cannabinoids should be studied as other drugs are in order to continue seeking answers as to the potential benefits of marijuana use in patients who have neurologic illness, and if found to be effective, it should be prescribed. Most recently in January 2015, the American Academy of Pediatrics recommended that the government and DEA re-classify marijuana as a Schedule 2 drug to allow further research to be done on its therapeutic benefits.

In 1996, California was the first state to pass the Compassionate Use Act, which allowed the legal use of marijuana for medicinal purposes. Since then, at the time of this writing (March 2015), the number of states which have legalized medical marijuana is rapidly growing, currently at 23 (AK, AZ, CA, CO, CT,

DE, HI, IL, ME, MD, MA, MI, MN, MT, NV, NH, NJ, NM, NY, OR, RI, VT, WA), in addition to Washington, DC. Furthermore, 10 states (AL, FL, IA, KY, MO, MS, SC, TN, UT, WI) have legalized CBD-only (CBD; extracted from cannabis) medical marijuana bills, and 4 states (AK, CO, OR, WA) and Washington, DC have successfully voted to legalize marijuana for both medical and recreational purposes. More states will be voting on upcoming election ballots for similar variable measures, increasing its availability for self-medication and/or physician-prescribed medication. Several Congress members introduced the “Charlotte’s Web Medical Hemp Act of 2014 (H.R.)” to Congress on July 28, 2014. The bill proposes to exclude industrial hemp and CBD from the definition of marijuana in the Controlled Substances Act, so that patients can have legal access to CBD oil and therapeutic hemp.

THE ENDOCANNABINOID SYSTEM

A breakthrough in the understanding of how cannabis works in the brain occurred with the discovery of the endogenous cannabinoids and receptors,⁴⁰⁻⁴⁴ which comprise the endocannabinoid system. The endocannabinoid system is widely distributed throughout the brain and spinal cord, and plays a role in many regulatory physiological processes including inflammation, appetite regulation, metabolism, energy balance, thermogenesis, neural development, immune function, cardiovascular function, digestion, synaptic plasticity and learning, pain, memory, psychiatric disease, movement, nociception/pain, psychomotor behavior, sleep/wake cycles, regulation of stress and emotion, and digestion.⁴⁵⁻⁵⁰

The endocannabinoid system consists of the cannabinoid 1 (CB1) and 2 (CB2) receptors, the endogenous cannabinoid receptor ligands (endogenous cannabinoids) N-arachidonylethanolamine (anandamide, or AEA) and 2-arachidonoylglycerol (2-AG), as well as their degrading enzymes fatty acid amide hydrolase (FAAH) and monoacylglycerol lipase, respectively.^{40,46,51,52} The CB1 and CB2 receptors were cloned in 1990 and 1993, respectively.⁵³⁻⁵⁵ The CB1 receptor is primarily expressed on presynaptic peripheral and central nerve terminals, and to a lesser degree on many other peripheral organs. This is in contrast to CB2 receptors, which are concentrated primarily in the peripheral tissues and immune cells where they influence the release of cytokines and cell migration, although are also present to a lesser degree in the nervous system.⁵⁶⁻⁵⁸ Discovery of AEA, which notably is the ethanolamide of arachidonic acid, occurred in 1992,⁴⁰ and this is a primary mediator of endocannabinoid signaling, although a multitude of other endogenous mediators with “cannabinoid-like” effects continue to be discovered.^{46,51,59-61}

The CB1 and CB2 receptors are both located pre-synaptically and modulate neurotransmitter release.⁵⁶ The endocannabinoids AEA and 2-AG, as well as the phytocannabinoids found in cannabis, bind to and activate (with variable affinities) the

pre-synaptic G-protein coupled CB1 and CB2 receptors.⁶²⁻⁶⁴ Activation of these receptors leads to opening of potassium channels causing a hyperpolarization of the pre-synaptic terminal, and closing of calcium channels which inhibits release of stored inhibitory and excitatory neurotransmitters, including glutamate, acetylcholine, and dopamine when neuronal excitation is present.^{48,52,65} Indirect effects on 5-hydroxytryptamine (5HT) (serotonin), N-methyl-D-aspartate (NMDA), opiate, and γ -aminobutyric acid (GABA) receptors allow endocannabinoids to modulate other networks.⁶⁶ AEA is a partial agonist at CB receptors, and binds with slightly higher affinity at CB1 compared with CB2 receptors, as does 2-AG.^{46,53,67}

In the central nervous system, CB1 activation inhibits neurotransmitter release of GABA, glutamate, serotonin, dopamine, acetylcholine, noradrenaline, cholecystokinin, and D-aspartate at both inhibitory and excitatory synapses.^{46,58,68} The CB1 receptor is one of the most abundant G-protein coupled receptors in both the peripheral and central nervous system.⁶² Notably, CB1 receptors are prominent not only in the anatomical pain pathways including the periaqueductal gray (PAG) matter, rostral ventrolateral medulla (RVM), dorsal primary afferent and substantia gelatinosa spinal cord regions, spinal interneurons, and peripheral nerves/nociceptors, but also in other brain regions such as the amygdala, cerebral cortex, hippocampus, substantia nigra pars reticulata, basal ganglia, globus pallidus (internal and external segments), and molecular layer of the cerebellum.^{45,58,69,70} The cardiopulmonary centers in the brainstem are sparsely populated with CB1 receptors, which is why there is a lack of respiratory depression with the cannabinoids, as opposed to opiate receptors.¹¹

The presence of CB1 receptors in this wide array throughout the central and peripheral nervous system provides the substrate for a multitude of potential therapeutic neurologic targets. The CB1 receptors are widely expressed throughout the rest of the body and organ systems, but this is beyond the scope of this review. The CB2 receptors are primarily concentrated in the peripheral tissues, especially cells of the immune system, but can be found in lower concentrations in some brain regions including the PAG and some neuronal subpopulations astrocytes, microglia, and oligodendrocytes.^{39,71,72} AEA and other cannabinoid agonists have also been shown to have inhibitory effects on serotonin type 3 (5HT₃) receptors, which further suggests its role as an anti-emetic and in analgesia.⁷³

The endocannabinoids are arachidonic acid derivatives synthesized “on demand” in the post-synaptic terminals from membrane phospholipid precursors in response to cellular metabolic needs, and there appears to be cross-talk between the eicosanoid and endocannabinoid pathways.^{46,52,74-76} The CB1 receptor mediated anti-inflammatory effects of cannabinoids are suspected to be secondary to inhibition of arachidonic acid conversion by cyclooxygenase,^{11,77} although CB2 receptor activation induces immunosuppression, which also reduces inflammation.⁷⁸

THE PHYTOCANNABINOIDS

The plant genus *Cannabis* is within the plant family Cannabaceae. Three cannabis species are described: *C. sativa*, *C. indica*, and *C. ruderalis*, although there has been a long-standing debate among taxonomists regarding classification of these variants into species, so a biochemical method to classify cannabis variants is typically used.¹ As noted previously, cannabis that has high levels of the psychoactive cannabinoid, Δ^9 -THC, and low levels of the non/anti-psychoactive cannabinoid, CBD, is generally referred to as “marijuana,” while cannabis that has high levels of CBD and very low insignificant levels of Δ^9 -THC is referred to as “industrial hemp,” or “hemp.”

The leaves and flowering tops of cannabis plants contain at least 489 distinct compounds among 18 different chemical classes, and contain at least 100 different phytocannabinoid compounds identified thus far, potentially holding therapeutic benefit individually, or in variable combinations.^{79,80} The primary cannabinoids studied to date include Δ^9 -THC, CBD, cannabitol (CBN), cannabigerol (CBG), and tetrahydrocannabinol (THCV), although there are many others.^{79,81-84} The percentage present of these and other cannabinoids vary depending on the cannabis strain, climate, soil, and techniques of cultivation, and these factors also account for the wide variability in medicinal benefits as well as side effects.^{85,86} Δ^9 -THC is the most studied and responsible for most of the physical, and particularly the psychotropic effects of cannabis.⁸⁷ All species contain the psychoactive component, Δ^9 -THC, in variable amounts, although *C. sativa* contains the highest Δ^9 -THC, while *C. ruderalis* contains the least.^{1,78} The other cannabinoids including CBD, CBN, and CBG have little to no psychotropic properties,⁸⁷ which makes them very attractive for potential therapeutics.

Δ^9 -THC was first isolated in 1964,⁸⁸ and is a partial agonist at both CB1 and CB2 receptors, but also acts at other non-CB receptors. Its actions at the CB1 receptor account for the psychoactive effects of cannabis, thought to be mediated to some extent by suppression of both glutamate and GABA release.^{39,64,89-91}

CBD was isolated in 1963, lacks psychoactivity, and does not appear to bind to CB1 or CB2 receptors, but rather interacts with a multitude of various ion channels, enzymes, and other receptors that are felt to explain its potential analgesic, anti-epileptic, anti-nausea, anti-emetic, anti-inflammatory, anxiolytic, anti-psychotic, and anti-ischemic properties.^{39,64,92-95} Its potential analgesic and anti-inflammatory effects are mediated by both cyclooxygenase and lipoxygenase inhibition, and its anti-inflammatory effect is several hundred times more potent than aspirin in animal studies.^{84,96} Both CBD and Δ^9 -THC also have strong anti-oxidant actions, more potent than α -tocopherol and ascorbate, and have been shown to reduce NMDA, α -amino-3-hydroxyl-5-methyl-4-isoxazole-propionate, and kainate receptor-mediated neurotoxicities.^{97,98}

CBN may have some immunosuppressive properties, and CBG may have some analgesic and anti-inflammatory properties as a partial agonist at CB1 and CB2, as well as actions as a 5HT^{1A} receptor antagonist and α 2-adrenoceptor agonist.^{94,99-103} It has also been suggested that THCV may have some anti-convulsant properties^{104,105} by acting as a CB1 receptor antagonist and CB2 receptor partial agonist.^{106,107}

Cannabinoids including Δ^9 -THC have been shown to have anti-nociceptive effects in the PAG gray matter,¹⁰⁸ an area in the brainstem that has been suspected to play an integral role in migraine generation,¹⁰⁹ as well as involvement in both descending and ascending pain transmission.^{108,110} CB1 receptors have also been shown to have a dense concentration in the hypothalamus.⁵⁶ Cannabinoid analgesic properties are mediated through CB1 receptors¹¹¹ in the brain, spinal cord, and peripheral nerves.^{108,110,112-117} Studies suggest that the endogenous cannabinoid system may modulate anti-nociceptive effects in isolation, or through simultaneous potentiation of specific opioid receptors.¹¹⁸⁻¹²⁹ CB1 receptors are 10 times more concentrated than μ -opioid receptors in the brain, and cannabinoid receptors co-localize with opioid receptors in many regions such as the dorsal horn of the spinal cord, leading to synergistic augmentation of the analgesic opioid effects, with subsequent lower dose requirements of opioid therapy.^{11,119,120,123,127,130-135} Administration of cannabinoid receptor agonists leads to endogenous opioid peptide release and chronic Δ^9 -THC use increases endogenous opioid precursor gene expression in supraspinal and spinal structures involved in pain perception.¹³⁰ This interaction is suspected to be from pharmacodynamic mechanisms, since studies show marijuana use does not affect blood levels of oxycodone or morphine.^{11,136}

Little is known about the potential therapeutic role of the extensive number of other compounds that cannabis contains, including flavonoids, terpenes, phenols, amino acids, vitamins, proteins, steroids, nitrogenous compounds, enzymes, glycoproteins, simple alcohols, hydrocarbons, ketones, aldehydes, fatty acids, simple esters and lactones, and pigments.^{79,137} This makes it difficult to appropriately assess the potential beneficial contribution by each of these compounds in studies evaluating possible therapeutic uses of cannabis, since different strains have different ratios of Δ^9 -THC, CBD, additional cannabinoids, and other compounds. Variable routes of administration add to this complexity. Ultimately, studying each isolated constituent is mandatory to determine each compound's individual therapeutic benefits. For example, the terpenes are thought to contribute to the distinctive differences in fragrance among cannabis strains, as well as the smoking qualities and character of the subsequent "high."⁸⁶ However, terpenes have a broad range of other actions including anti-inflammatory, anti-anxiety, anti-oxidant, anti-neoplastic, anti-bacterial, and anti-malarial properties.⁸⁶

POTENTIAL MEDICINAL USES OF CANNABIS FOR HEADACHE

Literature review shows that medicinal marijuana and its derived cannabinoids have reported therapeutic benefit in an extensively wide area of medicine encompassing many specialties,^{118,137,138} as compiled and referenced in Table 1. This is not an all-inclusive list, and it is important to remember that much of the included data are anecdotal, case based, or laboratory-based scientific research, although there are some randomized trials as well. One of the most documented uses of medicinal marijuana is in the treatment of pain, particularly chronic pain, and suppression of hyperalgesia and allodynia, with most studies involving endocannabinoids, Δ^9 -THC, or synthetic cannabinoids.^{58,139,140} The cannabinoid–opioid interactions and "opioid-sparing effect" of cannabinoids has attracted interest in medicinal marijuana for a possible alternative to narcotics with less potential for dependence, addiction, and abuse. These interactions also raise the question of a theoretical role in helping patients to wean down or off of opiates.

Components of the endocannabinoid system are found throughout the nervous system in supraspinal, spinal, and peripheral pain pathways. Both Δ^9 -THC and CBD have analgesic properties, although they act through different mechanisms, and the psychotropic side effects of Δ^9 -THC may be a limiting factor in its use.¹⁴¹⁻¹⁴⁴ Medicinal cannabis and its cannabinoid extracts increase pain thresholds¹⁴⁵ and possess analgesic properties.^{66,146-149} Delta-9-THC doses of 15-20 mg have been shown to be comparable to the analgesic effects of codeine 60-120 mg.¹⁵⁰ Therapeutic uses of cannabis are reported in a wide range of chronic pain disorders as detailed and referenced in Table 1. A review of 38 published randomized controlled trials evaluating cannabinoids in pain management revealed that 71% (27) concluded that cannabinoids had empirically demonstrable and statistically significant pain-relieving effects, whereas 29% (11) did not.⁴⁵

Given the pharmacology and reported therapeutic benefits of cannabis in pain medicine, it is only logical that this benefit may extend to the arena of headache medicine, including migraine. There is supporting literature for this, although it is primarily anecdotal and case based. Cannabinoids are active through CB1 receptors in areas of the brain and brainstem involved with migraine pathophysiology including the PAG (which may be a migraine generator area), rostral medulla, area postrema of the medulla, nucleus trigeminal caudalis,^{49,151-156} and trigeminal ganglia.¹¹

The endogenous endocannabinoid AEA modulates pain signaling in the central nervous system in various ways. AEA inhibits dural blood vessel dilation induced from neurogenic, calcitonin gene-related peptide (CGRP), electrical stimulation, capsaicin, and nitric oxide (NO) sources, and this effect is reversed by a cannabinoid antagonist.^{40,153,154,157,158} AEA also activates the transient receptor potential vanilloid receptor on

Table 1.—Medicinal Uses Reported With Cannabis and Cannabinoids**Central Nervous System (CNS)**

Chronic non-cancer pain:^{45,58,136,140,150,267-289} chronic neuropathic pain,^{136,139,277,287-301} phantom limb pain,³⁰² fibromyalgia,^{300,303-307} rheumatoid arthritis,³⁰⁸⁻³¹¹ chronic abdominal pain from inflammatory bowel diseases,³¹²⁻³¹⁸ cancer-related pain (especially with potent opiate failure)^{150,244,268,319,320}

Headache and facial pain: chronic headaches,^{146,196} migraine,^{49,192-196,321} cluster headache,^{217,221,222} pseudotumor cerebri,¹⁹⁸ multiple sclerosis-associated trigeminal neuralgia²²⁶

Epilepsy^{80,104,105,322-339}

Spasticity and related central pain and bladder dysfunction in multiple sclerosis^{35,121,140,226,250,328,340-376} and spinal cord injury^{121,140,328,340,341,362,377-382}

Additional multiple sclerosis associated symptoms: tremor,³⁴³ pendular nystagmus suppression,³⁸³ dystonia³⁴⁵

Reduce muscle cramps and fasciculations in amyotrophic lateral sclerosis (ALS),³⁸⁴ and delay disease progression (ALS and MS)³⁸⁵⁻³⁸⁷

Reduce intracranial pressure in traumatic brain injury, aid in cerebral ischemia and neuro/excitotoxicity,^{199-203,388} and regulation of neuroinflammatory response^{372,373,389-391}

Tourette's syndrome³⁹²⁻⁴⁰³

Dystonic movement disorders,^{399,404-408} oral dyskinesia⁴⁰⁹

Parkinson's disease; reduction of levodopa-induced dyskinesia,^{399,410} and disease progression⁴¹¹⁻⁴¹⁴

Huntington's disease⁴¹⁵⁻⁴¹⁷

Meige's syndrome⁴¹⁸

Intractable hiccups⁴¹⁹

Depression, anxiety, and mood disorders^{143,144,203,266,290,376,420-437}

Post-traumatic stress disorder (PTSD)^{242,438-448}

Neuroprotective antioxidants^{97,98,201,202,391}

Alzheimer's; behavioral/agitation,⁴⁴⁹⁻⁴⁵¹ disease progression and cognitive symptoms^{452,453}

Insomnia (majority in setting of pain relief)^{242,277,290,297,303,306-308,314,346,347,349,362,377,379,435-437,454,455}

Fulminant hepatic encephalopathy⁴⁵⁶

Autism and autistic spectrum disorders⁴⁵⁷⁻⁴⁶¹

General Medical Systems

Nausea and vomiting from chemotherapy in adults^{93,276,462-497} and children⁴⁹⁷⁻⁵⁰⁰

Appetite stimulation in healthy subjects as well as cancer and AIDS-associated anorexia/cachexia syndrome ± altered chemosensory perception^{143,162,203,435-437,455,463,482,497,501-519} and associated nausea⁵¹⁹⁻⁵²¹

Reducing intraocular pressure in glaucoma²⁰⁴⁻²¹⁶

Gastrointestinal disorders (irritable bowel syndrome, inflammatory bowel disease, pain)^{312-318,522-536}

Anti-cancer/neoplastic including breast, brain (glioma), lung, colon, skin cancer (melanoma), leukemia^{489,537-568}

Asthma (oral or aerosol rather than smoked)⁵⁶⁹⁻⁵⁷¹

Regulation and decrease of inflammation associated with autoimmune diseases⁵⁷²⁻⁵⁷⁴

trigeminal ganglion neurons, modulating the release of CGRP, and influencing vasomotor tone.^{157,159}

Modulation of serotonergic pain transmission is well established in migraine treatment, particularly with the mechanism of action of the triptans. Endocannabinoids interact with serotonergic neurons in the brainstem dorsal raphe to modulate pain mechanisms,^{160,161} and AEA potentiates 5HT_{1A} and inhibits 5HT_{2A} receptors.^{153,154} Cannabinoids have been shown to inhibit 5HT release from platelets during a migraine.¹⁶² Endocannabinoids, via CB1 receptor activation, have anti-nociceptive effects by descending modulation of pain at the spinal level through PAG and RVM connections,¹⁶³⁻¹⁶⁸ and modulation of descending cutaneous-evoked C-fiber spinal nociceptive responses from the brainstem regions including the ventrolateral PAG and RVM.^{168,169} CB1 receptor activation inhibits dural trigeminovascular nociceptive responses.^{158,170} When CB1 receptors are activated in the ventrolateral PAG, there is subsequent descending

attenuation and modulation of dural-evoked nociceptive trigeminovascular processing and transmission, including A δ -fiber and C-fiber responses, and basal trigeminal neuronal tone in the trigeminocervical complex.¹⁷¹⁻¹⁷⁴ Furthermore, variations in the *cnr1* gene on chromosome 6, which encodes for the CB1 receptor, in a region that has shown linkage with migraine, are associated with a greater risk of developing migraine.^{175,176}

The CB1 activation pathways are notable, given that triptan activation of 5HT_{1B/1D} receptors in the ventrolateral PAG also leads to descending modulatory inhibition of dural nociceptive A δ -fiber and C-fiber neuronal responses and basal trigeminal neuronal tone in the trigeminal nucleus caudalis, but not cutaneous responses.¹⁷⁷ Experimental studies show that in the ventrolateral PAG, the CB1 receptor-mediated trigeminovascular responses are modulated by the serotonergic system, particularly via the 5HT_{1B/1D} triptan receptor,¹⁷¹ and other studies of neuropathic pain models have shown that serotonergic neuron firing in

the brainstem dorsal raphe are modulated by CB1 receptor activation.^{160,161} Furthermore, 5HT_{1B/1D} antagonists inhibit CB1 responses in the ventrolateral PAG.¹⁷¹ These findings show how serotonergic and endocannabinoid neurons in the brainstem can modulate the effects of either system as trigeminal or spinal nociceptive inputs are processed.¹⁷¹ This suggests that the endocannabinoid neurotransmitter system is a potential target for treating migraine, and that triptans may help to break migraines by activating the brain's endocannabinoid system.¹⁷¹

Triptans are suspected to inhibit GABAergic and glutamatergic signaling in the PAG by preventing neurotransmitter release from nerve terminals as part of their mechanism of action.¹⁷⁸ Similarly, activation of CB1 receptors in the PAG and RVM also inhibit GABAergic and glutamatergic transmission by preventing release of neurotransmitters.^{179,180} Triptan action may in part be secondary to modulation of endocannabinoidergic neurons in the brainstem, and descending control of trigeminovascular nociceptive transmission may occur through interactions between serotonergic and endocannabinoid receptor systems.¹⁷¹ Pharmacological manipulation of the CB2 receptor suggests a potential therapeutic target for the treatment of migraine as well.¹⁸¹

The endogenous endocannabinoid AEA, the phytocannabinoid Δ^9 -THC, and synthetic cannabinoids suppress glutamatergic neurotransmission via inhibitory modulation of the NMDA receptors, mediated by CB1 receptors.^{153,154,182-186} Activation of CB1 receptors suppresses cortical spreading depression (CSD). This is suspected to be due to decreased glutamatergic transmission via inhibitory NMDA modulation, although modulation of NO, CGRP, or lipoxygenase and cyclooxygenase pathways are also possible contributors to the suppressive effect of cannabinoids on CSD.¹⁸³ Activation of CB1 receptors may stop migraine pain by inhibition of CSD and subsequent trigeminal neuronal activation.¹⁸³

Endocannabinoid deficiency has been theorized as a possible cause for migraine and other chronic pain disorders, including chronic migraine and medication overuse headache.^{187,188} Levels of AEA are decreased in the cerebrospinal fluid of individuals with chronic migraine compared with normal controls, while levels of CGRP and NO (normally inhibited by AEA) are increased.^{153,189,190} Platelets of female migraineurs as opposed to male have also shown increased activity of the AEA-degrading enzyme FAAH, suggesting increased endocannabinoid degradation.¹⁹¹ A widely recognized migraine trigger, nitroglycerin, increases activity of endocannabinoid degrading enzymes, leading to increased breakdown of endogenous endocannabinoids in the midbrain, where the PAG is located.¹⁵⁶

Unfortunately, there have been no controlled clinical trials evaluating smoked or oral formulations of medicinal cannabis or prescription cannabinoids for either acute or prophylactic therapy in migraine or other headache disorders. A small case series of cannabis use for patients with pain included 3 subjects with chronic headaches that were relieved by smoking cannabis,

with results similar or superior to ergotamine and aspirin.¹⁴⁶ Another small case series of 3 patients reported that abrupt cessation of chronic daily marijuana smoking was followed by migraine attacks, while subsequent remission of headaches was seen with resumption of episodic marijuana use in 1 of the patients.¹⁹² It is not certain whether this suggests effective prevention by the marijuana or medication overuse headache with withdrawal headache upon cessation.

A case of a migraineur who had failed standard medical therapy, and ultimately received relief with small doses of smoked marijuana was reported.¹⁹³ Similarly, this author has encountered multiple patients with chronic migraine, and a similar history of failing all standard medical therapy, but receiving a significant positive response to smoked cannabis (usually admitted reluctantly) or synthetic cannabinoids.

One study suggested that cannabinoid compounds may provide benefit in migraine treatment due to platelet stabilization and inhibition of serotonin release.¹⁹⁴ A small survey of 54 patients in a drug treatment center reported that marijuana use was commonly used as a self-medication treatment for migraine.¹⁹⁵

An anonymous standardized survey investigating reasons for self-medication with cannabis in Germany, Austria, and Switzerland was conducted by the Association for Cannabis as Medicine (Cologne, Germany).¹⁹⁶ There were 128 patient questionnaires evaluated, and of the many reported medical uses, 6.6% used cannabis for migraine, and 3.6% used it for headache. Another survey of 2480 patients of the Oakland Cannabis Buyer's Club revealed that 5% used it for migraine relief.¹⁹⁷

Medicinal cannabis may have a role in headache disorders other than migraine as well. A case study reported a woman with pseudotumor cerebri would smoke a marijuana cigarette about once per week when her headache was more severe. She would have complete resolution of her headache within 5 minutes, and it would not recur that day.¹⁹⁸ This is interesting given other studies that suggest that cannabinoids may reduce intracranial pressure in traumatic brain injury,¹⁹⁹⁻²⁰³ as well as intraocular pressure in glaucoma.²⁰⁴⁻²¹⁶ The synthetic cannabinoid, Dexamibinol, has no psychotropic activity, but blocks NMDA receptors, and suppresses production of tumor necrosis factor. In phase II trials in Israeli hospitals, it lowered intracranial pressure with a trend toward faster and better neurologic outcome.^{199,203}

Cannabis has been reported to treat cluster headache. In a case report,²¹⁷ a 19-year-old male who was refractory to a multitude of preventive and abortive medications reported that smoking marijuana at the onset of a cluster headache attack would consistently give complete headache relief within 5 minutes of inhalation, and was the only thing that helped. Given the dramatic improvement with smoked cannabis, his physician decided to substitute the smoked cannabis with Dronabinol (Marinol®) 5 mg, a synthetic cannabinoid. Dronabinol taken at the onset of cluster headache consistently provided complete and rapid relief within 5-15

minutes. Notably, CB1 receptors have a dense concentration in the hypothalamus,⁵⁶ of which the posterior inferior ipsilateral hypothalamus has been suspected to be a site of activation in cluster headache.²¹⁸⁻²²⁰

A survey of 113 patients with chronic cluster headaches in France found that 26% regularly consumed cannabis, although whether cannabis was used for treatment of cluster headache or only recreationally was not further evaluated.²²¹ In another study conducted in 2 French headache centers with a patient questionnaire evaluating marijuana use in cluster headache patients, 63/139 (45.3%) had a history of cannabis use, of which 27 patients (19.4% of total cohort) had used it to treat cluster headache attacks.²²² Efficacy was reported in 25.9%, variable or uncertain effects in 51.8%, and negative effects in 22.3%. Thus, in almost three quarters, the cluster headache subjects did not report efficacy. The authors noted the need for controlled trials with synthetic selective cannabinoids to show a more convincing therapeutic benefit.

Similar to cluster headache, this hypothalamic region is also activated during short-lasting unilateral neuralgiform headache attacks, including those with specific conjunctival injection and tearing,²²³ paroxysmal hemicranias,²²⁴ and hemicrania continua,²²⁵ raising a theoretical question of whether refractory cases of these headache disorders may also be responsive to medical cannabis and the cannabinoids.

A trial of 112 patients with MS who smoked cannabis reported that 90% had significant chronic pain relief, and particularly 70% had relief of MS-associated trigeminal neuralgia.²²⁶

PHARMACOKINETICS

Cannabis can be used by smoked, vaporized, oral, oral mucosal, topical, or rectal routes of administration. The majority of cannabinoid metabolism occurs in the liver, with variable levels of different metabolites, dependent on the route of administration.²²⁷⁻²²⁹ Health Canada (US FDA equivalent) published an excellent in-depth review of the pharmacokinetics and pharmacodynamics of cannabis, and it is recommended for more detailed discussion of these topics.¹³⁷

Smoked cannabis results in the fastest onset of action, within minutes, due to the lipophilicity of Δ^9 -THC, and results in higher cannabinoid blood levels and shorter duration of effects compared with oral routes.^{227,228} When smoked, the psychotropic effects start within seconds to a few minutes, peak in 15-30 minutes, and wear off within 2-3 hours. Depending on efficiency and method of smoking, bioavailability of Δ^9 -THC ranges from 2% to 56% based on puff duration, breath hold duration, and depth of inhalation, but typical use is predicted to be about 25-27%.^{228,230-232}

Smoking cannabis by vaporization is a more recent technique of smoking cannabis, developed due to the fact that inhalation of a combustion product is an undesirable delivery system.²³³ The goal of this technique is to suppress irritating respiratory toxins

by heating cannabis to a temperature where active cannabinoid vapors form, but below the point of combustion where smoke and associated toxins are produced.²³⁴ Vaporization may be advantageous to smoking due to less toxic byproducts such as tar, polycyclic aromatic hydrocarbons, carbon monoxide, and more efficient extraction of Δ^9 -THC.²³⁴⁻²³⁸ Plasma concentrations and effects are similar to those of smoking cannabis by standard methods, although absorption has been suggested to occur faster.²³³

Oral administration is associated with a slower onset of action with delayed psychotropic effects beginning in 30-90 minutes, slower peak at 2-3 hours, lower peak blood Δ^9 -THC levels (5-6 times lower as compared with smoking²³⁹), and longer duration of action and effects lasting 4-12 hours, depending on dose and specific psychotropic effect.^{227,230} Delta-9-THC is often ingested by adding it to foods such as brownies, oils, butters, cookies, and teas.

There are 2 synthetic pharmaceutical versions of oral Δ^9 -THC available. The first is Dronabinol (Marinol[®]), which comes in 2.5 mg, 5 mg, or 10 mg Δ^9 -THC tablets. It is typically used once to twice daily, and dose ranges vary from 2.5 to 40 mg/day.²⁴⁰ It is Schedule III and approved by the FDA for nausea/vomiting associated with chemotherapy, and acquired immune deficiency syndrome (AIDS)-associated anorexia and weight loss.

The second is Nabilone (Cesamet[®]), which comes in 0.25, 0.5, and 1 mg Δ^9 -THC tablets, and is used once to 3 times daily, with dose ranges varying from 0.2 to 6 mg/day.^{241,242} It is Schedule II and FDA approved for nausea/vomiting associated with chemotherapy. These 2 medications contain only Δ^9 -THC, without other cannabinoids such as CBD, which typically provides much of the analgesic effects of cannabis. Another oral formulation from the United Kingdom is called Epidiolex[®]. It has received Orphan Drug Designation from the FDA for the treatment of severe, drug-resistant epilepsy syndromes such as Dravet and Lennox-Gastaut syndromes, and is currently in clinical trials.

An oral mucosal formulation called Nabiximols (Sativex[®]) is available in the United Kingdom for spasticity in MS. It is also approved by Health Canada as an adjunct treatment for neuropathic pain in MS, and for moderate to severe cancer-related pain for patients who have failed the highest tolerated opiate dosing. In April 2014, the FDA granted Fast Track designation to Sativex[®] for the treatment of pain in patients with advanced cancer, who experience inadequate analgesia during optimized chronic opioid therapy, and it is currently undergoing phase III clinical trials in the US for this indication. It is also undergoing phase III trials in the US for MS spasticity. Each spray delivers a total dose of 2.7 mg Δ^9 -THC and 2.5 mg CBD, along with additional cannabinoids, flavonoids, and terpenoids since it is a tincture of cannabis, made from cannabis plants rather than a synthetic form, and doses range from 1 to 16 sprays per day.^{243,244} Peak plasma concentrations of the CBD and Δ^9 -THC occur in 2-4 hours, although there is wide variation between patients in

peak blood levels, time to onset, and peak of effects.²⁴³ Similar to the oral formulations, Δ^9 -THC and cannabinoid blood levels are lower as compared with smoking, although Δ^9 -THC blood levels are similar to Dronabinol.^{243,245}

Topical transdermal formulations of cannabinoids exist in ointments, creams, and lotions, although there are no clinical studies evaluating these. However, some research has been done evaluating a dermal patch for delivery of synthetic cannabinoids with good permeation results, suggesting the utility for development of a transdermal therapeutic system.²⁴⁶⁻²⁴⁸

Rectal formulations have been studied, and blood concentrations of Δ^9 -THC are dose and vehicle dependent.²⁴⁹ The pro-drug Δ^9 -THC hemisuccinate is absorbed rectally rather than Δ^9 -THC, and this in combination with decreased first-pass metabolism leads to higher bioavailability of Δ^9 -THC (52-61%) as compared with the oral route.²⁴⁹⁻²⁵³

Intramuscular and intravenous Δ^9 -THC has been evaluated in limited studies,^{251,254} and the authors of 1 study involving monkeys suggested that intramuscular Δ^9 -THC may be a useful alternative route of administration, since it is more completely bioavailable as compared with the oral route.²⁵¹

ADVERSE EFFECTS OF CANNABIS

There are a multitude of variables that may influence the presence or severity of adverse effects with cannabis use, as well as benefits. The majority of information regarding adverse effects reported with cannabis use come from studies and case reports primarily evaluating recreational users, rather than from controlled therapeutic clinical studies. It is important to remember that none of the studies or reported adverse effects of cannabis specifically compare and take into account many potential variables. These include route of administration, patient age, concurrent medications being taken, patient comorbidities, standardized dosing, type of cannabis strain, ratio of the phytocannabinoids in the cannabis strain (particularly the CBD:THC ratio), sterility of cannabis growing conditions, cannabis analyzation for commonly encountered issues of toxins, pesticides, and fungal and bacterial microbial contaminants, among others.

The importance of sterility and potential side effects from non-sterile growing environments is illustrated by a case of allergic bronchopulmonary aspergillosis due to microbial contamination from smoking moldy cannabis.²⁵⁵ These variables will be extremely important in future studies, as there are suspected to be at least 100 different types of phytocannabinoids, and only a few of them have been studied and evaluated. Some (such as Δ^9 -THC) cause psychoactive side effects, while others (such as CBD) have no psychoactive side effects, as previously discussed. Therefore, these reported adverse side effects are based on entirely non-standardized evaluations, similar to many of the anecdotal and case-based reports suggesting benefit. This is synonymous to evaluating adverse reactions in a random combination of the

widely variable antidepressant medications, and then lumping all reported adverse effects into the same adverse effect profile for antidepressants as a general class. However, in reality, it is understood that different antidepressants have different pharmacologic properties and adverse reactions. Cannabis use as a medication should be thought of no differently. Therefore, these reported adverse side effects should not be assumed to be universal cannabis side effects, but need to be more appropriately correlated with specific phytocannabinoids, phytocannabinoid ratios, and the aforementioned variables as medical research moves forward. This is critical for evaluating adverse side effects, as well as therapeutic benefits.

Unfortunately, cannabinoid science and associated medical research is in its infancy, and these many variables and factors have yet to be evaluated and incorporated into research for more specific data regarding both benefits and adverse side effects. With that said, adverse reactions reported in the central nervous system and cardiovascular system are seen in Table 2, while adverse reactions in the respiratory system, gastrointestinal, reproductive, and immune systems are reported in Table 3.

Regarding cannabis dependency, the problem may be less significant compared with other substances. A study reported by the health arm of the National Academy of Sciences, The Institute of Medicine, showed that dependency occurs in 32% of tobacco users, 23% of heroin users, 17% of cocaine users, 15% of alcohol drinkers, and 9% of marijuana users.²⁵⁶ Withdrawal symptoms following prolonged cannabis use have been reported to include anger, depressed mood, irritability, anxiety, restlessness, insomnia, strange dreams, weight loss, and decreased appetite. The question of cannabis overuse headache and withdrawal headache remains unstudied.²⁵⁷⁻²⁵⁹

To date, there has been no documented evidence of death exclusively attributed to cannabis overdose or use.¹³⁷ A recent comparative risk assessment to quantify the risk of death associated with commonly used recreational substances using the margin of exposure approach was conducted.²⁶⁰ The *margin of exposure* is defined as a ratio between toxicological threshold (benchmark dose) and estimated human intake. This method uses the most recent guidelines for risk assessment of chemical substances, which also takes the population-based exposure into account. The toxicological margin of exposure approach validates epidemiological and social science-based drug ranking approaches. Results showed that alcohol was the deadliest substance, followed by heroin, cocaine, tobacco, ecstasy, methamphetamine, and lastly, cannabis. These results suggested that cannabis was approximately 114 times less lethal than alcohol, and reinforced similar results in comparative toxicology studies and drug safety rankings developed decades prior under different methodologies.^{261,262}

The ratio between Δ^9 -THC and CBD appears to be an important factor in relation to side effects based on currently available literature, and some cannabinoids such as CBD may modulate

Table 2.—Adverse Effects Reported With Use of Cannabis and Cannabinoids on Central Nervous and Cardiovascular Systems

Central Nervous System (CNS)	Adverse Effects Reported
Sedative	Somnolence, generalized CNS depression, additive with other CNS depressants, amotivational syndrome in chronic use ^{137,232,272,290-292,303,314,346,347,435,436,575-578}
Psychological	Euphoria (“high”), dysphoria, depersonalization, anxiety/panic attacks (primarily from Δ^9 -THC and lessened by presence of CBD), aggravation of psychosis in those predisposed for or having psychotic disorders (however, a study of 10,000 psychiatric hospital admissions found no evidence that use of cannabis induced psychosis in previously asymptomatic patients, ⁵⁷⁸ and a recent study reported no correlation with high risk individuals and development of psychosis from cannabis use ⁵⁷⁹) ^{87,137,232,259,292,303,314,427,580-603}
Perception	Synesthesia (stimulation of 1 sense stimulates a totally different sense; hearing colors, seeing sounds, feeling/tasting sounds, etc.), distortion of sense of time and space, heightened sensory perception, misperceptions, hallucinations ^{137,259,488,594,597,604-607}
Motor function	Ataxia, weakness, disequilibrium, incoordination, dysarthria ^{84,137,232,291,605,608}
Psychomotor/cognitive function	Mental clouding, thought fragmentation, impaired memory, impairment in general cognitive performance (especially complex/demanding tasks), and driving may be impaired in occasional > chronic smokers (less as compared with alcohol, but increased in combination with alcohol), ^{137,314,605,609-627} possible impairment in neurocognitive brain development in users who begin at a younger age including adolescence ^{628,629}
Dependence	Physical and psychological dependence associated with chronic, heavy cannabis use ^{258,259,630-632}
Stroke	Limited and somewhat loosely associated case reports of stroke following recent use of smoked cannabis (one of which was cardioembolic from myocardial infarction) ^{137,633-636}
Cerebral blood flow	Increased with acute cannabis use, chronic use may decrease, variations exist between regions, ^{137,637,638} possible association with reversible cerebral vasoconstriction syndrome (RCVS), ⁶³⁹ and multifocal intracranial stenosis ⁶³⁶
Other	Headache, ^{240,241,243,290,359,362} especially with withdrawal ⁶⁴⁰
Cardiovascular	Adverse Effects Reported
Peripheral circulation	Conjunctival injection, vasodilatation, postural hypotension, supine hypertension, ^{137,144,490,577,635,637,641-643} and arteritis ⁶⁴⁴⁻⁶⁴⁷
Heart rate	Tachycardia with acute use, but tolerance develops with chronic use ^{137,144,232,303,314,490,637,648-654}
Heart rhythm	Ventricular arrhythmia, atrial fibrillation, premature ventricular contractions ^{635,652,653,655-658}
Myocardial infarction (MI)	Possible increased risk of MI after acutely smoking cannabis, particularly with pre-existing cardiovascular disease, increased myocardial oxygen demand ^{137,642,653,659,660}

the activity of Δ^9 -THC.²⁶³ Delta⁹-THC accounts for the vast majority of the psychotropic and physical side effects of cannabis.⁸⁷

In contrast, as noted, CBD lacks psychoactivity, which is why the specialized bred high-CBD, low-THC strain of *Charlotte’s Web*TM has become such a popular treatment for refractory childhood epilepsy.³⁸ CBD-mediated attenuation of Δ^9 -THC side effects may be observed when the CBD:THC ratio is at least 8:1 (± 11.1),^{264,265} while CBD may potentiate some of the THC side effects when the CBD:THC ratio is around 2:1 (± 1.4).²⁶⁴ CBD has been shown to have anxiolytic effects in animals and humans by reducing the anxiety reaction induced by Δ^9 -THC.²⁶⁶

There are no studies evaluating the therapeutic benefits correlating to varying cannabis strains or CBD:THC ratios, despite the wide spectrum of diseases and symptoms that the medical literature suggests cannabis is beneficial for. This is clearly a wide open area containing many potential therapeutic medical treatments for which research is desperately needed. Determining which cannabis strains and CBD:THC ratios are the most effective for specific diseases and symptoms, including acute and chronic pain should be a primary research focus.

There are an extensive number of variables that make it difficult for establishing standardized dosing schedules. Some of these variables include the complex cannabinoid pharmacology, potency of cannabis being used such as CBD:THC ratios, the large number of other compounds found in cannabis, different dosing regimens, different routes of administration, tolerance to cannabinoids, inter-individual differences in cannabinoid receptor structure, function, and density, as well as differences in cannabinoid metabolism.¹³⁷ Current dosing recommendations are highly individualized, relying significantly on titration.²³¹

For new patients, it is recommended that waiting a few minutes between puffs of smoked/inhaled cannabis, and waiting 30-60 minutes between bites of cannabis-based oral products to monitor for effects or adverse symptoms is most prudent.¹³⁷ Based on peer-reviewed literature, the majority of patients using smoked or orally ingested cannabis for medical purposes have been observed to use between 10 and 20 g of cannabis per week, or approximately 1-3 g per day.¹³⁷ Detailed estimated dose amounts and percentages of Δ^9 -THC between various routes of administration, including conversion factors between smoked and oral forms can be seen in Health Canada’s publication of

Table 3.—Adverse effects Reported With Use of Cannabis and Cannabinoids on Respiratory, Gastrointestinal, Reproductive, and Immune Systems

Respiratory System	Adverse Effects Reported
Carcinogenesis	Cannabis smoke contains many similar chemicals as tobacco smoke, and cannabis smoke condensates may be more cytotoxic and mutagenic than tobacco smoke condensates, ^{137,661,662} although evidence linking cancer and cannabis smoke are conflicting and inconclusive. ^{137,663-666}
Inflammation	Chronic cannabis smoking associated with histopathologic changes, cough, wheezing, bronchitis, and phlegm production. ^{137,667-671}
Bronchial tone	Acute use of smoked cannabis causes bronchodilation, ^{667,672-674} but long term heavy smoking may lead to increased obstruction and decreased lung function. ^{137,667,670,671,675,676}
Gastrointestinal System	Adverse Effects Reported
General	Decreased secretion, decreased motility and gastric/colonic emptying, anti-inflammatory ^{137,312-315,535}
Pancreas	Pancreatitis has been reported with heavy acute and chronic daily use. ^{137,677-680}
Liver	Possible increased risk of hepatic fibrosis/steatosis, particularly in patients with hepatitis C. ^{137,681-686}
Reproductive System	Adverse Effects Reported
Females	Inconclusive and unclear as most data are from animal studies; dose-dependent stimulatory or inhibitory effects on sexual behavior, ^{137,687} possible ovulation suppression and menstrual cycle changes. ^{137,688-690}
Males	Inconclusive as most data are from animal studies with limited human studies. With chronic and daily use, possibly decreased sperm count, morphology, and motility, anti-androgenic, ^{137,490,689,691-693} possible inhibitory sexual effects. ^{220,304}
Immune System	Adverse Effects Reported
General	Complex and unclear with both suppressive and stimulatory actions reported. ^{137,574,694,695}

*Information for Health Care Professionals: Cannabis (marihuana, marijuwana) and the cannabinoids.*¹³⁷ There are no standard clinical guidelines in terms of contraindications for use of cannabis and cannabinoids, although Health Canada has outlined some suggestions, as modified and seen in Table 4.¹³⁷ The risk/benefit ratio needs to be evaluated in patients with certain medical conditions until further research becomes available to form more standardized guidelines.

CONCLUSIONS AND SUMMARY

The historical use of cannabis for medicinal purposes is described for numerous diseases. There is an abundance of support for its

many medicinal uses as well as potential benefit in some forms of headache disorders, including migraine and cluster. With the majority of the US now legalizing medicinal cannabis and/or limited CBD-only use, it is important for physicians to be educated on the history and proper clinical use of cannabis, because patients will become increasingly aware of it as a potential treatment, including for chronic pain and headache disorders. Cannabis contains an extensive number of pharmacological and biochemical compounds, of which only a small fraction are understood, so many therapeutic uses likely remain undiscovered. Cannabinoids appear to modulate and interact at many pathways inherent to migraine, triptan mechanisms of action,

Table 4.—Suggested Contraindications and/or Precautions Requiring Evaluation of Risk/Benefit Ratio of Cannabis and Cannabinoids

- Use with caution in patients with a history of substance abuse including alcohol, given abuse potential.
- Use with caution in patients using sedative-hypnotics, alcohol, or other psychoactive drugs due to potential synergistic sedative effects.
- Use with caution in severe renal or liver disease, including chronic hepatitis C (daily use not recommended due to potential for worsening steatosis severity).
- Avoid use under the age of 18 due to potential for increased adverse effects on mental health during development and adolescence.
- Avoid use while driving, operating heavy machinery, or performing other hazardous tasks or activities.
- Avoid use with history of cannabinoid or smoke hypersensitivity.
- Avoid use in patients with severe cardio-pulmonary disease due to risk for potential hypotension, hypertension, tachycardia, or syncope.
- Avoid use of smoked cannabis in patients with pulmonary diseases including asthma and chronic obstructive pulmonary disease.
- Avoid use in women who are pregnant or breastfeeding. Use with caution in women of childbearing age who are planning pregnancy or not using a reliable contraceptive.
- Avoid use in patients with psychiatric disease, particularly schizophrenia, or a family history of schizophrenia.
- Careful psychiatric monitoring is recommended for patients with mania or depression.

and opiate pathways, suggesting a potential synergistic or related benefit. Modulation of the endocannabinoid system through agonism or antagonism of its receptors, targeting its metabolic pathways such as inhibition of endocannabinoid-degrading enzymes, or combining cannabinoids with other analgesics for synergistic effects, may provide the basis for many new classes of medications. Despite the limited evidence and research suggesting a therapeutic role for cannabis and cannabinoids in some headache disorders, randomized clinical trials are necessary for confirmation and further evaluation.

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