

MMP-035

New Jersey Department of Health
Medicinal Marijuana Program
PO 360
Trenton, NJ 08625-0360

MEDICINAL MARIJUANA PETITION
(N.J.A.C. 8:64-5.1 et seq.)

INSTRUCTIONS

This petition form is to be used only for requesting approval of an additional medical condition or treatment thereof as a "debilitating medical condition" pursuant to the New Jersey Compassionate Use Medical Marijuana Act, N.J.S.A. 24:6I-3. Only one condition or treatment may be identified per petition form. For additional conditions or treatments, a separate petition form must be submitted.

NOTE: This Petition form tracks the requirements of N.J.A.C. 8:64-5.3. Note that if a petition does not contain all information required by N.J.A.C. 8:64-5.3, the Department will deny the petition and return it to petitioner without further review. For that reason the Department strongly encourages use of the Petition form.

This completed petition **must** be postmarked **August 1 through August 31, 2016** and sent by **certified mail** to:

New Jersey Department of Health
Office of Commissioner - Medicinal Marijuana Program
Attention: Michele Stark
369 South Warren Street
Trenton, NJ 08608

Please complete each section of this petition. If there are any supportive documents attached to this petition, you should reference those documents in the text of the petition. If you need additional space for any item, please use a separate piece of paper, number the item accordingly, and attach it to the petition.

RECEIVED

SEP 6 2016

OFFICE OF THE
CHIEF OF STAFF

**MEDICINAL MARIJUANA PETITION
(Continued)**

1. Petitioner Information

Name: [REDACTED]
Street Address: [REDACTED]
City, State, Zip Code: [REDACTED]
Telephone Number: [REDACTED]
Email Address: [REDACTED]

2. Identify the medical condition or treatment thereof proposed. Please be specific. Do not submit broad categories (such as "mental illness").

Chronic pain as a result of daily sciatic nerve pain (Sciatica)

3. Do you wish to address the Medical Marijuana Review Panel regarding your petition?

- Yes, in Person
- Yes, by Telephone
- No

4. Do you request that your personally identifiable information or health information remain confidential?

- Yes
- No

If you answer "Yes" to Question 4, your name, address, phone number, and email, as well as any medical or health information specific to you, will be redacted from the petition before forwarding to the panel for review.

5. Describe the extent to which the condition is generally accepted by the medical community and other experts as a valid, existing medical condition.

In response to Sciatica as a valid medical condition, here is the definition/listing as per *The Mayo Clinic* website (The Mayo clinic is generally regarded as one of the leading medical organizations in the country):

"Sciatica refers to pain that radiates along the path of the sciatic nerve, which branches from your lower back through your hips and buttocks and down each leg. Typically, sciatica affects only one side of your body.

Sciatica most commonly occurs when a herniated disk, bone spur on the spine or narrowing of the spine (spinal stenosis) compresses part of the nerve. This causes inflammation, pain and often some numbness in the affected leg."

Source: <http://www.mayoclinic.org/diseases-conditions/sciatica/basics/definition/con-20026478>

6. If one or more treatments of the condition, rather than the condition itself, are alleged to be the cause of the patient's suffering, describe the extent to which the treatments causing suffering are generally accepted by the medical community and other experts as valid treatments for the condition.

The extent of my suffering is due to the Sciatica condition itself, however treatments with opiod painkillers such as Hydrocodone (Percocet & Vicodin) had proven to be troublesome as they brought an all too brief respite from the pain, and ultimately led to dependency issues and extreme lethargy throughout my daily routine. I avoid those medications/treatments for those reasons, and prefer to use products containing the cannabinoids THC, CBD, and CBN for non-addictive pain remedies that allow me to still be active and participate in my life.

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7. Describe the extent to which the condition itself and/or the treatments thereof cause severe suffering, such as severe and/or chronic pain, severe nausea and/or vomiting or otherwise severely impair the patient's ability to carry on activities of daily living.

Sciatica causes daily, everyday, chronic pain (**Neuropathy**) that radiates all the way from my lower back down to my big toe. The pain is only on my right side, which is my active side because I am right-handed. Any simple activities such as walking, running, and sitting are met with reoccurring pain from the nerve damage that is a result of Sciatica. I especially have difficulty while at work, as my profession requires me to sit for long periods of time, which causes pain from the muscles and tendons being inactive. That pain is usually introduced in the morning on my drive into work, whereby I sit in traffic for upwards of 45 minutes – 1 hour, and the pain in my ankle and calves is amplified from my leg's need to always be either on the brake pedal or accelerator so as to maintain the flow of traffic and avoid any careless driving on the road. This pain builds up during the course of the day, and is again amplified on the commute home from work. Sometimes the pain is too severe to even do anything or be involved with my family when I get home from work. I need to either ice, stretch, or soak my leg for long periods of time; something of which often takes me away from the brief amount of time I get spend with my family.

8. Describe the availability of conventional medical therapies other than those that cause suffering to alleviate suffering caused by the condition and/or the treatment thereof.

I have often read that surgery is a feasible option to help remedy Sciatica, and I would love to even have that as an option for myself, Unfortunately, the reality is that my wife and I simply do not make enough money and have a large quantity of debt that would only be added to with the vast and large medical bills that would stem from such a thing. Though I continue to have an active lifestyle that involves exercise, proper nutrition, and stretching of the problem area – I still have pain that returns through it all. As mentioned before, opioid painkillers are not an effective treatment, and are a dangerously addictive temporary solution that many people unfortunately think is the answer.

9. Describe the extent to which evidence that is generally accepted among the medical community and other experts supports a finding that the use of marijuana alleviates suffering caused by the condition and/or the treatment thereof.

[Note: You may attach articles published in peer-reviewed scientific journals reporting the results of research on the effects of marijuana on the medical condition or treatment of the condition and supporting why the medical condition should be added to the list of debilitating medical conditions.

Cannabinoids as Pharmacotherapies for Neuropathic Pain: From the Bench to the Bedside

I have attached a published, peer-reviewed scientific article that through extensive research, supports the claim that cannabinoids should be used as pharmacotherapies for neuropathic pain and chronic pain that includes Sciatica. I have also included links to the article:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755639/>

http://download.springer.com/static/pdf/639/art%253A10.1016%252Fj.nurt.2009.08.002.pdf?originUrl=http%3A%2F%2Flink.springer.com%2Farticle%2F10.1016%2Fj.nurt.2009.08.002&token2=exp=1472573720~acl=%2Fstatic%2Fpdf%2F639%2Fart%25253A10.1016%25252Fj.nurt.2009.08.002.pdf%3ForiginUrl%3Dhttp%253A%252F%252Flink.springer.com%252Farticle%252F10.1016%252Fj.nurt.2009.08.002*~hmac=f112e29ea0999d50773b1b6548d773af9c5b35efd08aa3811090e049c29df51b

Cannabis and Its Derivatives: Review of Medical Use

I have attached an article from the Journal of the American Board of Family Medicine that highlights the outdated social outlook that affects patients suffering from neuropathy from getting marijuana for treatment, as opposed to opioids. Evidence is also given that supports receptors in the brain are not as likely to suffer addiction with marijuana vs. opioids.

<http://www.jabfm.org/content/24/4/452.full>

Cannabinoids for the Treatment of Chronic Non-Cancer Pain: An Updated Systematic Review of Randomized Controlled Trials

I have attached an abstract from the Journal of Neuroimmune Pharmacology that states that cannabinoids “*are safe, modestly effective analgesics that provide a reasonable therapeutic option in the management of chronic non-cancer pain.*”

<http://link.springer.com/article/10.1007/s11481-015-9600-6>

Lynch, M.E. & Ware, M.A. J Neuroimmune Pharmacol (2015) 10: 293. doi:10.1007/s11481-015-9600-6

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A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain

Attached is the abstract from this study from the Journal of Pain. This study adds to a growing body of evidence that cannabis may be effective at ameliorating neuropathic pain, and may be an alternative for patients who do not respond to, or cannot tolerate other drugs.

[http://www.jpain.org/article/S1526-5900\(08\)00369-6/ppt](http://www.jpain.org/article/S1526-5900(08)00369-6/ppt)

Low Dose Vaporized Cannabis Significantly Improves Neuropathic Pain

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3566631/>

[J Pain](#). Author manuscript; available in PMC 2014 Feb 1.

Published in final edited form as:

[J Pain](#). 2013 Feb; 14(2): 136–148.

Published online 2012 Dec 11. doi: [10.1016/j.jpain.2012.10.009](https://doi.org/10.1016/j.jpain.2012.10.009)

10. Attach letters of support from physicians or other licensed health care professionals knowledgeable about the condition. List below the number of letters attached and identify the authors

1 Letter – Dr. Igor Grant, MD

I certify, under penalty of perjury, that I am 18 years of age or older; that the information provided in this petition is true and accurate to the best of my knowledge; and that the attached documents are authentic.

Signature of Petiti

8-30-16

Cannabis and Its Derivatives: Review of Medical Use

Lawrence Leung, MBBChir, MFM(Clin)

Background: Use of cannabis is often an under-reported activity in our society. Despite legal restriction, cannabis is often used to relieve chronic and neuropathic pain, and it carries psychotropic and physical adverse effects with a propensity for addiction. This article aims to update the current knowledge and evidence of using cannabis and its derivatives with a view to the sociolegal context and perspectives for future research.

Methods: Cannabis use can be traced back to ancient cultures and still continues in our present society despite legal curtailment. The active ingredient, $\Delta 9$ -tetrahydrocannabinol, accounts for both the physical and psychotropic effects of cannabis. Though clinical trials demonstrate benefits in alleviating chronic and neuropathic pain, there is also significant potential physical and psychotropic side-effects of cannabis. Recent laboratory data highlight synergistic interactions between cannabinoid and opioid receptors, with potential reduction of drug-seeking behavior and opiate sparing effects. Legal rulings also have changed in certain American states, which may lead to wider use of cannabis among eligible persons.

Conclusions: Family physicians need to be cognizant of such changing landscapes with a practical knowledge on the pros and cons of medical marijuana, the legal implications of its use, and possible developments in the future. (J Am Board Fam Med 2011;24:452–462.)

Keywords: Cannabis, Clinical Effects, Controversy, Drug Therapy, Marijuana, Substance Abuse

Case 1

Scenario

You are a family physician in Ontario, Canada. A 54-year-old man suffering from multiple sclerosis came to your office asking for a prescription for medical marijuana to control his pain. He was taking continuous-release morphine, gabapentin, and lamotrigine, but this combination was still insufficient. He visited Florida a few times, where he smoked cannabis, which helped tremendously to reduce the neuropathic pain and detach his mind from it. He would like to continue using cannabis but is worried about the legal implications and the purity of sample he may obtain on the street.

Suggested Management

The evidence of various forms of cannabis (smoked, oral, and oromucosal spray) for treating neuropathic pain caused by multiple sclerosis should be discussed against the known harms and challenges of usage. Sativex (legally available form of cannabis in Canada; GW Pharmaceuticals, Salisbury, Wiltshire, UK) could be recommended as a first-line treatment. If the patient still decided to pursue a smoked or oral extract of cannabis, referral should be made to recognized specialists in Quebec for a full assessment of eligibility of patient's use and possession of medical marijuana. Close monitoring of the patient would be necessary.

Case 2

Scenario

You are a family physician in the state of California. A 65-year-old male veteran came to your office as a new patient. He had a history of chronic leg pain caused by a shrapnel injury he suffered during the Vietnam War in 1968. Since the 1970s, he has been treated at the local veterans hospital under a pain management program, but control has been unsatisfactory. When asked if he used any recreational

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From the Department of Family Medicine, Queen's University, Kingston, Ontario, Canada.

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Corresponding author: Lawrence Leung, Department of Family Medicine, Queen's University, Kingston ON K7L 5E9, Canada (E-mail: leungl@queensu.ca).

drugs, including marijuana, he evaded your question and said he needed to stay on the pain program. You suspected he was using marijuana for his chronic pain.

Suggested Management

The patient should be informed of the new directive from the Veterans Health Administration regarding veterans' use of marijuana and be reassured that he would not be denied his pain management services at the veterans hospital on that basis. He also should be encouraged to discuss his marijuana use with you so that you can monitor his progress. Liaising with an addiction medicine specialist can be helpful to ensure the best follow-up of this patient.

Cannabis, also known as marijuana, refers to the preparation 53 from the plant belonging to the family *Cannabaceae*, the genus *Cannabis*, and the species *Cannabis sativa*, which possess psychoactive effects. The flowering tops, leaves, and stalks of the mature female plant are commonly used as the herbal form of cannabis, but sometimes the resinous extract of compressed herb is also used and is called "hash." Archaeologists have identified fibers from cannabis stems in specimens dating back to 4000 BC, and its incorporation into textiles and paper was found in the tombs of the Chinese Han dynasty (~100 BC).¹ The first record of cannabis as a medicine can be found in the oldest Chinese pharmacopeia, *Shen Nong Ben Cao Jing*, written in the Eastern Han Dynasty (AD 25 to AD 220), which was indicated for rheumatic pain, malaria, constipation, and disorders of the female reproductive system.² Though the cannabis leaf and stem is rarely used nowadays in Chinese herbal medicine, cannabis seeds, which contain very few psychoactive ingredients, are still commonly prescribed for their laxative effects.² Smoking cannabis is often an under-reported behavior in our society, with a reported prevalence from the World Health Organization of 3.9% among the global population aged 15 to 64 years.³ There are more than 70 psychoactive compounds called "cannabinoids" that have been identified in cannabis,⁴ among which Δ^9 -tetrahydrocannabinol (THC) accounts for most of the psychological and physical effects, and its content is often used as a measure of sample potency. We now know that THC acts on 2 types of cannabinoid receptors: CB₁ and CB₂. CB₁ receptors are mainly found in the brain, peripheral nerves,

and autonomic nervous system,⁵ whereas CB₂ receptors are found both in the neurons and immune cells.⁶ THC exerts its effects primarily via CB₁ receptors.

The Laws Regarding Cannabis

In the United States, cannabis is an illicit drug either to possess or trade. Since the inception of the Controlled Substance Act in 1970, the US Federal Law penalizes any act of possessing, dispensing, and prescribing marijuana. Enforcement of prohibition carries an annual price tag of up to \$7.7 billion in the United States alone.⁷ However, since 1996 the situation has been changing rapidly—14 states (California, Alaska, Oregon, Washington, Maine, Hawaii, Colorado, Nevada, Vermont, Montana, Rhode Island, New Mexico, Michigan, and New Jersey) already have amended their state laws to allow the use of marijuana by persons with debilitating medical conditions as certified by licensed physicians.^{8,9} The impact has been significant: a recent study in Washington estimated that per annum, up to 2000 licensed physicians have prescribed medical cannabis¹⁰; in California, more than 350,000 patients already possess a physician's recommendation to use cannabis.¹¹ Nevertheless, among these 14 states, there is substantial variation in the regulation of the quality control, prescription limit, patient registry, and dispensing outlets. For example, in Oregon and Washington, it is legal to possess up to 24 ounces of marijuana, but in Nevada, Montana, and Alaska, the legal limit is only 1 ounce.⁸ Cannabis is currently schedule I; additional research would be facilitated if the drug were reclassified to schedule II.⁸ From a public health standpoint, there is some evidence that decriminalization of cannabis could free up law enforcement resources to curtail other trafficking activities without leading to increased cannabis abuses.¹² Overall, however, the US Federal law remains unchanged regarding the penal stance toward marijuana, creating various ambiguities and difficulties. For those veterans who are permitted to use medical marijuana by law of their state, these difficulties have been lessened. This has posed an administrative dilemma for those veterans who are allowed to use; the Department of Veterans Affairs issued a directive in July 2010 that permits veterans to continue their use of medical marijuana in states where it is legal without losing their medical benefits from Veterans Affairs.¹³

Recent news from *USA Today*¹⁴ reports that the US federal government has issued warning letters to several states that have approved the use of medical marijuana with an implication that anyone involved in the growth, operation, or legal regulation of medical marijuana will be subjected to prosecution. These states include Washington, California, Montana, and Rhode Island. This was coupled by recent large-scale raids at marijuana growing operations in Montana. Despite reassurance from Eric Holder, US Attorney General, that the penal policy is directed at those who violate both deferral and state laws, this unexpected siren from the federal government has been heard loud and clear, leading Governor Chris Gregoire, of the state of Washington, to abort a proposal to create licensed marijuana dispensaries and Governor Chris Christie, of the state of New Jersey, to postpone plans for marijuana operators.

In Canada, it is also illegal to trade or possess 104 marijuana according to provincial and government laws. However, access to marijuana for medical use is possible under Health Canada's Marijuana Medical Access Regulations, which came into force on July 30, 2001.¹⁴ The regulations clearly outline 2 categories of persons who can apply to possess for an authorization to possess marijuana for medical purposes. Category 1 refers to people with end-of-life care; seizures from epilepsy; severe pain and/or persistent muscle spasms caused by multiple sclerosis, spinal cord diseases, or spinal cord injury; severe pain; cachexia; anorexia; weight loss and/or severe nausea from cancer or HIV/AIDS infection. A medical declaration from a licensed medical practitioner is required. Category 2 refers to people who have debilitating symptom(s) of medical condition(s), other than those described in category 1, which have failed conventional medical treatment. An assessment by a designated specialist is necessary along with a medical declaration from a licensed medical practitioner.

Under the regulations, the maximum amount of marijuana that can be possessed by any authorized user is a 30-day total of daily requirement. Health Canada sources its supply of dried marijuana and seeds from Prairie Plant Systems Incorporated (Saskatoon, Saskatchewan, Canada), a company that specializes in the growing, harvesting, and processing of plants for pharmaceutical products and research. Alternatively, authorized marijuana users can apply for a permit to produce

and grow their own supply provided they meet specific and detailed criteria.

The Harms of Cannabis

Physical and Psychiatric Effects

Among naive users, cannabis smoking often leads to adverse effects. Physical symptoms include increased heart rate and fluctuations in blood pressure¹⁵; psychomotor sequelae include euphoria, anxiety, psychomotor retardation, and impairment of cognition and memory.¹⁶ The estimated lethal dose for humans is between 15 g and 70 g.³ When compared with cigarette smoke, cannabis contains a similar array of detrimental and carcinogenic compounds, some of which are present even at higher concentrations.¹⁷ Among chronic users, population studies have associated cannabis use with decreased pulmonary function, chronic obstructive airway diseases, and pulmonary infections,¹⁸ although data may be confounded by concomitant tobacco smoking and other social factors. In vitro and in vivo animal studies have demonstrated mutagenic effects of cannabis smoke, and precancerous pulmonary pathology as seen in tobacco smokers has been described in cannabis users.¹⁹ Nevertheless, there is still inconsistency from the published literature regarding an increased risk for upper respiratory tract cancer caused by cannabis smoking.^{3,18} Various reports have associated cannabis with cardiac arrhythmias,^{20,21} coronary insufficiency²²⁻²⁴ and myocardial infarction.^{25,26} A retrospective cross-sectional study revealed a 4.8-times increased risk of developing myocardial infarction within the first hour after smoking cannabis. Earlier data from population studies^{27,28} and meta-analysis²⁹ have associated cannabis smoking with low birth weight,²⁹ which is maybe confounded by cigarette smoking and socioeconomic status and is not supported by more recent studies.^{30,31} Finally, the controversial link of cannabis use and psychosis has found more support in recent publications.³²⁻³⁴

Dependence and Abuse

Cannabis is recognized as a substance with a high potential for dependence, which occurs in 1 out of 10 people who have ever used cannabis. It leads to behaviors of preoccupation, compulsion, reinforcement, and withdrawal after chronic use.³⁵ An Australian survey found that symptoms of cannabis

withdrawal satisfied the diagnostic criteria of both International Classification of Diseases 10 and Diagnostic and Statistical Manual of Mental Disorders IV for substance dependence, which included sleep disturbance, anorexia, irritability, dysphoria, lethargy, and cravings.³⁶ In the United States, cannabis is now ranked among alcohol and tobacco as one of the most common substances of among adolescents.³⁷ There is also ample evidence indicating that regular use of cannabis predicts subsequent psychosocial problems and abuse behavior of other addictive substances. A review of cohort studies by McLaren et al³⁸ supported a causal link between cannabis use and psychosis. A recent 10-year follow-up study of adolescents in Australia who used cannabis occasionally were found to be at higher risks of drug abuse and educational problems.³⁹ However, several issues have been identified in the published literature about cannabis, which have limited our understanding on the adverse effects of cannabis: (1) lack of consensus on the definition and classification of different types of cannabis users (heavy, regular, occasional, and non-users); (2) variable quality of studies regarding design, effect sizes, and control of confounding factors; and (3) the polarization of the approach to either studying nonusers versus light/infrequent users or, infrequent/light/nondependent users versus frequent/heavy/dependent users.⁴⁰

New Kids on the Block

Recently, synthetic analogues of marijuana, known generically as “spice” or “K2,” have gained rapid popularity among youths in the United States and Europe. Marketed as an incense or herbal blend, the exact constituents of spice has been a myth, and its place of origin is often unclear. Despite sharing similar psychotropic effects as genuine cannabis, spice cannot be reliably tested by drug screens and poses a technical problem for the law enforcement; hence it is capable of evading legal scrutiny among most states in America. A report from the Drug Enforcement Administration of the US Department of Justice in June 2010 had divulged the possible constituents of spice (or K2), which included HU-210, JWH-018, JWH-073 and CP-47,497,⁴¹ all of which were synthetic cannabinoids legally endorsed for scientific research. This was echoed by a recent research publication that identified a synthetic cannabinoid in commercially obtained spice, JWH-018, which activated CB₁.⁴²

Analgesic Potential and Synergism With Opioids

Despite legal curtailment, cannabis is still used by 10% to 15% of patients with multiple sclerosis⁴³ and noncancer types of chronic pain⁴⁴ for both analgesia and psychological detachment. Various well-designed, randomized, placebo-controlled trials have shown that smoked cannabis can relieve peripheral,⁴⁵ posttraumatic,⁴⁶ and HIV-induced^{47,48} neuropathic pain. Evidence has been accumulating from molecular and cell-signaling studies that suggest that the opioids and cannabinoid systems can interact synergistically to enhance analgesic effects.⁴⁹ Animal studies have shown that topical cannabinoid enhances the action of topical morphine,⁵⁰ an effect that is preserved in a morphine-tolerant state.⁵¹ Moreover, cannabinoids are increasingly being recognized in animal models for their potential sparing effects with opioids⁵² of neuropathic pain and arthritic pain.⁵³ Although similar effects have not been translated to human studies, Robert et al⁵⁴ found a synergistic affective analgesia between Δ 9-THC and morphine in experimentally induced pain in human volunteers.

Evidence from Clinical Studies

To review the latest evidence of cannabis use and its derivatives, a literature search was conducted from the MEDLINE, EMBASE, PsycINFO, and Cochrane Database of Systematic Reviews from their inception dates to 30 November 2010, using the following keywords: “cannabis,” “marijuana,” “ Δ 9-tetrahydrocannabinol,” “clinical trial,” “benefits,” and “side effects.” Relevant articles were selected and their quality of evidence was rated according to the Strength of Recommendations Taxonomy (SORT),⁵⁶ with recommendations rated as A, B, or C. The results are summarized in Table 1. In brief, the efficacy of smoked cannabis has been studied for Gilles de la Tourette syndrome, glaucoma, and pain, with good evidence for clinical benefits in HIV-induced neuropathic pain. Oral extract of cannabis has better evidence of relieving self-reported symptoms of spasticity caused by multiple sclerosis. Finally, the oromucosal form of cannabis extract (Sativex, GW Pharmaceuticals) is efficacious for peripheral and central neuropathic pain, especially that caused by multiple sclerosis.

Table 1. Clinical Studies of Cannabis and Its Derivatives with SORT Level of Recommendation⁵⁶

Agent	Condition Indicated	Form of delivery	Nature of Study	Patients (n)	Outcome Measures	Outcome	SORT Level of Recommendation	Reference
Cannabis	Gilles de la Tourette Syndrome	Smoking	Case report	3	Self-reported frequency of motor tics	50% to 70% remission	C	Sandyk et al ⁵⁷
Cannabis	Gilles de la Tourette Syndrome	Smoking	Case report	1	Self-reported symptoms	100% remission	C	Hemming et al ⁵⁸
Cannabis	Glaucoma	Smoking single dose	Double-blinded cross-over placebo-controlled RCT	18	Intraocular pressure	Significant reduction	B	Merritt et al ⁵⁹
Cannabis	Neuropathic pain in HIV patient	Smoking 5 days a week for 2 weeks	Prospective placebo-controlled RCT	28	Pain intensity using Descriptor Differential Scale	Improvement in pain ($P = .016$)	A	Ellis et al ⁴⁹
Cannabis	Sensory neuropathic pain in HIV patient	Smoking 3 times a day for 5 days	Double-blinded cross-over placebo-controlled RCT	50	Chronic pain ratings	Reduction of pain by 34% ($P = .03$)	A	Abrams et al ⁴⁸
Cannabis	Capsaicin-induced pain in volunteers	Smoking single dose at various concentrations	Double-blinded cross-over placebo-controlled RCT	15	Pain scores and McGill Pain Questionnaire	Pain reduction at medium dose within a certain time frame only	B	Wallace et al ⁶⁰
Cannabis	Acute inflammatory pain in volunteers	Single oral dose of encapsulate extract	Double-blinded cross-over placebo-controlled RCT	18	Threshold to heat and electricity in areas with UV-induced sunburnt	No effect on pain thresholds	B	Kraft et al ⁶⁴
Cannabis	Spasticity due to multiple sclerosis	Escalating dose of oral encapsulate extract	Double-blinded cross-over placebo-controlled RCT	50	Spasms frequency and mobility	Improvement in spasms frequency ($P = .013$) and mobility ($P = .01$)	A	Vaney et al ⁶²
Cannabis	Spasticity caused by multiple sclerosis	Titration oral dose of cannabis extract	Double-blinded placebo-controlled RCT	327	Ashworth score and self-reported spasticity	Improvement of self-report ratings of pain and spasticity ($P = .003$)	A	Zajicek et al ⁶³
Δ^9 -THC	Gilles de la Tourette Syndrome	Single oral dose	Cross-over placebo-controlled RCT	12	TSSL, STSS, YGTSS scores	Significant reduction in TSSL score ($P = .015$), nil for STSS and YGTSS	A	Müller-Vahl et al ⁶⁴
Δ^9 -THC	Gilles de la Tourette Syndrome	Daily oral dose for 6 weeks	Placebo-controlled RCT	24	TSSL, TS-CGI, STSS, YGTSS	Significant reduction in TSSL score using ANOVA ($P = .037$), nil for TS-CGI, STSS, YGTSS	A	Müller-Vahl et al ⁶⁵
Δ^9 -THC	Spasticity caused by multiple sclerosis	Escalating dose for 5 days	Double-blinded cross-over placebo-controlled RCT	13	Subjective rating and objective measure of spasticity	Significant in both scores	A	Ungerleider et al ⁶⁶
Δ^9 -THC	Spasticity due to multiple sclerosis	Titration oral dose of Δ^9 -THC	Double-blinded placebo-controlled RCT	330	Ashworth score and self-reported spasticity	Improvement of self-report ratings of pain and spasticity ($P = .003$)	A	Zajicek et al ⁶³
Δ^9 -THC	Postoperative pain	Single oral dose on postoperative day 2	Double-blinded placebo-controlled RCT	40	Summed pain intensity difference 6 hours after administration	No significant difference	B	Buggy et al ⁶⁷
Δ^9 -THC	Refractory neuropathic pain	Titration oral dose	Open label pilot	8	Neuropathic pain score and quality of life	No apparent effect	C	Attal et al ⁶⁸

Continued

Table 1. Continued

Agent	Condition Indicated	Form of delivery	Nature of Study	Patients (n)	Outcome Measures	Outcome	SORT Level of Recommendation	Reference
Δ^9 -THC	Glioblastoma multiforme	Daily intracranial tumour injection up to 64 days	Phase I cohort pilot study	9	Safety of intracranial route of administration	Intracranial route seems to be safe and may slow down tumour growth	C	Guzman et al ⁶⁹
Dronabinol (synthetic Δ^9 -THC)	Alzheimer's disease	Twice-daily oral dose for 6 weeks	Double-blinded cross-over placebo-controlled RCT	15	Body weight, triceps skin fold, disturbed behavior, affect	A trend of improvement reported but no significance quoted	B	Volicer et al ⁷⁰
Dronabinol (synthetic Δ^9 -THC)	Alzheimer's disease	Daily oral dose for 2 weeks	Open label pilot	6	Nocturnal motor activity score and Neuropsychiatric Inventory	Significant improvement in both ($P = .028$ and $P = .0027$)	C	Waither et al ⁷¹
Dronabinol (synthetic Δ^9 -THC)	Anorexia and weight loss in AIDS	Twice-daily oral dose for 6 weeks	Placebo-controlled RCT	139	VAS for appetite, mood, and nausea	Significant change in appetite (38%; $P = .015$); mood (10%; $P = .06$); and nausea (20%; $P = .05$)	A	Beal et al ⁷²
Nabilone	Spasticity caused by spinal cord injury	Twice-daily oral dose for 4 weeks	Double-blinded cross-over placebo-controlled RCT	12	Ashworth Scale, Total Ashworth Score	Significant reduction, $P = .003$ and 0.001 respectively	A	Pooyania et al ⁷³
Nabilone	Pain caused by fibromyalgia	Oral dose for 4 weeks	Double-blinded placebo-controlled RCT	40	VAS and Fibromyalgia impact questionnaire	Significant reduction in both scores ($P < .02$)	A	Skrabek et al ⁷⁴
Sativex (extract of cannabis containing Δ^9 -THC and cannabidiol)	Peripheral neuropathic pain	Self-titrating dose of oromucosal spray for 5 weeks	Double-blinded placebo-controlled RCT	125	Various pain intensity scores	Significant reduction, ($P = .001$ to $P = .04$)	A	Nurmikko et al ⁷⁵
Sativex (extract of cannabis containing Δ^9 -THC and cannabidiol)	Intractable neurogenic symptoms	Self-titrating dose of oromucosal spray for 2 weeks	Double-blinded cross-over placebo-controlled RCT	20	Self-report symptoms and adverse effects	Significant relief in pain with certain domains reaching significance of $P < .05$	A	Wade et al ⁷⁶
Sativex (extract of cannabis containing Δ^9 -THC and cannabidiol)	Central pain in multiple sclerosis	Self-titrating dose of oromucosal spray for 4 weeks	Double-blinded placebo-controlled RCT	66	11-point scale for pain and sleep disturbance	Significant reduction of pain ($P = .005$) and sleep disturbance ($P = .003$)	A	Rog et al ⁷⁷
Sativex (extract of cannabis containing Δ^9 -THC and cannabidiol)	Bladder dysfunction in multiple sclerosis	Single daily dose for 8 weeks	Open label pilot study	15	Occurrence of urinary incontinence, frequency, nocturia	Significant reduction in all 3 domains ($P < .05$)	A	Brady et al ⁷⁸

RCT, randomized controlled trial; UV, ultraviolet; TSSL, ; STSS, ; YGTSS, ; TS-CGI, ANOVA, analysis of variance; VAS, Visual Analog Scale; THC, tetrahydrocannabinol.

The Challenges of Using Cannabis

Despite the evidence of benefits in certain conditions, the use of medical marijuana within a legal jurisdiction still faces a number of challenges:

- *Method of delivery and quality control.* Smoking raw cannabis remains the most common and easiest route of delivery, but the actual amount of cannabinoids deliverable to the alveolar space varies considerably depending on the individual's techniques of inhalation/exhalation, the percentage of aeroingestion, and the individual's functional lung capacity. Without prior training, it could be difficult for a family physician in daily practice to advise an eligible patient on the proper techniques of administration and quality control of prescription regarding medical marijuana. The content of THC in cannabis may vary remarkably according to geographic origin,⁵⁶ the parts of plant being used (buds versus stem and seeds), the methods of storage, and the techniques of cultivation.⁷⁹ There are 2 main strains used in medical marijuana: the Sativa and the Indica. The Sativa plant is usually taller with longer leaves that grow better outdoors, whereas the Indica plant is more bushy with shorter leaves that thrive better indoors. Although both strains exist in pure forms, various combinations of the 2 strains are packaged as medical marijuana, which may result in variable therapeutic and side effects. Health Canada's policy of adopting a centralized source of medical marijuana from an approved plantation is a good way to assure quality; however, it is still technically difficult to endorse it globally for all licensed users and growers. As a prescription, standardization and titration of dose efficacy remain a challenge for medical marijuana.
- *Adequate monitoring and prevention of addiction.* As with other substances of abuse, cannabis may lead to varying adverse effects and addiction potential among different individuals. Before facilitating an eligible person to receive medical marijuana, family physicians should possess the knowledge and skills to screen for addiction potential. During the course of treatment, close surveillance of the patient to prevent addiction and adverse effects, in collaboration with a specialist when necessary, remains a top priority. In Canada and in those American states where it is legal to use

medical marijuana, more training and educational resources should be made available for the practicing family physician to enhance their competence in approaching cannabis.

- *Contaminants in cannabis.* Studies have reported an alarming level of biological contaminants in cannabis, which include *Aspergillus* fungus^{80,81} and bacteria,⁸² potentially leading to fulminant pneumonia, especially among the immunosuppressed.⁸³ Nonbiological contaminants also have been found, which include heavy metals from soil like aluminum⁸⁴ and cadmium, the latter of which seems to be absorbed by the cannabis plant in particularly high concentrations.⁸⁵ Organophosphate pesticides are other nonbiological contaminants that are found less in cannabis cultivated outdoors than indoors.³⁶ Finally, tiny glass beads or sand have been found in street samples of cannabis, which were added for weight to boost profits and can cause damage to the oral mucosa and lungs.⁸⁶
- *Contamination by cannabis.* Secondary inhalation of cannabis fumes released by primary smokers is a theoretical but negligible threat, as shown by a study of airborne particulates in urban Spain⁸⁷ and another study of passive exposure to cannabis smoke in a Netherlands coffee shop.⁸⁸ More research in this area is warranted from the perspective of public health.

The Controversy Remains

In 1969, an article published in the *New England Journal of Medicine* quoted from the Wootton Report that cannabis is "a potent drug, having as wide a capacity as alcohol to alter mood, judgment, and functional ability, and admitted that it is a dangerous drug in that sense, but in terms of physical harmfulness much less dangerous than opiates, amphetamines, and barbiturates and also less dangerous than alcohol."⁸⁹ Since then, scientific and clinical data have helped us understand the mechanisms of actions of cannabis and its derived compounds for treating chronic and neuropathic pain, highlighting the potential analgesic synergism with opioids and the potential of an opiate sparing effect in clinical settings. In particular, animal studies have recently shown that cannabidiol (CBD), a nonpsychoactive constituent of marijuana, is capable of decreasing self-administration and drug-seeking behavior caused by heroin,⁹⁰ in addition to other anti-in-

flammatory antipsychotic and neuroprotective effects.^{91,92} Another observational study of the ratio of CBD:THC from street cannabis samples suggests that a higher CBD content reduced reinforcing behavior and attention bias to marijuana. Further directions of research include a better understanding of the mechanisms of action of CBD and its interplay with THC, plus bioengineering a safer marijuana strain that contains the appropriate composition of CBD and THC for optimal therapeutic effects with the least adverse profile and addictive potential. Thus, important issues of dosage standardization, quality control, adverse effects profiling, and prevention of addiction could be resolved. Until then, family physicians in North America and Canada continue to face the under-reported use of cannabis in our society and its risks of abuse.

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Cannabinoids as Pharmacotherapies for Neuropathic Pain: From the Bench to the Bedside

Elizabeth J. Rahn and Andrea G. Hohmann

Neuroscience and Behavior Program, Department of Psychology, University of Georgia, Athens, Georgia 30602

Summary: Neuropathic pain is a debilitating form of chronic pain resulting from nerve injury, disease states, or toxic insults. Neuropathic pain is often refractory to conventional pharmacotherapies, necessitating validation of novel analgesics. Cannabinoids, drugs that share the same target as Δ^9 -tetrahydrocannabinol (Δ^9 -THC), the psychoactive ingredient in cannabis, have the potential to address this unmet need. Here, we review studies evaluating cannabinoids for neuropathic pain management in the clinical and preclinical literature. Neuropathic pain associated with nerve injury, diabetes, chemotherapeutic treatment, human immunodeficiency virus, multiple sclerosis, and herpes zoster infection is considered. In animals, cannabinoids attenuate neuropathic nociception produced by traumatic nerve injury, disease, and toxic insults. Effects of mixed cannabinoid CB_1/CB_2 agonists, CB_2 selective agonists, and modulators of the endocannabinoid system (i.e., inhibitors of transport or

degradation) are compared. Effects of genetic disruption of cannabinoid receptors or enzymes controlling endocannabinoid degradation on neuropathic nociception are described. Specific forms of allodynia and hyperalgesia modulated by cannabinoids are also considered. In humans, effects of smoked marijuana, synthetic Δ^9 -THC analogs (e.g., Marinol, Cesamet) and medicinal cannabis preparations containing both Δ^9 -THC and cannabidiol (e.g., Sativex, Cannador) in neuropathic pain states are reviewed. Clinical studies largely affirm that neuropathic pain patients derive benefits from cannabinoid treatment. Subjective (i.e., rating scales) and objective (i.e., stimulus-evoked) measures of pain and quality of life are considered. Finally, limitations of cannabinoid pharmacotherapies are discussed together with directions for future research. **Key Words:** Endocannabinoid, marijuana, neuropathy, multiple sclerosis, chemotherapy, diabetes.

NEUROPATHIC PAIN

Neuropathic pain is a debilitating form of treatment-resistant chronic pain caused by damage to the nervous system. Neuropathic pain may result from peripheral nerve injury, toxic insults, and disease states. Neuropathic pain remains a significant clinical problem because it responds poorly to available therapies. Moreover, adverse side effect profiles may limit therapeutic dosing and contribute to inadequate pain relief. Drug discovery efforts have consequently been directed toward identifying novel analgesic targets for drug development. This review will evaluate the efficacy of cannabinoids as analgesics for the treatment of neuropathic pain from the bench to the bedside.

CANNABINOID RECEPTOR PHARMACOLOGY

Evidence for the use of *Cannabis sativa* as a treatment for pain can be traced back to the beginnings of recorded history. The discovery by Gaoni and Mechoulam¹ of Δ^9 -tetrahydrocannabinol (Δ^9 -THC), the primary psychoactive ingredient in cannabis, set the stage for the identification of an endogenous cannabinoid (endocannabinoid) transmitter system in the brain. The endocannabinoid signaling system includes cannabinoid receptors (e.g., CB_1 and CB_2), their endogenous ligands (e.g., anandamide and 2-arachidonylglycerol), and the synthetic and hydrolytic enzymes that control the bioavailability of the endocannabinoids. Both CB_1 ² and CB_2 ³ receptors are G-coupled protein receptors that are negatively coupled to adenylate cyclase. Activation of CB_1 receptors suppresses calcium conductance and inhibits inward rectifying potassium conductance, thereby suppressing neuronal excitability and transmitter release. CB_2 receptor activation stimulates MAPK activity but does not modulate calcium or potassium conductances.⁴ The development of CB_1 ⁵ and CB_2 ⁶ receptor knockout mice has helped elucidate the

Address correspondence and reprint requests to: Andrea G. Hohmann, Neuroscience and Behavior Program, Department of Psychology, University of Georgia, Athens, GA 30602-3013. E-mail: ahohmann@uga.edu.

physiological roles of cannabinoid receptors in the nervous system. Generation of $CB_1^{-/-}$ mice that lack CB_1 receptors in nociceptive neurons in the peripheral nervous system while retaining CNS expression (SNS- CB_1^{-}) has also documented a role for these receptors in controlling nociception.⁷

CB_1 and CB_2 receptors exhibit disparate anatomical distributions.³ CB_1 receptors are localized to the CNS and the periphery. CB_1 receptors are found in sites associated with pain processing, including the periaqueductal gray,⁸ rostral ventromedial medulla,⁸ thalamus,⁹ dorsal root ganglia (DRG),¹⁰ amygdala,⁸ and cortex.⁸ Densities of CB_1 receptors are low in brainstem sites critical for controlling heart rate and respiration. This distribution explains the low toxicity and absence of lethality after marijuana intoxication. Activation of the CB_1 receptor also results in hypothermia, sedation, catalepsy, and altered mental status.¹¹ Thus, it is critical for any cannabinoid-based pharmacotherapy targeting CB_1 receptors to balance clinically relevant therapeutic effects with unwanted side effects. The CB_2 receptor was originally believed to be restricted to the periphery, primarily to immune cells (e.g., mast cells).¹² They may be present neuronally in some species. The CB_2 receptor protein has been reported in the DRG,¹³ brainstem,¹⁴ thalamus,¹⁵ periaqueductal gray,¹⁵ and cerebellum^{15,16} of naïve rats. CB_2 receptor levels in most CNS sites are present at only low levels under basal conditions (or are below the threshold for detection). However, an upregulation of CB_2 receptor immunoreactivity or mRNA is observed in sites implicated in nociceptive processing under conditions of induced neuropathy.^{17,18} CB_2 receptors are localized to microglia, a resident population of macrophages within the CNS that are functionally and anatomically similar to mast cells. Microglia secrete pro-inflammatory factors and induce the release of several mediators (e.g., nitric oxide, neurotrophins, free radicals) that are associated with synaptogenesis and plasticity, leading to changes in neuronal excitability.

ENDOCANNABINOIDS

The first endogenous ligand for cannabinoid receptors¹⁹ was named anandamide (AEA) after the Sanskrit word for bliss. Several other endocannabinoids including 2-arachidonoylglycerol (2-AG),^{20,21} noladin ether,²² virodhamine,²³ and N-arachidonol-dopamine²⁴ have been described. Fatty-acid amide hydrolase (FAAH) is the principle catabolic enzyme for fatty-acid amides including AEA and N-palmitoylethanolamine (PEA).²⁵ PEA does not bind cannabinoid receptors and has recently been described as an endogenous ligand for peroxisome proliferator receptor- α (PPAR- α).²⁶ PEA may indirectly alter levels of endocannabinoids by competing with anandamide and other fatty-acid amides for degradation

by FAAH or by suppressing FAAH expression at the transcriptional level.^{27,28} FAAH^{-/-} mice are hypoalgesic in models of acute and inflammatory pain; these effects are blocked by a CB_1 antagonist.^{29,30} This basal hypoalgesia is absent in FAAH^{-/-} mice subjected to nerve injury, where genotype differences in evoked neuropathic pain behaviors are not apparent.³⁰

Anandamide also acts as an endovanilloid at the transient receptor potential cation channel (TRPV1) receptor.³¹ AEA shows affinity for TRPV1 that is 5- to 20-fold lower than its affinity for CB_1 . TRPV1 is not activated by classical, nonclassical, or aminoalkylindole cannabinoid agonists. AEA can also activate the peroxisome proliferator receptor- γ (PPAR γ) receptor.³² Thus, not all effects of AEA are mediated by cannabinoid receptors.

The metabolic pathways responsible for endocannabinoid degradation are well-characterized. Several FAAH inhibitors (e.g., OL135, URB597) have been developed and used to investigate physiological effects of increasing accumulation of AEA and other fatty-acid amides. Monoacylglycerol lipase (MGL) is a key enzyme implicated in the hydrolysis of 2-AG.^{33,34} MGL inhibitors (e.g., URB602, JZL184) have been developed and can be used to selectively increase accumulation of this endocannabinoid. The endocannabinoid system has complex relationships with other metabolic pathways. Both AEA and 2-AG can be metabolized by cyclooxygenase-2, a phenomenon that may contribute to the antinociceptive properties of nonsteroidal anti-inflammatory drugs that act through inhibition of cyclooxygenase-2.⁴ Table 1 provides a summary of cannabinoids and related compounds that have been evaluated for efficacy in preclinical and clinical studies of neuropathic pain.

CANNABINOID MODULATION OF NEUROPATHIC NOCICEPTION IN ANIMAL MODELS

W. E. Dixon³⁵ was the first scientist to systematically study the antinociceptive properties of *Cannabis sativa*. Dixon³⁵ reported that cannabis smoke delivered to dogs attenuated their responsiveness to pin pricks. He observed that normally "evil-tempered and savage" dogs became "docile and affectionate" after exposure to cannabis, reflecting the psychotropic and mood-altering effects of cannabinoids. Motor effects observed after high doses of cannabinoids included drowsiness, awkward gait, and ataxia. Work by Walker's group subsequently demonstrated that cannabinoids suppress nociceptive transmission (for review see³⁶). Early observations of the antinociceptive properties of cannabinoids laid a foundation for future research examining the impact of canna-

Table 1. *Cannabinoids Evaluated for Suppression of Neuropathic Nociception*

Natural cannabinoid ligands and synthetic analogues

- Δ^9 -THC (Dronabinol/Marinol)
- Cannabidiol (CBD)
- Cannador (cannabis extract, Δ^9 -THC:CBD, 2.5 mg:1.25 mg)
- Cannabis
- eCBD (Cannabis with high CBD content)
- Nabilone (Cesamet, Δ^9 -THC analogue)
- Sativex (oral-mucosal spray, Δ^9 -THC:CBD, 2.7 mg:2.5 mg)

Endocannabinoids

- Anandamide (AEA)
- 2-arachydonoylglycerol (2-AG)

Fatty acids

- L-29
- N-arachidonoyl glycine (NaGly)
- Palmitoylethanolamine (PEA)

CB₁-selective agonists

- ACEA
- Met-F-AEA

Mixed CB₁/CB₂ agonists

- BAY59-3074
- CP55,940
- CT-3 (Ajulemic acid)
- HU-210
- WIN55,212-2

CB₂-selective agonists

- A-796260
- A-836339
- AM1241 ((R,S)-AM1241)
- (R)-AM1241
- (S)-AM1241
- AM1714
- Compound 27
- GW405833 (L768242)
- JWH015
- JWH133
- MDA7
- MDA19

Endocannabinoid modulators

Uptake Inhibitors:

- AM404
- VDM11

FAAH inhibitors:

- Compound 17
- OL135
- URB597

MGL inhibitors:

- JZL184
- URB602

FAAH = fatty-acid amide hydrolase; MGL = monoacylglycerol lipase; THC = tetrahydrocannabinol.

binoids and modulation of the endocannabinoid system on neuropathic pain.

Models of surgically-induced traumatic nerve injury

Cannabinoids suppress neuropathic nociception in at least nine different animal models of surgically-induced traumatic nerve or nervous system injury. Here, we review the literature with a focus on uncovering effects of

different classes of cannabinoids on both neuropathic nociception and central sensitization in each model. We also consider the impact of nerve injury on the endocannabinoid signaling system. Where applicable, we review effects of neuropathic injury on levels of endocannabinoids and related lipid mediators, and we describe regulatory changes in CB₁ and CB₂ receptors induced by nerve injury. Finally, we will consider implications of the preclinical findings for cannabinoid-based pharmacotherapies for neuropathic pain in humans.

Chronic constriction injury

Chronic constriction injury (CCI) produces mechanical allodynia as well as thermal allodynia and hyperalgesia in the ipsilateral paw as early as 2 days post-surgery.³⁷ Initial reports failed to find mechanical hyperalgesia, although several of the reviewed articles report its presence after surgery. Very few studies have investigated the presence of cold allodynia after this nerve injury; however, those that have evaluated its presence uniformly demonstrate efficacy of cannabinoids in suppressing cold allodynia. CB₁ receptors are upregulated in the spinal cord after CCI; these effects are believed to be modulated by tyrosine kinase³⁸ and glucocorticoid³⁹ receptors. Not surprisingly, several classes of cannabinoids have been shown to suppress CCI-induced neuropathic nociception in rodents and include mixed cannabinoid agonists, which target both CB₁ and CB₂ receptors, CB₂ selective agonists, and modulators of the endocannabinoid system that inhibit FAAH or MGL (Tables 2 and 3).

Chronic administration of synthetic analogues of natural cannabinoid ligands containing cannabidiol (CBD) attenuate or reverse established thermal and mechanical hyperalgesia in the CCI model. However, anti-hyperalgesic effects observed with these compounds are likely to be independent of cannabinoid receptors, and may be mediated through TRPV1. Those studies investigating pharmacological specificity have demonstrated blockade with the TRPV1 antagonist capsazepine, but not a cannabinoid CB₁ or CB₂ antagonist.^{40,41} The CB₁ specific antagonist SR141716 has been tested in this model with disparate results. SR141716, administered acutely, is pro-hyperalgesic and pro-allodynic in this model.⁴² However, SR141716 (by mouth), administered chronically, suppresses thermal and mechanical hyperalgesia in both rats and CB₁^{+/+} mice, while failing to produce an effect in CB₁^{-/-} mice.⁴³ These reports are interspersed with a host of articles that indicate no antinociceptive or pro-nociceptive effects of either CB₁ or CB₂ antagonists, administered alone. Thus, it is important to emphasize that the behavioral phenotype induced by antagonist treatment may depend on the level of endocannabinoid tone present in the system, the injection paradigm (chronic

Table 2. Antinociceptive Effects of Cannabinoids after Chronic Constriction Injury in Rats

	Compound	Route	Thermal	Mechanical Hyperalgesia	Mechanical Allodynia	Mechanism		Ref No.
						CB ₁	CB ₂	
Synthetic Analogues of Natural Cannabinoid Ligands	eCBD	p.o.	Yes	—	Yes	—	—	41
		p.o. [‡]	Yes	—	Yes	No (SR1 i.p.)	No (SR2 i.p.)	
	CBD	p.o.	No	No	—	—	—	40
			No	—	No	—	—	41
		p.o. [‡]	Yes	—	Yes	—	—	41
			Yes	Yes	—	No (SR1 i.p.)	No (SR2 p.o.)	40
		Δ ⁹ -THC	p.o.	Yes	—	Yes	—	41, 171
			p.o. [‡]	No	—	No	—	41
		pCBD+pTHC	p.o. [‡]	Yes	—	Yes	—	41
	Mixed CB ₁ /CB ₂ agonists	BAY 59-3074	p.o.	Yes	—	Yes	—	—
CP55,940		i.p.	Yes	—	Yes	—	—	171
WIN55,212-2		s.c.	No	No	—	—	—	48
			—	No	No	—	—	172
			—	Yes	—	—	—	173
		s.c. [‡]	Yes	Yes	—	—	—	48
			Yes	—	Yes	Yes (SR1 i.v.)	Yes (SR2 i.v.)	54
			Yes	—	Yes	Yes (SR1 s.c. [†])	—	57
		i.p.	Yes-heat Yes-cold	Yes	Yes	Yes* (SR1 i.p.)	—	42
			Yes	—	Yes	Yes (SR1 i.p.)	—	119
		i.v.	Yes	—	—	—	—	47
		i.t.	Yes [†]	—	Yes [†]	Yes (AM281 i.t.)	—	38
CB ₂ Agonists				—	Yes	—	—	—
		i.pl.	Yes [†]	—	Yes [†]	—	—	119
	A-796260	i.p.	—	—	Yes	—	—	174
	A-836339	i.p.	—	—	Yes	—	Yes (SR2 i.p.)	51
		i.p. [‡]	—	—	Yes	—	—	
	GW405833 (L768242)	i.p.	—	—	Yes	—	—	50
Endocannabinoid Modulators	AM404	s.c.	No	—	No	—	—	52
			Yes	—	Yes	—	—	57
			Yes	—	—	—	—	53
		s.c. [‡]	Yes	—	Yes	Yes (SR1 i.p.)	Yes (SR2 i.p.)	52
			Yes	Yes	—	Yes (SR1 i.p.)	No (SR2 i.p.)	53
			Yes	—	Yes	Yes (SR1 i.v.)	No (SR2 i.v.)	54
			Yes	—	Yes	Yes (SR1 s.c. [‡])	—	57
VDM11	s.c. [‡]	Yes	—	Yes	—	—	52	

eCBD = *Cannabis sativa* with high CBD content; i.p. = intraperitoneal; i.pl. = intraplantar; i.t. = intrathecal; i.v. = intravenous; pCBD = pure cannabidiol; p.o. = per os; pTHC = pure Δ⁹-tetrahydrocannabinol; s.c. = subcutaneous; SR1 = SR141716; SR2 = SR144528.
*Only tested in thermal hyperalgesia and mechanical allodynia; [†]increased measurements in contralateral paw at dose(s) tested; [‡]chronic postinjury.

vs acute), and the presence of regulatory changes in cannabinoid receptors or endocannabinoids.

Several mixed cannabinoid CB₁/CB₂ agonists have been shown to suppress all forms of neuropathic nociception observed in the CCI model, primarily through CB₁ mediated mechanisms. Several studies, including the original study by Herzberg et al.⁴² were conducted before the development of a CB₂ antagonist and recognition that CB₂ receptor mechanisms modulate neuropathic pain.⁴⁴ Mixed CB₁/CB₂ agonists, such as CP55,940 or WIN55,212-2, typically act as CB₁ selective agonists after systemic administration,⁴⁵ although CB₂ mediated effects may be unmasked after administration of CB₂ selective agents or after local administra-

tion of the same compounds. A neurophysiological basis for these findings is derived from the observation that WIN55,212-2 (intravenously) dose dependently inhibits windup,⁴⁶ as well as CCI-induced increases in spontaneous firing⁴⁷ of spinal wide dynamic range (WDR) neurons through a CB₁ dependent mechanism. Spontaneous firing of WDR neurons is believed to contribute to behavioral hypersensitivity and neuronal sensitization in neuropathic pain states. WIN55,212-2 also normalizes prostaglandin E₂ levels and nitric oxide activity, two mediators of neuropathic pain that are increased after CCI.⁴⁸

Multiple CB₂ selective agonists have been demonstrated to suppress CCI-induced mechanical allodynia,

Table 3. Antinociceptive Effects of Cannabinoids after Chronic Constriction Injury in Mice

Compound	Route	Thermal	Mechanical Hyperalgesia	Mechanical Allodynia	Mechanism		Ref No.
					CB ₁	CB ₂	
Endocannabinoid Modulators	JZL184	i.p. Yes-cold (FAAH ^{+/+} and FAAH ^{-/-}) Yes-cold (FAAH ^{+/+}) No-cold (FAAH ^{-/-})	—	Yes (FAAH ^{+/+} and FAAH ^{-/-})	Yes (SR1 i.p.) —	No (SR2 i.p.) —	59
	OL-135	i.p. Yes-cold (FAAH ^{+/+}) No-cold (FAAH ^{-/-})	—	Yes (FAAH ^{+/+}) No (FAAH ^{-/-})	Yes (SR1 i.p.) —	Yes (SR2 i.p.) —	55
	URB597	p.o. p.o.* i.p. Yes-cold (FAAH ^{+/+}) No-cold (FAAH ^{-/-})	Yes Yes	—	Yes (FAAH ^{+/+}) No (FAAH ^{-/-})	Yes (SR1 i.p.) Yes (SR1 i.p.) —	Yes [†] (SR2 i.p.) Yes (SR2 i.p.) —
Fatty Acids	PEA	i.p. i.p.*	—	Yes Yes	—	—	60

FAAH = fatty-acid amide hydrolase; i.p. = intraperitoneal; PEA = palmitoylethanolamine; p.o. = per oral; SR1 = SR141716; SR2 = SR144528.

*Chronic postinjury; [†]only for thermal hyperalgesia and mechanical allodynia, no blockade observed for mechanical hyperalgesia.

although pharmacological specificity has not been consistently assessed (Table 2). Thus, it is noteworthy that CB₂ receptor mRNA is upregulated in the lumbar spinal cord after CCI. This upregulation is restricted to nonneuronal cells (e.g., glia).⁴⁹ Interestingly, GW405833, a CB₂ specific agonist, also reduces depression-like behavior associated with this mononeuropathy in the forced swim test.⁵⁰ Tolerance, a feature that may contribute to loss of analgesic efficacy of currently available analgesics, failed to develop after repeated administration of the CB₂ specific agonist, A-836339. Thus, CB₂ agonists may show therapeutic potential for suppressing neuropathic pain without producing tolerance when administered either alone or as adjuncts to existing treatments.⁵¹

Endocannabinoid modulators suppress neuropathic pain symptoms associated with CCI (Tables 2 and 3). AM404, an endocannabinoid transport inhibitor, increases accumulation and, hence, bioavailability, of anandamide (and potentially other endocannabinoids) through a mechanism that remains incompletely understood. AM404 also normalizes CCI-induced changes in nitric oxide activity,^{52,53} cyclooxygenase-2⁵³ activity, cytokine levels (e.g., tumor necrosis factor- α and interleukin-10),⁵² and nuclear factor- κ B⁵² levels. In CCI rats, chronic administration of either AM404 or URB597 suppresses plasma extravasation, a condition associated with neuropeptide release at peripheral levels.^{54,55} AM404, administered chronically or acutely, does not affect locomotor behavior, indicating a low propensity of this agent to produce unwanted motor side effects associated with direct activation of CB₁ receptors.^{52,53}

CCI produces regulatory changes in endocannabinoid levels. CCI increases AEA and 2-AG levels in the periaqueductal gray and rostral ventromedial medulla, sites implicated in the descending modulation of pain.⁵⁶ CCI also increases levels of endogenous AEA, but not 2-AG, in the dorsal raphe, which was an observation that may help explain the antihyperalgesic efficacy of an anandamide transport inhibitor in this model.⁵⁷ CCI increases serotonin (5-HT) levels in the dorsal raphe and this effect was suppressed by both WIN55,212-2 and AM404 in a CB₁ dependent manner.⁵⁷ CCI-induced Fos expression was observed in response to non-noxious mechanical stimulation in spinal cord laminae I and II, the site of termination of A δ and C fibers, which carry nociceptive sensory information from the periphery to the CNS. Lower levels of evoked Fos expression were observed in laminae III and IV of CCI rats. Chronic administration of AM404 significantly decreased CCI-induced Fos expression in the lumbar spinal cord through CB₁/CB₂ and TRPV1-mediated mechanisms.⁵⁸ Antinociceptive effects of FAAH inhibitors (OL135 and URB597) have also been reported in mice after CCI. OL135 and URB597 attenuate cold and mechanical allodynia in a manner that is dependent on activation of both CB₁ and CB₂ recep-

tors.⁵⁹ In addition, both OL135 and URB597 are antinociceptive in FAAH^{+/+} mice, but fail to produce an effect in FAAH^{-/-} mice.⁵⁹ The novel MGL inhibitor, JZL184, attenuates CCI-induced mechanical and cold allodynia through indirect activation of the CB₁ receptor; JZL184 was efficacious in attenuating neuropathic nociception in both FAAH^{+/+} and FAAH^{-/-} mice.⁵⁹ The fatty acid PEA, administered chronically, attenuated the development of thermal hyperalgesia and mechanical allodynia in the CCI model through CB₁, PPAR γ , and TRPV1-mediated mechanisms.⁶⁰ Chronic administration of PEA also normalized levels of three neurotrophic factors (nerve growth factor, glial cell line-derived neurotrophic factor, and neurotrophin-3) that were increased by CCI.⁶⁰ Thus, activation of CB₁ and CB₂ receptors, as well as pharmacological manipulation of endocannabinoid accumulation or breakdown, suppresses neuropathic nociception in rodents.

Partial sciatic nerve ligation (Seltzer Model)

Mechanical hyperalgesia and allodynia are observed after partial ligation of the sciatic nerve.⁶¹ Thermal hyperalgesia was present in all studies reviewed here that evaluated this measure with one exception.⁶² Only two studies we reviewed examined the presence of cold allodynia after partial sciatic nerve ligation; the first study found that both CB₂^{+/+} and CB₂^{-/-} mice showed evidence of cold allodynia after surgery.⁶³ Cold allodynia has also been reported in rats after partial sciatic nerve ligation.⁶⁴ All classes of cannabinoids evaluated produced anti-allodynic and antihyperalgesic effects in the Seltzer model (Table 4).

Pro-hyperalgesic effects of SR141716 and SR144528 have been reported in the Seltzer model,⁶⁵ indicating a potential alteration in endocannabinoid tone after nerve injury. No other articles we reviewed reported similar effects of cannabinoid antagonists administered alone in this model. Exogenously applied endocannabinoids, AEA and 2-AG, suppress changes in neuropathic nociception induced by partial sciatic nerve ligation. Interestingly, AEA produced anti-hyperalgesic and anti-allodynic effects through a CB₁ mechanism,^{65,66} whereas 2-AG produced anti-hyperalgesic and anti-allodynic effects through activation of both peripheral CB₁ and CB₂ receptors.⁶⁷ AEA and PEA exerts effects, at least in part, through a peripheral mechanism; both fatty-acid amides suppressed release of calcitonin gene-related peptide and somatostatin evoked by the irritant resiniferotoxin without altering peptide release under basal conditions.⁶⁵ Antihyperalgesic effects of AEA and PEA were blocked by a CB₁ and CB₂ antagonist, respectively.⁶⁵ One limitation with studies using exogenous administration of endocannabinoids is that they do not imply that endocannabinoids are released under physiological conditions to produce these effects. Several studies report efficacy of mixed canna-

binoid CB₁/CB₂ agonists in this model, although CNS side effects were nonetheless observed in the same dose range that resulted in full reversal of neuropathic nociception.⁶⁸ Ajulemic acid (CT-3), which was developed as a peripherally restricted cannabinoid analogue, also produced activity in the tetrad, but antihyperalgesic effects occurred at doses lower than those producing side effects.⁶⁹

Structurally distinct CB₂ specific agonists are efficacious in suppressing neuropathic nociception in this model. Moreover, CB₂ receptors in the spinal cord contribute to CB₂ mediated suppression of mechanical allodynia.⁷⁰ CB₂^{-/-} mice reportedly develop thermal hyperalgesia and mechanical allodynia in the contralateral paw after surgery, whereas CB₂^{+/+} do not.⁶³ Microglia and astrocyte expression in the spinal dorsal horn is observed in both CB₂^{-/-} and CB₂^{+/+} mice ipsilateral to nerve injury. However, CB₂^{-/-} mice notably exhibit increased microglial and astrocyte expression in the contralateral spinal dorsal horn, a mechanism which may help to explain differences in neuropathic nociception between wild-types and knockouts.⁶³ Further support for this hypothesis is derived from the observation that overexpression of the CB₂ receptor attenuated enhanced expression of microglia.⁶³ These results suggest that genetic disruption of the CB₂ receptor has a disinhibitory effect on the responses of glial cells after partial sciatic nerve ligation. The cytokine, interferon-gamma, is produced by astrocytes and neurons ipsilateral to injury in both CB₂^{+/+} and CB₂^{-/-} mice. However, CB₂^{-/-} mice exposed to partial sciatic nerve ligation exhibit interferon-gamma immunoreactivity in the spinal dorsal horn contralateral to injury. Interferon- γ ^{-/-}/CB₂^{-/-} mice showed no evidence of neuropathic nociception when the contralateral paw was stimulated after surgery, suggesting that immune responses underlie neuropathic pain responses observable in the contralateral paw of CB₂^{-/-} mice.⁷¹ Deletion of a putative novel cannabinoid receptor, GPR55, is also associated with the failure to develop mechanical hyperalgesia after partial sciatic nerve ligation.⁷²

Compounds targeting three distinct mechanisms for modulating endocannabinoid levels also suppress neuropathic nociception after partial sciatic nerve ligation. The transport inhibitor AM404, administered systemically, suppressed mechanical allodynia in a CB₁ dependent manner without producing motor effects.⁷³ The FAAH inhibitor URB597, administered locally in the paw,⁶⁷ but not systemically,⁶² suppressed both thermal hyperalgesia and mechanical allodynia through a CB₁ mechanism. The MGL inhibitor URB602 (which can not be used systemically as a selective MGL inhibitor), administered locally in the paw, also suppressed neuropathic nociception in this model through activation of both CB₁ and CB₂ receptors.⁶⁷ The fatty-acid analogue of PEA, L-29, also suppressed thermal hyperalgesia and mechanical al-

Table 4. Antinociceptive Effects of Cannabinoids after Partial Sciatic Nerve Ligation (Seltzer Model)

	Compound	Route	Thermal	Mechanical Hyperalgesia	Mechanical Allodynia	Mechanism		Ref No.
						CB ₁	CB ₂	
Exogenous Endocannabinoids	AEA	i.p.	—	Yes	—	Yes (SR1 i.p.)	—	65
		i.paw	Yes	—	Yes	Yes (AM251 i.paw)	No (AM630 i.paw)	66
Mixed CB ₁ /CB ₂ Agonists	2-AG	i.paw	Yes	—	Yes	Yes (AM251 i.paw)	Yes (AM630 i.paw)	67
	CT-3 (AJA)	p.o.	—	Yes	—	Yes (SR1 s.c.)	No (SR2 s.c.)	69
		i.p.	—	—	Yes	—	—	175
	CP55,940	s.c.	—	Yes	—	—	—	68
	HU-210	s.c.	—	Yes	—	—	—	68
		i.p.	NP	—	—	Yes	—	62
				—	—	Yes	—	175
			i.t.	—	—	Yes	—	75
		WIN55,212-2	s.c.	Yes*	Yes	Yes	—	68
			s.c. [†]	Yes [‡]	—	Yes [§]	Yes (AM251 chronic s.c. [§])	Yes (AM630 chronic s.c. [§])
		i.t.	—	Yes	—	Yes (SR1 i.t.)	—	68
		i.pl.	—	Yes	—	Yes (blocked by SR1 s.c., but not i.t.)	—	68
CB ₂ Agonists	GW405833 (L768242)	i.p.	—	Yes	—	—	—	177
			—	—	Yes	—	—	178
	JWH133	i.p.	—	—	No	—	—	70
		i.t.	—	—	Yes (CB ₂ ^{+/-}) No (CB ₂ ^{-/-})	—	—	
		i.paw	—	—	No	—	—	
Endocannabinoid Modulators	AM404	i.p.	—	—	Yes	Yes (AM251 i.p.)	—	73
	URB597	i.p.	NP	—	No	—	—	62
Fatty Acids		i.paw	Yes	—	Yes	Yes (AM251 i.paw)	No (AM630 i.paw)	67
	URB602	i.paw	Yes	—	Yes	Yes (AM251 i.paw)	Yes (AM630 i.paw)	67
	L-29	i.p.	Yes-heat No-cold	—	Yes	Yes (SR1 i.p.)	Yes [†] (SR2 i.p.)	64
	NaGly	s.c.	—	—	No	—	—	75
		i.t.	—	—	Yes	No (AM251 i.t.)	No (SR2 i.t.)	
	PEA	i.p.	—	Yes	—	—	Yes (SR2 i.p.)	65

AEA = anandamide; 2-AG = 2-arachidonoylglycerol; AJA = ajulemic acid; i.p. = intraperitoneal; i.pl. = intraplantar; i.paw = intra-paw; i.t. = intrathecal; NaGly = N-arachidonoyl glycine; NP = not present; PEA = palmitoylethanolamine; p.o. = per oreum; s.c. = subcutaneous; SR1 = SR141716; SR2 = SR144528.

White cells = tested in rats. Shaded cells = tested in mice.

*Increased measurements in contralateral paw at dose(s) tested; [†]Chronic pre-emptive/postinjury or both; [‡]Postinjury; [§]Pre-emptive and postinjury combined; [¶]Only observed blockade for mechanical allodynia, not thermal hyperalgesia.

lodynia in the Seltzer model. The L29-induced suppression of thermal hyperalgesia was mediated by both the CB₁ receptor and PPAR- α , whereas suppression of mechanical allodynia was mediated by CB₁/CB₂ and PPAR- α receptors.⁶⁴ PEA abolished mechanical hyperalgesia after partial sciatic nerve ligation through a mechanism that was blocked by a CB₂ antagonist.⁶⁵ When considering the effects of PEA, it is important to emphasize that PEA does not bind directly to CB₂ receptors⁷⁴; therefore, blockade by a CB₂ specific antagonist could indicate indirect modulation of receptor activity (e.g., via activation of PPAR- α or entourage effects) or blockade of an uncharacterized cannabinoid receptor that binds the CB₂ antagonist SR144528. Intrathecal N-arachidonoyl glycine (NaGly), the arachidonic acid conjugate, also attenuated mechanical allodynia in this model; however, the anti-hyperalgesic actions of this compound are independent of spinal cannabinoid receptors.⁷⁵ Locally injected (intra-paw) paracetamol suppressed mechanical allodynia and thermal hyperalgesia present after partial sciatic nerve ligation, and these effects were blocked by local administration of either a CB₁ or a CB₂ antagonist.⁷⁶ Paracetamol may undergo local metabolic transformation into AM404, resulting in increased levels of endocannabinoids.

Spinal nerve ligation (SNL)

All studies reviewed here documented the presence of mechanical allodynia after SNL.⁷⁷ All studies with the exception of one⁷⁸ indicated the presence of thermal hyperalgesia when animals were tested. One study evaluated the presence of cold allodynia and confirmed that animals with this injury display hypersensitivity to non-noxious levels of cold stimulation.⁷⁹ Gabapentin successfully attenuated mechanical allodynia in this model, however, several other commonly prescribed neuropathic pain medications, including amitriptyline, fluoxetine, and indomethacin failed to show similar effects.⁸⁰ Thus, it is noteworthy that mixed cannabinoid agonists, cannabinoid CB₂ selective agonists, and FAAH inhibitors all attenuated neuropathic nociception induced by SNL (Table 5).

As with other nerve injury models, several mixed cannabinoid CB₁/CB₂ agonists suppress hyperalgesia and allodynia produced by SNL. Acute WIN55,212-2 suppresses all forms of neuropathic nociception tested in this model. Chronic administration of WIN55,212-2 also attenuates the development of mechanical allodynia and suppresses glial activation in the spinal cord after SNL, with no overt motor side effects.⁸¹ Chronic administration of WIN55,212-2 produced anti-allodynic effects for up to 6 days after the final injection. A reappearance of glial activation was also associated with return of neuropathic nociception in this study.⁸¹ CP55,940 produces antinociception in CB₁^{+/+}, CB₂^{+/+}, CB₂^{-/-}, but not

CB₁^{-/-} mice subjected to SNL, suggesting that activity at CB₁ dominates the antinociceptive profile of mixed CB₁/CB₂ agonists after systemic administration.⁴⁵ Spinal, but not systemic, administration of HU-210 has been reported to reduce A δ fiber-evoked responses on spinal WDR neurons in both shams and SNL rats, whereas HU-210 showed no effect on C-fiber responses of SNL rats.⁸²

SNL produces regulatory changes in CB₁ mRNA and endocannabinoid levels. Increases in CB₁ mRNA are observed in the uninjured (but abnormal) L4 DRG ipsilateral to injury.⁸³ Increases in both AEA and 2-AG have also been reported in the ipsilateral injured L5, but not the uninjured L4 DRG.⁸³ These findings collectively document the presence of regulatory changes in endocannabinoid levels associated with SNL, a finding which may contribute to the efficacy of peripherally administered cannabinoid agonists that activate CB₁ receptors in this model.

Noxious stimulation (e.g., C-fiber mediated activity) induces phosphorylation of extracellular signal-regulated protein kinase (ERK) in dorsal horn neurons. The CB₁ specific agonist ACEA inhibits pERK expression induced by *in vitro* application of capsaicin to the spinal cords of SNL rats. This observation contrasts with effects of opioids (i.e., morphine and DAMGO), which lose the ability to inhibit C-fiber induced ERK activation in the L5 spinal cord after SNL.⁸⁴

Multiple CB₂ specific agonists suppress neuropathic nociception induced by SNL. The CB₂ agonist AM1241 suppresses both thermal hyperalgesia and mechanical allodynia after SNL in both rats^{17,44,85} and mice.⁴⁴ CB₁^{-/-} mice receiving AM1241 showed enhanced antihyperalgesia.⁴⁴ An emerging body of literature now suggests that antinociceptive effects of CB₂ agonists may be mediated by suppression of microglial activation.⁴

Evidence for upregulation of CB₂ after SNL has been reported by several groups. CB₂ mRNA was upregulated in the lumbar spinal cord after SNL,⁴⁹ coincident with the expression of activated microglia. Colocalization studies, however, were not performed. Upregulation of CB₂ receptor immunoreactivity on sensory afferent terminals in the spinal cord has also been reported after SNL.¹⁸ This group failed to find co-localization of CB₂ with markers for glial cells in SNL rats, and concluded that CB₂ receptors were upregulated on sensory neurons after spinal nerve ligation.¹⁸ CB₂ mRNA was also shown to be upregulated in the ipsilateral (vs the contralateral) spinal cord and DRG after SNL, and the presence of CB₂ mRNA was confirmed in spinal cord microglial cells in culture.¹⁷

The CB₂ specific agonist GW405833, administered chronically, suppressed the development of mechanical allodynia concomitant with suppression of glial activation at the level of the spinal cord.⁸¹ The structurally

Table 5. Antinociceptive Effects of Cannabinoids after Spinal Nerve Ligation (Traditional and Modified)

	Compound	Route	Thermal	Mechanical Hyperalgesia	Mechanical Allodynia	Mechanism		Ref No.
						CB ₁	CB ₂	
Mixed CB ₁ /CB ₂ agonists	BAY 59-3074	p.o.	NP	—	Yes	—	—	78
	CP55,940	i.p.	—	—	Yes	No (SR1 i.p.)	Yes (SR2 i.p.)	179
			—	—	Yes (CB ₁ ^{+/-})	—	—	45
			—	—	No (CB ₁ ^{-/-}) Yes (CB ₂ ^{+/-} and CB ₂ ^{-/-})	—	—	
	WIN55,212-2	i.t.	—	—	Yes	No (SR1 i.t.)	—	179
		i.p.	Yes-heat Yes-cold	—	Yes*	Yes (SR1 i.p.)	No [†] (SR2 i.p.)	79
			—	—	Yes	—	—	80
			—	—	No	—	—	81
CB ₂ Agonists	AM1241	i.p. [‡]	—	—	Yes	—	—	81
		i.p.	Yes	—	Yes	No (AM251 i.p.)	Yes (AM630 i.p.)	44
			Yes (CB ₁ ^{+/-} and CB ₁ ^{-/-})	—	Yes (CB ₁ ^{+/-} and CB ₁ ^{-/-})	No (AM251 i.p.)	Yes (AM630 i.p.)	44
			—	—	Yes	—	—	85
			i.v.	—	—	Yes	Yes (SR2 i.p.)	17
	Compound 27	i.p.	—	—	Yes	—	—	180
	GW405833 (L768242)	i.p. [‡]	—	—	Yes	—	—	81
	L768242 (GW405833)	i.p.	—	—	Yes	—	—	17
	MDA19	i.p.	—	—	Yes	—	Yes (AM630 i.p.)	181
	MDA7	i.p.	—	—	Yes	No (AM251 i.p.)	Yes (AM630 i.p.)	85
Endocannabinoid Modulators	Compound 17	i.v.	—	—	Yes	—	—	90
	OL135	i.p.	—	—	Yes	No (SR1 i.p.)	Yes (SR2 i.p.)	91

i.v. = intravenous; i.p. = intraperitoneal; p.o. = per os; i.t. = intrathecal; NP = not present; SR1 = SR141716; SR2 = SR144528.

White cells = tested in rats. Shaded cells = tested in mice.

*Increased measurements in contralateral paw at dose(s) tested; [†]Only cold allodynia tested; [‡]Chronic postinjury.

distinct CB₂ specific agonist, JWH133, also attenuates mechanically-evoked responses of WDR neurons in both naive and spinal nerve ligated rats.⁸⁶ Local injection of JWH133 into the ventroposterolateral nucleus of the thalamus attenuated spontaneous and mechanically-evoked neuronal activity in SNL, but not sham rats, in a CB₂ dependent manner.⁸⁷ Thus, CB₂ receptor activation may exert little functional control under nonpathological conditions. Systemic and spinal administration of the novel CB₂ agonist, A-836339, also attenuates spontaneous and mechanically-evoked neuronal firing of spinal WDR neurons in a CB₂ dependent manner in SNL, but not sham rats.⁸⁸ Interestingly, pretreatment with the CB₁ antagonist, SR141716, enhanced the effects of A-836339 when applied to the L5 DRG,⁸⁸ indicating that blockade of CB₁ receptors enhanced the antinociceptive effects of a CB₂ agonist, as previously reported.⁸⁹

Two endocannabinoid modulators have been evaluated behaviorally in this model. Compound 17, a novel FAAH inhibitor, reversed mechanical allodynia in SNL rats with the same potency as a 5-fold higher dose of gabapentin.⁹⁰ In addition, OL135, a compound that accesses the CNS and inhibits FAAH, suppressed mechanical allodynia in a CB₂ dependent manner.⁹¹ Low doses of locally injected URB597 reduced mechanically-evoked responses of WDR neurons and increased endocannabinoid levels in ipsilateral paw tissue of sham-operated rats.⁹² A 4-fold higher dose was required for reduction of mechanically-evoked WDR neuronal responses in SNL rats; these rats showed no corresponding increase in endocannabinoid levels, suggesting that contributions of FAAH to endocannabinoid metabolism may be modified under conditions of neuropathic nociception.⁹² The antinociceptive effects of URB597 were blocked by a CB₁ specific antagonist in both sham and SNL rats.⁹² In the same study, spinal administration of URB597 was equally efficacious at attenuating mechanically-evoked responses and increasing levels of endogenous cannabinoids in SNL and sham rats, and these effects were CB₁ mediated.⁹²

Other nerve injury models

Cannabinoids alleviate neuropathic nociception in several other injury models. These studies support a role for CB₁ in the anti-hyperalgesic effects of cannabinoids, although pharmacological specificity has not been consistently assessed in the literature and high doses of cannabinoid agonists can produce motor side effects, which complicate interpretation of behavioral studies. *Chronic constriction injury of the infraorbital nerve* results in thermal hyperalgesia and mechanical allodynia (as measured by head withdrawals) ipsilateral to the site of injury.⁹³ WIN55,212-2 and HU-210 increased mechanical withdrawal responses and thermal withdrawal latencies on the ipsilateral side of the head in this mo-

del.⁹⁴ WIN55,212-2 was more efficacious in suppressing mechanical allodynia *versus* thermal hyperalgesia in the chronic constriction injury of the infraorbital nerve model. High antihyperalgesic doses of WIN55,212-2 decreased rotarod latencies and body temperature, whereas HU210, at the singular low dose used (10 µg/kg), had no effect on these dependent measures. CB₁ receptor up-regulation was observed in both the ipsilateral and contralateral superficial layer of the trigeminal caudal nucleus, and this effect was greater on the ipsilateral side. These and earlier findings from the same group⁹⁵ indicate that cannabinoids are negative modulators of nociceptive transmission at the superficial layer of the trigeminal caudal subnucleus.

CB₂ receptor immunoreactivity⁹⁶ is increased in the ipsilateral dorsal horn after *L5 spinal nerve transection*.⁹⁷ Importantly, co-localization of CB₂ immunoreactivity with markers of microglia and perivascular cells was observed on day 4 postsurgery.⁹⁶ In this study, neither neuronal cells nor astrocytes expressed immunoreactivity for CB₂ receptors.⁹⁶ CP55,940 reversed mechanical allodynia in this model 1 h after a second intrathecal injection, although this dosing paradigm was also associated with motor effects.⁹⁶ Intrathecal JWH015 dose dependently suppressed behavioral hypersensitivity after a second injection, indicating a cumulative anti-allodynic effect of this drug. Intrathecal JWH015 reduced spinal nerve transection-induced increases in activated microglia in a CB₂ dependent manner, further supporting a role for nonneuronal CB₂ receptors in antihyperalgesic effects of CB₂ agonists.⁹⁶

Two models developed by Walczak et al.^{98,99} involved injuries to the saphenous nerve in rats and mice, respectively. The advantage of injuring the saphenous nerve in comparison with other nerves is that the saphenous nerve is an exclusively sensory nerve, whereas other nerve injury models typically target nerves that subservise both sensory and motor functions. The first model was produced in rats by *saphenous partial nerve ligation*, which involves trapping 30% to 50% of the saphenous nerve in a tight ligature.⁹⁸ Saphenous partial nerve ligation rats presented with all symptoms except mechanical hyperalgesia, which was present inconsistently throughout testing. WIN55,212-2, administered systemically, suppressed all forms of hyperalgesia and allodynia present.⁹⁸ In rats, saphenous partial nerve ligation increased µ-opioid, CB₁, and CB₂ receptor protein in ipsilateral hind paw skin, DRG, and lumbar spinal cord.⁹⁸ In a second injury model, *chronic constriction of the saphenous nerve* was accomplished by tying two loose ligatures around the saphenous nerve in mice.⁹⁹ Systemic WIN55,212-2 suppressed all forms of neuropathic nociception present in this model, including thermal hyperalgesia, cold allodynia, mechanical hyperalgesia, and mechanical allodynia.⁹⁹ Mu-opioid, CB₁, and CB₂ receptor

protein was increased in the ipsilateral spinal cord and hind paw skin at 7 days postsurgery.⁹⁹ In addition, increased CB₁ receptor protein was observed in contralateral hind paw skin 7 days postsurgery and increased CB₂ receptor expression was observed in the contralateral spinal cord 1 and 7 days postsurgery. The neurobiological rearrangement of cannabinoid and mu-opioid receptors may contribute to the antinociceptive efficacy of WIN55,212-2 and morphine in this model.

The *spared nerve injury* (SNI) model reliably produces thermal hyperalgesia and mechanical allodynia in studies that tested for both measures. Initial reports of the SNI model indicated the presence of cold allodynia and mechanical hyperalgesia,¹⁰⁰ but none of the articles reviewed here assessed these behaviors in conjunction with cannabinoid treatment. Standard analgesics (e.g., morphine, gabapentin, amitriptyline) are efficacious in treating neuropathic nociception resulting from a crush injury of the sciatic nerve, but showed limited efficacy after SNI.¹⁰¹ Two mixed cannabinoid CB₁/CB₂ agonists have been tested in this model. Acute WIN55,212-2 suppressed thermal hyperalgesia and mechanical allodynia in both mice lacking CB₁ receptors in primary nociceptors (SNS-CB₁^{-/-}) and their wild-type controls; however, differences in the antinociceptive effects of WIN55,212-2 were observed between genotypes, and these effects were greater with mechanical than thermal sensitivity. Comparable responses to WIN55,212-2 were only observed at doses high enough to induce sedation and rigidity in all mice. SNS-CB₁^{-/-} mice showed exaggerated sensitivity to noxious levels of mechanical stimulation and a cold plate relative to their wild-type counterparts, whereas differential sensitivity was not observed between genotypes with non-noxious levels of mechanical stimulation and noxious levels of thermal stimulation.⁷ Thus, CB₁ receptors on nociceptors in the periphery account for much of the antinociceptive effects of cannabinoids.⁷ A dose-escalation study with BAY 59-3074 in the SNI model indicated that tolerance rapidly develops to side effects observed after chronic administration (e.g., hypothermia), whereas no loss in analgesic efficacy was observed.⁷⁸

Spinal cord injury (SCI)¹⁰² produces mechanical hyperalgesia and allodynia. WIN55,212-2 is the only compound that has been evaluated in the SCI model. Acute WIN55,212-2, administered systemically, suppressed SCI-induced mechanical allodynia in a CB₁ dependent manner, although other parameters of neuropathic pain were not assessed.¹⁰³ Unlike morphine, chronic administration of WIN55,212-2 reduced mechanical allodynia in the SCI model with no decrease in effectiveness over time.¹⁰⁴

Tibial nerve injury is performed by unilaterally axotomizing the tibial branch of the sciatic nerve. Mechanical allodynia and thermal hyperalgesia were present in the initial study describing this technique,¹⁰⁵ as well as the

study we reviewed. Systemic BAY 59-3074 was shown to attenuate both forms of neuropathic nociception, although pharmacological specificity was not assessed.⁷⁸ Tibial nerve injury resulted in an upregulation of CB₁ receptor mRNA in the contralateral thalamus on day 1 postsurgery,¹⁰⁶ indicating cannabinoid receptor regulation within an important relay nucleus in the ascending pain pathway.

Disease-related models of neuropathic pain

Cannabinoid agonists have been evaluated in animal models of disease-related neuropathic pain, although pharmacological specificity has not been consistently assessed. Herein, we review effects of cannabinoids in preclinical models of neuropathic pain induced by diabetes, chemotherapeutic treatment, HIV/antiretroviral treatment, demyelination disorders, multiple sclerosis (MS), and postherpetic neuralgia.

Single injection of streptozotocin-induced diabetic neuropathy

Diabetic neuropathy induced by a single injection of streptozotocin (STZ) resulted in increased sensitivity to noxious and non-noxious levels of mechanical stimulation, and failed to induce thermal hyperalgesia in the studies reviewed here (Table 6). None of the studies we reviewed evaluated the presence of cold allodynia. 2-Methyl-2'-F-anandamide (Met-F-AEA), a CB₁ specific agonist based on the structure of anandamide, the mixed cannabinoid agonist WIN55,212-2, and the CB₂ specific agonist AM1241, administered chronically, suppressed mechanical hyperalgesia associated with STZ-induced diabetic neuropathy. However, mediation by cannabinoid receptors has not been assessed for agonists tested in this model. Daily pretreatment with indomethacin (cyclooxygenase-1 inhibitor) or L-NG-nitro arginine ([L-NOArg] nonselective nitric oxide synthase inhibitor) increased the antihyperalgesic actions of low doses of WIN55,212-2, AM1241, and Met-F-AEA in STZ rats to a greater extent than the cannabinoid administered alone, suggesting the presence of antinociceptive synergism between cannabinoid and cyclooxygenase pathways.¹⁰⁷ Cyclooxygenase inhibitors may block oxidative metabolism of endocannabinoids, thereby increasing endocannabinoids available to interact with cannabinoid receptors.

Diabetic rats exhibit a decrease in the density of CB₁ receptor protein in DRG.¹⁰⁸ More work is necessary to determine whether this loss of cannabinoid receptors contributes to the neurodegenerative process in diabetes. Increased levels of endocannabinoids have been found in obese patients suffering from type II diabetes,¹⁰⁹ and this effect is likely to result from downregulation of FAAH gene expression, an effect which has also been observed in adipocytes sampled from obese women.¹¹⁰ Lean males subjected to hyperinsulinemia show a 2-fold increase in

Table 6. Antinociceptive Effects of Cannabinoids in Animal Models of Disease-Related Neuropathic Pain

Model	Compound	Route	Thermal	Mechanical Hyperalgesia	Mechanical Allodynia	Mechanism		Ref No.	
						CB ₁	CB ₂		
Diabetic Neuropathy	Met-F-AEA	i.p.	—	Yes	—	—	—	107	
		i.p.*	—	Yes	—	—	—		
	WIN55,212-2	i.p.	NP	—	Yes	—	—	—	182
				—	Yes	—	—	—	107
				NP	—	Yes	—	—	183
	AM1241		i.p.*	—	Yes	—	—	—	107
			i.paw	NP	—	Yes	—	—	183
		i.p.	—	Yes	—	—	—	107	
		i.p.*	—	Yes	—	—	—	107	
Chemotherapy-induced Neuropathy	Cisplatin								
	WIN55,212-2	i.p. [†]	—	—	Yes	—	—	116	
	Paclitaxel ^{118, 120}								
	WIN55,212-2	i.p.	Yes	—	Yes	Yes (SR1 i.p.)	—	119	
		i.pl.	Yes [‡]	—	Yes [‡]	—	—		
	MDA7	i.p.	NP	—	Yes	—	—	85	
	(R,S)-AM1241	i.p.	NP	—	Yes	No (SR1 i.p.)	Yes (SR2 i.p.)	89	
	(R)-AM1241	i.p.	NP	—	Yes	—	—		
	(S)-AM1241	i.p.	NP	—	No	—	—		
	AM1714	i.p.	NP	—	Yes	No (SR1 i.p.)	Yes (SR2 i.p.)		
	Vincristine ¹²¹								
WIN55,212-2	i.p.	NP	—	Yes	Yes (SR1 i.p.)	Yes (SR2 i.p.)	122		
	i.t.	NP	—	Yes	Yes (SR1 i.t.)	Yes (SR2 i.t.)			
	i.pl.	NP	—	No	—	—			
(R,S)-AM1241	i.p.	NP	—	Yes	No (SR1 i.p.)	Yes (SR2 i.p.)			
Other	HIV-SN								
	WIN55,212-2	i.p.*	NP-heat NP-cold	—	Yes [§]	—	—	124, 123	
	L-29	i.p. [¶]	NP-heat NP-cold	—	Yes	Yes (SR1 i.p.)	Yes (SR2 i.p.)	64	
	LDPN								
	WIN55,212-2	i.t.	Yes	—	Yes	Yes (AM251 i.t.)	—	125	
	VZV								
	L-29	i.p.	NP-heat NP-cold	—	Yes	No (SR1 i.p.)	No (SR2 i.p.)	64	
WIN55,212-2	i.p.*	NP-heat NP-cold	—	Yes	—	—	131		

ddc = zalcitabine; HIV-SN = HIV sensory neuropathy (includes antiretroviral treatment (ddc), HIV-gp120, and HIV-gp120 + antiretroviral treatment (ddc) models); i.t. = intrathecal; i.p. = intraperitoneal; i.pl. = intraplantar; LDPN = lysolecithin-induced demyelination-associated peripheral neuropathy of saphenous nerve; NP = not present; SR1 = SR141716; SR2 = SR144528; VZV = varicella zoster virus-induced neuropathy.

White cells = tested in rats. Shaded cells = tested in mice.

*Chronic postinjury; [†]Chronic, pre-emptive and postinjury; [‡]Increased measurements in contralateral paw at dose(s) tested; [§]In antiretroviral (ddc), HIV-gp120, and HIV-gp120 + antiretroviral (ddc) models; [¶]Only tested in the antiretroviral (ddc) model.

FAAH mRNA expression, whereas obese males subjected to the same conditions failed to show similar alterations in gene expression.¹¹¹ These findings are suggestive of a negative feedback mechanism that could result in downregulation of the endocannabinoid signaling system. The CB₁ antagonist rimonabant (Acomplia [Sanofi-Aventis, Montpellier, France]) ameliorates insulin resistance and decreases weight gain in patients suffering from metabolic syndromes.¹¹² In animal models, rimonabant improves resistance to insulin through pathways that are both dependent and independent of adiponectin, a hormone important for the regulation of glucose and catabolism of fatty acids.¹¹³ Although adverse side effects have limited the potential therapeutic efficacy of Acomplia, drugs modulating the endocannabinoid system should not be disregarded as targets for potential treatments of diabetes and its associated syndromes. STZ-diabetic mice showed a progressive decline in the radial arm maze and reduced neurological scores, both of which were recovered after treatment with HU-210.¹¹⁴ However, these effects were not blocked by a CB₁ specific agonist. HU-210 did not alter the hyperglycemia index; however, it did normalize cerebral oxidative stress present in diabetic mice.¹¹⁴ An increase in the number of apoptotic cells and impaired neurite growth was observed in PC12 cells cultured under hyperglycemic conditions, and these were effectively treated by HU-210.¹¹⁴

Cannabinoids may show greater therapeutic potential for treating painful diabetic neuropathy compared to opioids. Interestingly, Δ^9 -THC exhibited enhanced antinociceptive efficacy in diabetic rats, whereas morphine showed reduced antinociceptive efficacy.¹¹⁵ Moreover, a non-nociceptive dose of Δ^9 -THC, administered in conjunction with morphine, enhanced the antinociceptive properties of morphine in both diabetic and naive mice.¹¹⁵ Thus, combinations of opioids and cannabinoids may show promise as adjunctive analgesics in humans. Diabetic rats exhibit lower levels of dynorphin and β -endorphins in CSF relative to nondiabetic rats treated under the same conditions.¹¹⁵ Administration of Δ^9 -THC to diabetic rats restored CSF levels of endogenous dynorphin and leu-enkephalin to levels observed after morphine administration to nondiabetic rats.¹¹⁵ More work is necessary to understand the mechanism underlying these observations.

Chemotherapy-induced neuropathy

Cannabinoid modulation of chemotherapy-induced neuropathy has been evaluated with agents from three major classes of chemotherapeutic agents (Table 6). A singular study has evaluated cannabinoid modulation of neuropathic nociception induced by cisplatin, a platinum-derived agent. WIN55,212-2 prevented the development of mechanical allodynia induced by cisplatin, but

failed to produce an anti-emetic benefit in this study.¹¹⁶ It is possible that the dose of cannabinoid employed, the species used (rat) or toxicity of cisplatin-dosing paradigms may prevent detection of anti-emetic effects in this model. Cannabinoids have been shown to suppress cisplatin-induced emesis in the least shrew.¹¹⁷

Paclitaxel has been most frequently studied in the cannabinoid literature with three studies documenting cannabinoid-mediated suppression of paclitaxel-induced neuropathic nociception. In one study, paclitaxel¹¹⁸ produced mechanical allodynia starting on day 5 that continued throughout the course of study, although thermal hyperalgesia was only present from days 18 to 21.¹¹⁹ WIN55,212-2 suppressed neuropathic nociception in this model, but had no effect on body temperature or immobility. WIN55,212-2-induced decreases in spontaneous motor activity were nonetheless observed.¹¹⁹ A more recent study using the same paclitaxel dosing paradigm¹¹⁸ reported the presence of mechanical allodynia and the absence of thermal hyperalgesia.⁸⁵ Naguib et al.⁸⁵ demonstrated that a novel CB₂ specific agonist, MDA7, suppressed paclitaxel-induced mechanical allodynia, although mediation by CB₂ receptors was not assessed. Using the paclitaxel dosing paradigm described by Flatters and Bennett,¹²⁰ mechanical allodynia, but not thermal hyperalgesia, was observed. In this model, rats showed signs of mechanical allodynia up to 72 days post-paclitaxel.⁸⁹ Systemic administration of either the CB₂ agonist (*R,S*)-AM1241 or its receptor-active enantiomer (*R*)-AM1241 produced CB₂ mediated suppressions of paclitaxel-induced mechanical allodynia. (*S*)-AM1241, the enantiomer exhibiting lower affinity for the CB₂ receptor, failed to produce an anti-allodynic effect.⁸⁹ The novel cannabylactone, AM1714, also reversed mechanical allodynia associated with paclitaxel treatment in a CB₂ dependent manner.⁸⁹ Thus, both mixed CB₁/CB₂ agonists and selective CB₂ agonists suppress paclitaxel-evoked mechanical allodynia.

Cannabinoid modulation of neuropathic nociception has also been evaluated with vincristine, an agent from the vinca-alkaloid class of chemotherapeutic agents. Vincristine produced mechanical allodynia, but not thermal hyperalgesia, in a 10-day injection paradigm.¹²¹ Systemic and intrathecal, but not intraplantar, WIN55,212-2 suppressed vincristine-induced mechanical allodynia through activation of CB₁ and CB₂ receptors.¹²² These findings implicate the spinal cord as an important site of action mediating anti-allodynic effects of cannabinoids. Systemic (*R,S*)-AM1241 also partially reversed vincristine-induced mechanical allodynia in a CB₂ dependent manner.¹²² The anti-allodynic effects of WIN55,212-2 and (*R,S*)-AM1241 were observed at doses that did not produce intrinsic effects on motor behavior in the bar test.¹²² Our studies suggest that clinical trials of canna-

binoids for the management of chemotherapy-evoked neuropathy are warranted.

HIV-associated sensory neuropathy

The mixed cannabinoid agonist WIN55,212-2 is an effective anti-hyperalgesic agent in three distinct animal models of HIV-associated sensory neuropathy (Table 6). Rats treated with the antiretroviral agent zalcitabine (ddc) developed mechanical allodynia that persisted up to 43 days postinjection and peaked between days 14 and 32.¹²³ No hypersensitivity to thermal stimuli or motor deficits was observed after ddc treatment. HIV-1 has indirect interactions with neurons through its binding affinity to the external envelope binding protein gp120; researchers have exploited this mechanism to demonstrate development of peripheral neuropathy in rodents after exposure of the sciatic nerve to the HIV-1 gp120 protein. Perineural HIV-gp120 together with ddc treatment resulted in mechanical allodynia that was greater than either treatment alone; no changes in paw withdrawal latencies to thermal stimuli or motor deficits were reported.¹²³ Thigmotaxis was present in animals receiving ddc, either alone or in conjunction with HIV-gp120, indicating the presence of anxiety-like behavior in these rats.¹²³ Rats receiving ddc displayed modest levels of gliosis, whereas combined treatment with both HIV-gp120 and ddc increased levels of microglial activation.¹²³ Importantly, chronic WIN55,212-2 reversed mechanical allodynia induced by either ddc treatment¹²³ or HIV-gp120 exposure,¹²⁴ whereas animals subjected to both HIV-gp120 and ddc treatment exhibited a WIN55,212-2-induced attenuation of mechanical allodynia.¹²³ Increases in the density of microglia and astrocytes were observed in the ipsilateral dorsal horn after HIV-gp120 treatment. Thus, activated microglia may be a common target underlying cannabinoid-mediated suppressions of neuropathic nociception.

Demyelination-induced neuropathy

WIN55,212-2 has been evaluated in the lysolecithin-induced demyelination model (Table 6). Heightened sensitivity to both non-noxious and noxious mechanical stimulation is observed in lysolecithin-treated rats; this hypersensitivity emerged 5 days postexposure and peaked between 9 and 15 days postexposure.¹²⁵ Recovery to baseline levels was observed by day 23 post-lysolecithin. WIN55,212-2 attenuated mechanical allodynia and thermal hyperalgesia in this model and remained efficacious for up to 1 hour postinjection.¹²⁵ By contrast, DAMGO failed to produce an effect. Notably, the antihyperalgesic and anti-allodynic effects of WIN55,212-2 were reversed by a CB₁ specific antagonist in both tests.

MS-associated neuropathy

Animal models of MS have been described, although to our knowledge, no study to date has evaluated canna-

binoid-mediated suppression of MS-induced neuropathic nociception. Lynch et al.¹²⁶ reported the presence of thermal hyperalgesia (tail immersion) and mechanical allodynia in mice that were infected with Theiler's murine encephalomyelitis virus. Interestingly, female mice showed an increased rate of development and greater allodynia than their male counterparts, a finding which mimics the greater prevalence of neuropathic pain symptoms reported by female MS patients.¹²⁷ Cold and mechanical allodynia, but not thermal hyperalgesia, have been reported in a model of autoimmune encephalomyelitis in which mice were immunized with myelin oligodendrocyte glycoprotein (MOG[35–55])¹²⁸; autoimmune encephalomyelitis has been postulated to underlie the development of neuropathic pain in MS. Interestingly, a mouse model of MS (Theiler's murine encephalomyelitis virus infection) is also characterized by an upregulation of CB₂ receptor mRNA and increases in levels of 2-AG and PEA.¹²⁹ Animals treated subchronically with PEA showed improvements in tests of motor performance, measures that were impaired after Theiler's murine encephalomyelitis virus infection.¹²⁹ Thus, we postulate that cannabinoid CB₂ agonists and modulators of endogenous cannabinoids (e.g., MGL inhibitors) would exhibit anti-allodynic efficacy in this model.

Postherpetic neuralgia

Cannabinoids and fatty-acid amides suppress neuropathic nociception in an animal model of postherpetic neuralgia (Table 6). However, pharmacological specificity has not been consistently assessed in this model. Approximately 50% of rats exposed to the varicella-zoster virus developed mechanical allodynia in the ipsilateral paw by 14 days postinfection; no thermal hyperalgesia or cold allodynia was observed.⁶⁴ The PEA analogue L-29 suppressed mechanical allodynia in this model with an earlier onset relative to gabapentin. However, neither a CB₁ nor CB₂ specific antagonist blocked L-29 mediated suppression of varicella-zoster virus-induced mechanical allodynia.⁶⁴ This finding is perhaps unsurprising given that PPAR- α mediates effects of PEA in suppressing neuronal sensitization.¹³⁰ However, L-29, nonetheless, suppressed neuropathic nociception in the Seltzer model via activation of CB₁ and CB₂ receptors (see Table 4). Systemic WIN55,212-2, administered from days 18 to 21 postinfection, fully reversed mechanical allodynia to baseline levels in this model of postherpetic neuralgia, although pharmacological specificity was not assessed.¹³¹

CANNABINOID MODULATION OF NEUROPATHIC PAIN IN CLINICAL STUDIES

Cannabinoids have been evaluated in clinical studies for their suppression of acute, postoperative and neuro-

pathic pain. Based on our reviews of the literature, cannabinoids exhibit their greatest efficacy when used for the management of neuropathic pain (Tables 7 and 8).¹³² There are approximately 460 known chemical constituents in cannabis. Thus, at the outset, it is important to emphasize that smoked cannabis is not the same as oral Δ^9 -THC or different mixtures of Δ^9 -THC and CBD (e.g., Sativex [GW Pharmaceuticals, United Kingdom] and Cannador [Institute for Clinical Research, IKF, Berlin, Germany]). Other drug delivery mechanisms (e.g., oral-mucosal sprays and rectal suppositories containing cannabinoids) have been developed. Evidence to date from clinical studies suggests that these compounds show therapeutic efficacy in suppressing neuropathic pain (Table 7 and 8).

Three of the articles reviewed here used smoking as the route of administration, whereas the other 13 used oral preparations in the form of pills or oral-mucosal sprays. Side effects were reported in all studies in a proportion of patients receiving cannabinoid-based medications. The most frequently reported side effects were dizziness, impairment of balance, feelings of intoxication, dry mouth, and dysgeusia (most commonly observed with oral-mucosal sprays), sedation, and hunger. One study reported severe gastrointestinal effects for 10% of patients taking Sativex versus 0% reporting similar problems in the placebo group.¹³³ However, unwanted side effects, in contrast to analgesic effects, may undergo tolerance.¹³⁴ Side effects may be minimized using dosing paradigms employing low doses that are only gradually escalated. As follows, we review effects of cannabinoid-based medications in clinical studies using populations of patients presenting with neuropathic pain. Neuropathic pain induced by HIV infection and/or antiretroviral treatment, MS, brachial plexus avulsion, mixed treatment-resistant neuropathic pain, and others were considered.

HIV-associated neuropathy

Two studies have examined effects of smoked cannabis for the treatment of HIV-associated sensory neuropathy (resulting from HIV infection, dideoxynucleoside antiretroviral therapy, or both) and have reported positive results (Table 7). Abrams et al.¹³⁵ reported that 52% of patients (i.e., 13 of 25 receiving cannabis cigarettes) experienced a greater than 30% reduction in pain (visual analogue scale daily ratings [VAS]). Stimulus-evoked pain testing revealed that the group receiving cannabis experienced a reduction in the area sensitive to mechanical allodynia (with a foam brush or 26 g von Frey hair) in the heat and capsaicin sensitization model. Moreover, CD4+, CD8+, and T-cell counts were not negatively impacted by cannabinoid treatment in HIV patients.¹³⁶ In 2009, Ellis et al.¹³⁷ reported similar results in a crossover study using multiple concentrations of Δ^9 -THC in can-

nabis cigarettes administered to patients. Cannabis was superior to a placebo in either phase of the crossover, as measured with the descriptor differential scale or VAS. This study found no changes in heart rate, blood pressure, plasma HIV RNA (viral load; VL), or blood CD4+ lymphocyte counts after cannabis treatment, suggesting that cannabis did not negatively impact the already compromised immune system in these patients. An anonymous cross-sectional questionnaire study revealed that as many as one third of patients suffering from HIV have used cannabis to treat symptoms.¹³⁸ Patients reported self-dosing with marijuana primarily between 6 PM and 12 AM. Among the symptoms improved after cannabis were appetite (97% reported improvement), pain (improved in 94% of the patients with pain), nausea (93% reported improvement), and anxiety (93% reported improvement).¹³⁸

Dronabinol (Marinol [Solvay Pharmaceuticals Inc, Marietta, GA]) is used to counteract AIDS-related wasting and promote appetite in patients suffering from AIDS-related anorexia.¹³⁹ The benefits of Δ^9 -THC and Nabilone (Cesamet [Valeant Pharmaceuticals International, Aliso Viejo, CA]) for the treatment of chemotherapy-induced nausea and vomiting have also been validated.^{140,141} Thus, several features of cannabinoid pharmacology are particularly desirable for an analgesic intervention aimed at managing neuropathic pain in AIDS and cancer patients.

MS-induced neuropathic pain

Several cannabinoid-based medicines have been evaluated in patients suffering from MS-related neuropathic pain. Cannabinoid-based medications have more frequently been evaluated for efficacy in suppressing MS-related spasticity.¹⁴² Dronabinol reduced spontaneous pain intensity as measured with a numerical rating scale (NRS) for a 3-week treatment period,¹³⁴ and improved overall pain ratings on the category rating scale for a 15-week treatment period.¹⁴³ In addition, this drug improved median radiating pain intensity and pressure threshold,¹³⁴ sleep quality, spasms, and spasticity¹⁴³ in MS patients. Cannador is a medicinal cannabis preparation containing Δ^9 -THC and CBD in a 2:1 ratio. CBD is a natural constituent in cannabis, which has very low affinity for cannabinoid CB₁ and CB₂ receptors. It may act as a high potency antagonist of cannabinoid agonists and an inverse agonist at CB₂ receptors.¹⁴⁴ CBD may compete with cannabinoid agonists for cannabinoid receptor binding sites, thereby minimizing psychoactivity of drugs that use a combination of Δ^9 -THC and CBD. The antinociceptive effects of CBD have also been attributed to inhibition of anandamide degradation, the antioxidant properties of the compound, or binding to an unknown cannabinoid receptor.¹⁴⁴ CBD also acts as an agonist at serotonin 5-HT_{1a} receptors.¹⁴⁴ Cannador, ad-

Table 7. Effects of Cannabinoids on Disease-Related Neuropathic Pain in Clinical Studies

	Compound/Route	Primary Outcome Measure	Stimulus Evoked Pain	Secondary Outcome Measures	Ref No.
HIV-SN	Cannabis cigarettes (3.56% Δ^9 -THC)* Smoking	VAS daily pain ratings – 52% reported > 30% reduction in pain	LTS – No effect; Heat and capasaicin sensitization model – Reduced area sensitive to mechanical allodynia	POMS – No effect	135
	Cannabis cigarettes (1–8% Δ^9 -THC) [†] Smoking	DDS and VAS pain ratings – 46% reported \geq 30% reduction in pain	—	POMS/SIP/BSI/plasma VL and CD4+ lymphocyte counts – No effect	137
Multiple Sclerosis-related Neuropathic Pain	Dronabinol (Marinol) [†] p.o.	NRS of median spontaneous pain intensity – Reduction from BL on this measure was 20.5% (–0.6 pt.) with Dronabinol vs. placebo	Median radiating pain intensity/pressure pain threshold – Improved; Cold and warm sensibility/tactile detection/tactile pain detection/vibration sense/temporal summation/mechanical or cold allodynia – No effect	SF-36 – Improvements in bodily pain and mental health categories	134
	Sativex ^{**‡} Oral-Mucosal Spray	*NRS-11 (pain) – –1.25 pt reduction in favor of Sativex	—	NPS/NRS-11 Pain-related sleep disturbances – Improved PGIC – Sativex treated 3.9 \times more likely than placebo to rate themselves in an improved category HADS/MS-related disability scale – No effect	146
		[‡] NRS-11 (pain) – No changes in pain scores from randomized 5-wk trial (up to 2 y) – Sativex still suppressing pain vs. BL	—	44% of patients completed approximately 2 years of open-label study. No increase in titration of dose – No tolerance	147
	Dronabinol (Marinol) [§] p.o. Cannador [§] p.o.	Ashworth spasticity score – No effect	—	Category-rating scales – Improved pain, sleep quality, spasms and spasticity with CBM 10 m walk – Improved with CBM Rivermead Mobility Index/Barthel Index/GHQ-30/UKNDS – No effect	143
	Dronabinol (Marinol) [¶] p.o. Cannador [¶] p.o.	Ashworth spasticity score – Improvement after dronabinol	—	Category rating scales – Improved pain, spasms, spasticity, sleep, shakiness, energy level and tiredness with CBM Rivermead Mobility Index/Barthel Index/GHQ-30/UKNDS/10 m walk – No effect	145

BL = baseline; BSI = brief symptom inventory; CBM = cannabinoid-based medicine; DDS = descriptor differential scale; GHQ = general health questionnaire; HADS = hospital anxiety and depression scale; HIV-SN = HIV-associated sensory neuropathy; LTS = long-term thermal stimulation; MS = multiple sclerosis; NPS = neuropathic pain scale; NRS = numerical rating scale; PGIC = patient global impression of change; p.o. = per ore; pt. = point; POMS = profile of mood states; SF-36 = short form health questionnaire; SIP = sickness impact profile; THC = tetrahydrocannabinol; UKNDS = United Kingdom neurological disability score; VAS = visual analogue scale; VL = viral load.

*Double-blind, placebo-controlled; [†]double-blind, placebo-controlled crossover; [‡]open label extension of randomized, double-blind, placebo-controlled study; [§]randomized, placebo-controlled; [¶]double-blind, placebo-controlled 1-year extension.

Table 8. *Effects of Cannabinoids in Injury-Related and Mixed Neuropathic Pain in Clinical Studies*

	Compound/Route	Primary Outcome Measure	Stimulus Evoked Pain	Secondary Outcome Measures	Ref No.
Brachial Plexus Avulsion	Sativex/ Δ^9 -THC* Oral Mucosal Spray	BS-11 (pain) – <i>Sativex reduced pain by 0.58 boxes vs. placebo</i> Δ^9 -THC reduced pain by 0.64 boxes vs. placebo	—	Pain review BS-11/Sleep quality BS-11/Sleep disturbances – <i>Improved with CBM</i> GHQ-12 – <i>Improved with Sativex</i> SF-MPQ Pain rating index and VAS – <i>Improved with Δ^9-THC</i> PDI – <i>No Effect</i>	150
Mixed Neuropathy	Dronabinol (Marinol) [†] p.o.	VAS daily pain ratings – <i>No effect</i>	Brush-induced mechanical allodynia – <i>No effect</i>	MPQ/BPI/HADS/Nottingham health profile – <i>No effect</i>	164
	Nabilone (Cesamet)/DHC [‡] p.o.	VAS daily pain ratings – <i>DHC better than Nabilone</i>	—	SF-36 – <i>Physical role improved with nabilone; Bodily pain improved with DHC</i>	166
	CT-3 (AJA)* p.o.	VAS (pain) – <i>CT-3 reduced pain ratings in the morning (3 h postdrug), but not afternoon (8 hrs. postdrug); VRS (pain) – No effect</i>	<i>Decrease in mechanical hypersensitivity (von Frey) in group receiving AJA prior to placebo (p = 0.052)</i>	TMT; ARCI-M – <i>No effect</i>	152, 153
	Cannabis cigarettes (3.5–7% Δ^9 -THC)* Smoking	Spontaneous pain relief VAS – <i>Improved</i>	Mechanical allodynia (foam brush) VAS; Thermal hyperalgesis VAS – <i>No effect</i>	Pain Unpleasantness VAS/NPS – <i>Improved</i> Degree of pain relief PGIC/Psychoactive effects/Neurocognitive effects – <i>Greater with cannabis; Mood VAS – No effect</i>	155
	Δ^9 -THC/CBD/Sativex* Oral-Mucosal Spray (Open-label phase with Sativex prior to crossover)	VAS of 2 worst symptoms – <i>Decrease in symptoms following Δ^9-THC and Sativex relative to placebo</i>	—	Quality of sleep – <i>Improved with all CBM</i> Duration of sleep – <i>No effect</i> BDI/GHQ-28 – <i>Qualitative improvement in mood following CBM</i>	156
	VAS daily ratings of target symptoms – <i>CBD and Δ^9-THC improved pain; Δ^9-THC and Sativex improved spasms; Δ^9-THC improved spasticity</i>	—	Numerical symptom scale – <i>Spasticity severity improved with all CBM; frequency of muscle spasms improved with Δ^9-THC and Sativex</i> VAS daily ratings – <i>Δ^9-THC improved appetite; Sativex improved sleep</i>	159	

(Table continues)

Table 8. Continued

	Compound/Route	Primary Outcome Measure	Stimulus Evoked Pain	Secondary Outcome Measures	Ref No.
Unilateral Mixed Neuropathy	Sativex [§] Oral-Mucosal Spray	NRS (pain) – –1.48 pt. reduction (22%) in Sativex condition versus –0.52 pt. (8%) reduction in placebo condition	Mechanical dynamic allodynia NRS – Reduction with Sativex Punctate mechanical allodynia – No effect	Sleep disturbances NRS/NPS/ PDI/PGIC (neuropathic pain)/ PGIC (pain at allodynic sites) – Improved with Sativex	133
UMNS	Nabilone (Cesamet)* P.o.	11-Point box test of spasticity-related pain – Decreased a median of 2 pt. with Nabilone versus a placebo	—	GHQ-12/BRB-N – No effect Ashworth score/Rivermead Motor Assessment/Barthel Index – No effect	160

ARCJ-M = addiction research center inventory-marijuana; BDI = body disability index; BPI = Wisconsin brief pain inventory; BRB-N = brief repeatable battery of neuropsychological tests; BS-11 = box scale; CBM = cannabinoid based medicine; DHC = dihydrocodeine; GHQ = general health questionnaire; HADS = hospital anxiety and depression scale; MPQ = McGill pain questionnaire; NPS = neuropathic pain scale; NRS = numerical rating scale; PDI = pain disability index; PGIC = patient global impression of change; p.o. = per os; pt. = point; SF-36 = short form health questionnaire; SF-MPQ = short form of McGill questionnaire; TMT = trial making test; UMNS = (chronic) upper motor neuron syndrome; VAS = visual analogue scale; VRS = verbal rating scale.

*Double-blind, placebo-controlled crossover; †open-label, no placebo; ‡double-blind, crossover; §Double-blind, placebo-controlled.

ministered for a 15-week treatment period, improved overall pain ratings, as well as sleep quality, spasms, and spasticity on category rating scales in patients suffering from MS-related neuropathic pain.¹⁴³ A 1-year, double-blind, placebo-controlled follow-up study in MS patients demonstrated improved symptoms of pain, spasms, spasticity, sleep, shakiness, energy level, and tiredness after administration of either dronabinol or Cannador.¹⁴⁵ This study reported that 74% of the patients in the placebo group, versus 45% of the patients receiving cannabinoid-based medications, cited a lack of benefit derived from experimental medication as the reason for discontinuation of the trial.¹⁴⁵ MS patients receiving Sativex (a medicinal cannabis extract containing approximately a 1:1 ratio of CBD:Δ⁹-THC, administered as an oral-mucosal spray) reported significant reductions in pain symptoms, as measured with the NRS-11 and neuropathic pain scale in a 4-week treatment period, double-blind, placebo-controlled study.¹⁴⁶ Ninety-five percent of the patients in the placebo-controlled study chose to enter a 2-year open-label study with Sativex.¹⁴⁷ Fifty-four percent of the patients completed 1 year and 44% of the patients completed 2 years of the study. Twenty-five percent withdrew due to adverse events, and 95% experienced one or more adverse events during the course of treatment. The NRS-11, completed at the end of the trial, or upon withdrawal, was not different from the earlier randomized study indicating that Sativex was still suppressing pain. In addition, patients did not increase the titration of their dose indicating that no tolerance developed to Sativex. Most doses of Sativex were administered between 6 PM and 12 AM, demonstrating that pain symptoms may be at their worst during normal sleeping hours for MS patients. A recent meta-analysis examining six studies of cannabinoid-based medications used for the treatment of MS-related neuropathic pain revealed that cannabis preparations were superior to a placebo.¹⁴⁸

Increased CB₂ immunoreactivity has been reported in spinal cords derived from MS patients.¹⁴⁹ Here, greater numbers of microglia/macrophage cells expressing CB₂ immunoreactivity were observed relative to controls.¹⁴⁹ Thus, cannabinoid-based pharmacotherapies consistently show efficacy for suppressing pain due to MS, a disease state associated with an upregulation of CB₂ receptors in microglia.

Brachial plexus avulsion-induced neuropathy

A single study has examined patients with neuropathic pain resulting exclusively from a brachial plexus avulsion (Table 8). This study¹⁵⁰ used a 3-period crossover design with patients self-administering Δ⁹-THC, Sativex, or a placebo for 14 to 20 days per drug. Both Δ⁹-THC and Sativex reduced the primary outcome measure (box-scale 11 ordinal rating scale) in patients suffering from brachial plexus avulsion, indicating a reduction in pain

symptoms *versus* placebo. Sleep quality disturbance scores were improved in patients receiving either active drug *versus* placebo. Eighty percent of the patients chose to enter an open-label study with Sativex after completion of this randomized study.

CB₂ receptor immunoreactivity has been reported in normal and injured human DRG neurons, brachial plexus nerves, and neuromas, as well as peripheral nerve fibers.¹⁵¹ However, upregulation of CB₂ receptor immunoreactivity was specifically observed in injured human nerve specimens and avulsed DRG obtained during surgery for brachial plexus repair.¹⁵¹ These observations correspond to preclinical observations of cannabinoid receptor upregulation after nerve injury.¹⁸ However, possible changes in CB₁ receptor immunoreactivity were not evaluated in the human tissue, and therefore can not be excluded.

Mixed neuropathic pain

Recruitment of a patient population suffering from a specific form of neuropathic pain can be a difficult prospect; therefore, several studies include patients in which neuropathic pain is associated with different disease states or injuries (Table 8). A 21-patient study reported that ajulemic acid (CT-3) suppressed mixed forms of neuropathic pain, as assessed with the VAS, in the morning (3 h after drug administration), but not in the afternoon (8 h after drug administration).¹⁵² Eighteen of those same patients participated in stimulus-evoked pain testing during the study, and those patients showed a trend toward decreased mechanical allodynia after CT-3 administration.¹⁵³ CT-3 binds with high affinity to both CB₁ and CB₂ receptors, and also binds with low affinity to PPAR γ receptors.¹⁵⁴ CT-3 has limited CNS availability,⁶⁹ which translates into fewer CB₁-mediated side-effects.

Smoking cannabis cigarettes also improved spontaneous pain relief and pain unpleasantness VAS ratings in patients suffering from mixed forms of neuropathic pain, but failed to alter stimulus-evoked pain.¹⁵⁵ This study reported that cannabinoids compounded the decreased neurocognitive performance of patients that was present at baseline. Using an "N of 1" preparation, Notcutt et al.¹⁵⁶ determined if patients experienced improvements in pain after a 2-week open-label phase with Sativex prior to initiation of the double-blind, placebo-controlled crossover phase of the study. Δ^9 -THC and Sativex, but not placebo or CBD, reduced the VAS rating of the two worst pain symptoms during the crossover phase.¹⁵⁶ Quality of sleep was improved by all cannabinoid-based medications¹⁵⁶ and therefore may contribute to the therapeutic potential of the cannabinoids. By contrast, opioid analgesics produce deleterious effects on sleep architecture, including reductions in slow wave sleep and promotion of sleep apnea.^{157,158} A similarly structured study

reported improved pain ratings (VAS) and spasticity severity after CBD and Δ^9 -THC in patients with mixed neuropathic pain.¹⁵⁹ Δ^9 -THC and Sativex also improved muscle spasms and spasticity severity.¹⁵⁹

Sativex improved pain ratings as measured with the NRS in a 5-week, double-blind, placebo-controlled study performed in patients experiencing unilateral neuropathic pain.¹³³ In this study, Sativex reduced mechanical dynamic and punctate allodynia, and improved sleep disturbances.¹³³ Seventy-one percent of the patients tested chose to continue to the open-label study of Sativex with 63% withdrawing by the end of the study for various reasons. Nabilone (Cesamet) decreased measures of spasticity-related pain (11-point box test) in patients experiencing chronic upper motor neuron syndrome associated with a number of pain syndromes.¹⁶⁰ In a retrospective review of patient charts at the Pain Center of the McGill University Health Center from 1999 to 2003,¹⁶¹ 75% of patients received some benefit from taking Nabilone (whether it came in the form of pain relief, improved sleep, decreased nausea, or increased appetite).

Two studies have examined the effects of cannabinoid-based medications in patients suffering from spinal cord injuries. An early case study reported pain relief and improvement in spasticity in a patient with a spinal cord injury after oral Δ^9 -THC.¹⁶² A later study reported that 18% of the patients with spinal cord injuries reported pain relief after treatment with oral dronabinol (mean, 31 mg per day), whereas 23% experienced enhancement of pain resulting in subsequent withdrawal by several patients.¹⁶³ Changes in experimental design after initiation of the study complicate interpretation of these latter findings.¹⁶³

Caveats

We are aware of only two clinical studies that have failed to report efficacy of cannabinoids, relative to placebo, for treatment of mixed neuropathic pain.^{164,165} Our analysis of the study by Clermont-Gnamien et al.¹⁶⁵ is restricted to information provided in the abstract, published in English. Both of these studies used eight or fewer subjects and evaluated dronabinol titrated to a dose of 25 mg/day (where tolerated). The mean dose was 16.6 ± 6.5 mg oral dronabinol in one study¹⁶⁴ and 15 ± 6 mg in the other study.¹⁶⁵ The two studies associated with negative outcomes for cannabinoids in managing neuropathic pain shared several common features: 1) evaluation of mixed neuropathic pain syndromes known to be refractory to multiple analgesic treatments, 2) evaluation of orally-administered Δ^9 -THC (dronabinol) as opposed to mixtures of Δ^9 -THC and CBD, or smoked marijuana, 3) small numbers of subjects, and 4) observation of prominent side effects (e.g., sedation) resulting in high dropout rates. One study reported side effects that were more prominent in older patients and did not cor-

relate with analgesia.¹⁶⁴ Of course, one difficulty in evaluating efficacy of analgesics in patients with neuropathic pain refractory to all known treatments is that there is no indication that these patients would respond favorably to any analgesic under the study conditions. In a third study, effects of Nabilone were compared with dihydrocodeine in a randomized, crossover, double-blind study of 3-months duration that did not include a pharmacologically inert placebo condition. In this latter study,¹⁶⁶ it was concluded that the weak opioid dihydrocodeine was a statistically better treatment for chronic neuropathic pain than Nabilone.¹⁶⁶ Patients in this study exhibited a mean baseline VAS rating of 69.6 mm on a 0 to 100 mm VAS scale; mean VAS ratings were 59.93 ± 24.42 mm and 58.58 ± 24.08 mm for patients taking Nabilone and dihydrocodeine, respectively. However, the authors noted that a small number of subjects responded well to Nabilone, and side effects were generally mild and in the expected range.¹⁶⁶ Benefits of an add-on treatment with Nabilone have nonetheless been noted in patients with chronic therapy-resistant pain (observed in a causal relationship with a pathological status of the skeletal and locomotor system).¹⁶⁷ Oral dronabinol produced significant pain relief *versus* placebo when combined with opioid therapy in both a double-blind, placebo-controlled crossover phase and a subsequent open-label extension.¹⁶⁸ Patients also reported improvements in sleep problems and disturbances while experiencing an increase in sleep adequacy in the open-label phase of the study.¹⁶⁸ Thus, caution should be exerted prior to concluding that side effects of cannabinoids seriously limit the therapeutic potential of cannabinoid pharmacotherapies for pain. Combination therapies, including a cannabinoid and opioid analgesic, show efficacy for treatment-resistant neuropathic pain and may be used to limit doses of analgesics or adjuvants associated with adverse side effects.

Side effects

Diverse neuropathic pain states (characterized as idiopathic, diabetic, immune-mediated, cobalamin-deficiency related, monoclonal gammopathy-related, alcohol abuse-related, and other) were recently examined in a prospective evaluation of specific chronic polyneuropathy syndromes and their response to pharmacological therapies.¹⁶⁹ Intolerable side effects were observed in all groups of patients receiving either gabapentinoids, tricyclic antidepressants, anticonvulsants, cannabinoids (Nabilone or Sativex), or topical agents.¹⁶⁹ Notably, the presence of intolerable side effects was similar among the different classes of medications.¹⁶⁹ In this study, most forms of neuropathic pain had similar prevalence rates and responsiveness to the different pharmacotherapies evaluated.¹⁶⁹

A recent systematic review of adverse effects of medical cannabinoids concluded that most adverse events (96.6%) were not serious and no serious adverse events were related exclusively to cannabinoid administration. Moreover, 99% of serious adverse events from randomized clinical trials were reported in only two trials.¹⁷⁰ Greater numbers of nonserious adverse events were observed after cannabinoid treatment, as expected.¹⁷⁰ Side effects were equally associated with the different cannabinoid pharmacotherapies; the average rate of nonserious adverse events was higher in patients receiving Sativex or oral Δ^9 -THC than controls.¹⁷⁰ Thus, the main burden for the clinician is to balance therapeutic efficacy with the risk of intolerable side effects in the specific patient.¹⁶⁹ High-quality trials of long-term exposure to cannabinoids-based medications, together with careful monitoring of patients, are required to better characterize safety issues related to the use of medical cannabinoids.¹⁷⁰

CONCLUSIONS

Cannabis has been used for pain relief for centuries, although the mechanism underlying their analgesic effects was poorly understood until the discovery of cannabinoid receptors, and their endogenous ligands in the 1990s. During the last two decades, a large number of research articles have demonstrated the efficacy of cannabinoids and modulators of the endocannabinoid system in suppressing neuropathic pain in animal models. Cannabinoids suppress hyperalgesia and allodynia (i.e., mechanical allodynia, mechanical hyperalgesia, thermal hyperalgesia, and cold allodynia where evaluated), induced by diverse neuropathic pain states through CB₁ and CB₂ specific mechanisms. These studies have elucidated neuronal as well as nonneuronal sites (i.e., activated microglia) of action for cannabinoids in suppressing pathological pain states and documented regulatory changes in cannabinoid receptors and endocannabinoid accumulation in response to peripheral or central nervous system injury. Clinical studies largely reaffirm that cannabinoids show efficacy in suppressing diverse neuropathic pain states in humans. The psychoactive effects of centrally-acting cannabinoid agonists, nonetheless, represent a challenge for pain pharmacotherapies that directly activate CB₁ receptors in the brain. However, nonserious adverse events (e.g., dizziness), which pose the major limitation to patient compliance with pharmacotherapy, are not unique to cannabinoids. Approaches that serve to minimize unwanted CNS side effects (e.g., by combining Δ^9 -THC with CBD, or by targeting CB₂ receptors, peripheral CB₁ receptors, or the endocannabinoid system) represent an important direction for future research and clinical evaluation. The present review suggests that cannabinoids show promise for treatment of

neuropathic pain in humans either alone or as an add-on to other therapeutic agents. Therefore, further evaluations of safety profiles associated with long-term effects of cannabinoids are warranted.

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Cannabinoids for the Treatment of Chronic Non-Cancer Pain: An Updated Systematic Review of Randomized Controlled Trials

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- [M. E. Lynch](#),
- [Mark A. Ware](#)

INVITED REVIEW

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Abstract

An updated systematic review of randomized controlled trials examining cannabinoids in the treatment of chronic non-cancer pain was conducted according to PRISMA guidelines for systematic reviews reporting on health care outcomes. Eleven trials published since our last review met inclusion criteria. The quality of the trials was excellent. Seven of the trials demonstrated a significant analgesic effect. Several trials also demonstrated improvement in secondary outcomes (e.g., sleep, muscle stiffness and spasticity). Adverse effects most frequently reported such as fatigue and dizziness were mild to moderate in severity and generally well tolerated. This review adds further support that currently available cannabinoids are safe, modestly effective analgesics that provide a reasonable therapeutic option in the management of chronic non-cancer pain.

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A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain

[Barth Wilsey](#)



Press enter key for correspondence information



Press enter key to Email the

[author](#)

,
[Thomas Marcotte](#)

,
[Alexander Tsodikov](#)

,
[Jeanna Millman](#)

,
[Heather Bentley](#)

,
[Ben Gouaux](#)

,
[Scott Fishman](#)



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Abstract

The Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute for Drug Abuse (NIDA) report that no sound scientific studies support the medicinal use of cannabis. Despite this lack of scientific validation, many patients routinely use "medical marijuana," and in many cases this use is for pain related to nerve injury. We conducted a double-blinded, placebo-controlled, crossover study evaluating the analgesic efficacy of smoking cannabis for neuropathic pain. Thirty-eight patients with central and peripheral neuropathic pain underwent a standardized procedure for smoking either high-dose (7%), low-dose (3.5%), or placebo cannabis. In addition to the primary outcome of pain intensity, secondary outcome measures included evoked pain using heat-pain threshold, sensitivity to light touch, psychoactive side effects, and neuropsychological performance. A mixed linear model demonstrated an analgesic response to smoking cannabis. No effect on evoked pain was seen. Psychoactive effects were minimal and well-tolerated, with some acute cognitive effects, particularly with memory, at higher doses.

Perspective

This study adds to a growing body of evidence that cannabis may be effective at ameliorating neuropathic pain, and may be an alternative for patients who do not respond to, or cannot tolerate, other drugs. However, the use of marijuana as medicine may be limited by its method of administration (smoking) and modest acute cognitive effects, particularly at higher doses.

Low-Dose Vaporized Cannabis Significantly Improves Neuropathic Pain

Barth Wilsey  Press enter key for correspondence information  Press enter key to Email the author

[Thomas Marcotte](#)

[Reena Deutsch](#)

[Ben Gouaux](#)

[Staci Sakai](#)

[Haylee Donaghe](#)



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Abstract

We conducted a double-blind, placebo-controlled, crossover study evaluating the analgesic efficacy of vaporized cannabis in subjects, the majority of whom were experiencing neuropathic pain despite traditional treatment. Thirty-nine patients with central and peripheral neuropathic pain underwent a standardized procedure for inhaling medium-dose (3.53%), low-dose (1.29%), or placebo cannabis with the primary outcome being visual analog scale pain intensity. Psychoactive side effects and neuropsychological performance were also evaluated. Mixed-effects regression models demonstrated an analgesic response to vaporized cannabis. There was no significant difference between the 2 active dose groups' results ($P > .7$). The number needed to treat (NNT) to achieve 30% pain reduction was 3.2 for placebo versus low-dose, 2.9 for placebo versus medium-dose, and 25 for medium- versus low-dose. As these NNTs are comparable to those of traditional neuropathic pain medications, cannabis has analgesic efficacy with the low dose being as effective a pain reliever as the medium dose. Psychoactive effects were minimal and well tolerated, and neuropsychological effects were of limited duration and readily reversible within 1 to 2 hours. Vaporized cannabis, even at low doses, may present an effective option for patients with treatment-resistant neuropathic pain.

Perspective

The analgesia obtained from a low dose of delta-9-tetrahydrocannabinol (1.29%) in patients, most of whom were experiencing neuropathic pain despite conventional treatments, is a clinically significant outcome. In general, the effect sizes on cognitive testing were consistent with this minimal dose. As a result, one might not anticipate a significant impact on daily functioning.

Painful peripheral neuropathy comprises multiple symptoms that can severely erode quality of life. These include allodynia (pain evoked by light stimuli that are not normally pain-evoking) and various abnormal sensations termed dysesthesias (e.g., electric shock sensations, “pins and needles,” sensations of coldness or heat, numbness, and other types of uncomfortable and painful sensations). Common causes of peripheral neuropathy include diabetes, HIV/AIDS, spinal cord injuries, multiple sclerosis, and certain drugs and toxins. Commonly prescribed treatments come from drugs of the tricyclic and selective serotonin reuptake inhibitor (SSRI) antidepressant classes, anticonvulsants, opioids, and certain topical agents. Many patients receive only partial benefit from such treatments, and some either do not benefit or cannot tolerate these medications. The need for additional treatment modalities is evident.

Animal studies and anecdotal human evidence have for some time pointed to the possibility that cannabis may be effective in the treatment of painful peripheral neuropathy [1]. Recently, the Center for Medicinal Cannabis Research (CMCR) at the University of California [2] completed five placebo-controlled phase II clinical trials with smoked or inhaled cannabis [3-7]. Another study reported from Canada [8]. Patients included people with HIV neuropathy and other neuropathic conditions, and one study focused on a human model of neuropathic pain. Overall, the efficacy of cannabis was comparable to that of traditional agents, somewhat less than that of the tricyclics, but better than SSRIs and anticonvulsants, and comparable to gabapentin (see figure 1).

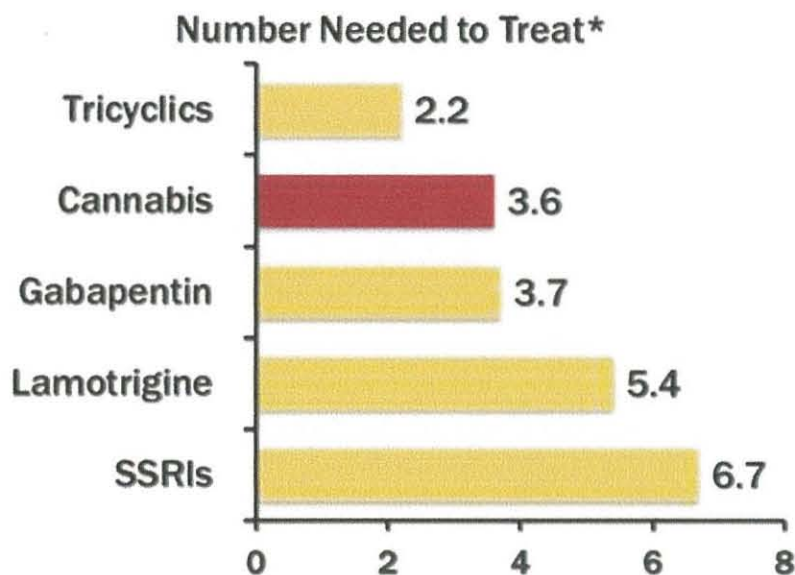


Figure 1. Common analgesics for neuropathic pain.

*to achieve a 30% reduction in pain.

Number needed to treat (NNT) = $1/(E-P)$, where E is the proportion improved in experimental condition and P is the proportion improved on placebo. Example: If 60% “improve” (according to a given definition) in the experimental condition, while 30% “improve” in the placebo condition, then $NNT = 1/(.6-.3) = 3.3$. Data adapted from Abrams et al. [3] and Ellis et al. [4].

The concentrations of tetrahydrocannabinol (THC) in these studies ranged from 2 to 9 percent, with a typical concentration of 4 percent resulting in good efficacy. Side effects were modest and included light-

headedness, mild difficulties in concentration and memory, tachycardia, and fatigue. Serious side effects (e.g., severe anxiety, paranoia, psychotic symptoms) were not observed. Mild cognitive changes resolved within several hours of drug administration.

While these were short-term trials with limited numbers of cases, the data suggest, on balance, that cannabis may represent a reasonable alternative or adjunct to treatment of patients with serious painful peripheral neuropathy for whom other remedies have not provided fully satisfactory results. Because oral administration of cannabinoids (e.g., as dronabinol, marketed as Marinol) can result in inconsistent blood levels due to variations in absorption and first-pass metabolism effects, inhalational (or potentially sublingual spray, e.g., nabiximols, marketed as Sativex) administration remains preferred to oral administration.

Cannabis as a smoked cigarette, while demonstrating efficacy, poses a number of challenges, inasmuch as it remains illegal under federal law, even though it is permitted in an increasing number of jurisdictions on physician recommendation. Figure 2 provides a schematic approach for physician decision making in jurisdictions where medicinal cannabis is permitted [9]. See figure 2

This decision tree suggests key points that a physician should consider in making a determination. In the case of a patient assumed to have persistent neuropathic pain, the first determination to be made is that the patient's signs and symptoms are indeed consistent with a diagnosis of neuropathy. Assuming a patient does not respond favorably to or cannot tolerate more standard treatments (e.g., antidepressants, anticonvulsants) and is willing to consider medicinal cannabis, the physician proceeds to compare risk and benefit. Among these considerations is whether the patient has a history of substance abuse or a serious psychiatric disorder that might be exacerbated by medicinal cannabis. Even the presence of such a risk does not necessarily preclude the use of medicinal cannabis; rather, coordination with appropriate substance abuse and psychiatric resources is necessary, and, based on that consultation, a risk-benefit ratio can be formulated. In patients for whom the ratio appears favorable, the physician should discuss modes of cannabis administration including oral, smoked, or vaporized. Once risks and benefits are evaluated and discussed with the patient, cannabis treatment may commence as with other psychotropic medications, with attention being paid to side effects as well as efficacy. Attention must also be paid to possible misuse and diversion, which can then trigger a decision to discontinue the treatment.

In summary, there is increasing evidence that cannabis may represent a useful alternative or adjunct in the management of painful peripheral neuropathy, a condition that can markedly affect life quality. Our society should be able to find ways to separate the medical benefits of making a treatment available to improve lives when indicated from broader social policy on recreational use, marijuana legalization, and unsubstantiated fears that medicinal cannabis will lead to widespread cannabis addiction