Quick Takes
A PODCAST
BY PHYSICIANS
FOR PHYSICIANS
HOSTED BY DR. DAVID GRATZER

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Episode 1 Bonus Content: In this clip you'll hear a more in-depth discussion on hyperemesis syndrome, dealing with sub-populations and the benefits of ginger – stat!

[Musical intro]

Dr. Gratzer: With regard to evidence. Something that's become popular amongst patients to talk about is opioid use disorder and then using cannabis. What are your thoughts?

Dr. Bertram: The interesting thing with the use of cannabis in the setting of opiate withdrawal – which is where you're often going to be seeing people with opiate use disorder speak to its effectiveness – its use in opiate withdrawal has been steady to an extent. There are studies that speak to some promise, but don't actually have established evidence of its use for opioid withdrawal. With that said, there are I think increasingly more voices lending themselves to discussion around using cannabis, and in some cases using synthetic THC analogues like Nabilone, for the sake of easing opiate withdrawal symptoms in a two to four-week period where you can sort of abruptly discontinue. Again, that's easier to look at when we talk about Nabilone because of measurements pharmaceutical, much harder to sort of measure what we're talking about medical marijuana dispensed out of marijuana clinics. That is not the same thing though as treating opiate use disorder. Which is an entirely different process.

Dr. Gratzer: To pivot for a moment. So we've talked about out-patient management, relevant also to docs who are doing shifts in their ED. In-patient wards – people who have been admitted and have been in the hospital for a few days, whether it's in the forensics department or in general division where I work. What might the patient present with?

Dr. Bertram: You know a patient could present with increased paranoia, psychosis. It could be an episode that led to them actually being admitted for that very reason or in some cases it could be a late presentation by virtue of them being an inpatient. Something I actually see far more often, because I wouldn't be, especially in a forensic setting, as experienced, but it's got some interesting parallels is long term care. Where you're seeing older adults who are transitioning, people who are really not all that old but for cognitive reasons are actually going into long term care. And they are often presenting in the same way but increased irritability, increased anxiety, more of a flight risk – which again I think is different depending on the care circumstances under which they're being seen.

But those are situations where there's perhaps an opportunity to have a conversation about cannabis if that's showing up in their drug screen. If that's in any way a part of their admission profile or if they're actually sort of openly speaking about it as the reason for why they're feeling the way that they are.

Dr. Gratzer: And for docs who are listening, what do you recommend in terms of resources outside of CAMH?

Dr. Bertram: You know, there are a few different projects that I'm involved in that we're hoping can provide some sort of clinical support to clinicians. One that we're looking to make available with legalization, in fact the ask for the ministry is that it's available before the 19th [17th], is a clinical working tool for non-medical cannabis. And we've aptly named it "non-medical cannabis" for a few different reasons. The first is we're trying to make sure that people are aware that this is not advice on medical cannabis. And the second is we didn't want to make it the cannabis use disorder tool because I think, case in point with our conversation, the legalization of cannabis is not just a cannabis use disorders discussion, in fact, it's mostly a cannabis use discussion. And so we're trying to speak to non-medical cannabis and not just recreational cannabis use. So that's coming out of the Centre for Effective Practice which is CEP.CA [https://effectivepractice.org]. And then I'm also working with the group who are putting out guidelines for older adults – and the older and older adults present a very interesting intersection because a lot of their asks around recreational cannabis are really how it can help them therapeutically as opposed to trying something purely for the sake of enjoying cannabis on its own. And so we are putting out a guideline, hopefully before Christmas, that'll be coming out on the Canadian Coalition for Seniors Mental Health website CCSMH.ca.

Dr. Gratzer: You've made mention of hyperemesis. Tell us what that means.

Dr. Bertram: So cannabis hyperemesis syndrome is a presentation where a person is, understandably, going to be present with nausea, vomiting, but also a number of other symptomatic features like diaphoresis, but also things like abdominal discomfort. In some cases diarrhea but that's not required for the diagnosis of the syndrome. In a setting where there's usually prolonged and usually problematic cannabis use. It's hard to quantify problematic use when it comes to cannabis, so we don't apply the same parameters as we do with say opiates or alcohol. But when it comes to frequency and obviously its impact on a person's activity, behaviour, connection, that all constitutes problematic. In most of those situations a person is presenting that way and, again, cannabis is in the background. And so their own insight into why they're coming to you and what they think is causing the problem usually doesn't account for cannabis.

Dr. Gratzer: A careful history is critically thus important. What you do in terms of treatment?

Dr. Bertram: So usually Haloperidol is kind of the mainstay.

Dr. Gratzer: And what sort of a dose are you looking at?

Dr. Bertram: That's a good question. It really depends. I would say whatever is used in your ED is the norm. I try not to be too prescriptive with doses.

Dr. Gratzer: And ginger?

Dr. Bertram: Ginger is fine. And in fact any of what we talked about with regard to acute intoxication with cannabis is probably appropriate when it comes to symptomatic management.

Dr. Gratzer: So how does one prescribe ginger?

Dr. Bertram: You actually can just through the formula you can say a ginger tablet. And it's available – I'm not even sure what the dose range is for it. If a person is worried about nausea, vomiting, kind of going forward I usually tell them if you go to the pharmacy and you seek some counsel from the pharmacist in terms of over-the-counter ginger tablets, they'll probably recommend Life Brand and they'll be able to tell you one to two ginger tablets every four to six hours.

Dr. Gratzer: Ginger stat.

Dr. Bertram: Ginger continuous!

[laughter]

Dr. Gratzer: You've made mention a couple of times of older adults. And we recognize that presentation and treatment might be a little bit different in this population because often management is a little bit different in this population. Let's turn it over to you.

Dr. Bertram: So older adults are an emerging issue from a population standpoint, presentation standpoint. We sometimes 1) don't expect that to be an issue in that population, but, more importantly we sometimes think that the considerations for different substances and older adults will apply the same as they do with mainstream. Cannabis hyperemesis, cannabis withdrawal – in both of these situations you're seeing a change in the vitals. You're seeing a change when it comes to nausea, vomiting, so some hypovolemia issues. You're also concerned again with how destabilizing that could be as far as hypotension. Those can actually be morbid in older adults. So medical clearance is usually something to consider in an out-patient setting, in a mental health setting, where we otherwise might not think we would need to because its cannabis.

Dr. Gratzer: This could be an emergency.

Dr. Bertram: That's right. And especially at CCSMH we've published on really thinking about medical supervision of withdrawal management in the setting of withdrawal from substances we normally wouldn't consider to be morbid or mortal like opiates and cannabis.

[Outro]

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