Submission to the Victorian Law Reform Commission

MEDICINAL CANNABIS REFERENCE

Number	30
Name	Dr Andrew Katelaris MD
Date	18 April 2015

Thank you for this opportunity to provide a submission. I give this submission as a clinically trained medical practitioner and researcher with many years experience in the cultivation, extraction and administration of cannabis based medicines. My current area of research is the role of CBD dominant cannabis in medical use, particularly for the control of intractable childhood epilepsy. Cannabidiol (CBD) is a non-psychotropic cannabinoid, which has been more or less bred out of the black market supply, as it ameliorates the psychotropic effect of THC. However, for medical use there exists a synergism between the various cannabinoids which improves patient tolerability and clinical outcomes, with whole plant products always performing better than single extracts. The medical use of cannabis is currently experiencing a resurgence of interest around the world. Anecdotal and clinical reports have documented success in a wide range of conditions and in diseases of seemingly unrelated aetiology. It is likely that as our understanding of the endocannabinoid system and its central role in homoeostasis grows, the underlying patho-physiological basis of this response will be elucidated.

A key question for this enquiry is for whom should access to cannabis medicines be facilitated. Prohibitionist policies, even when applying draconian sanctions, have never prevented distribution of a desired or needed commodity. Many people are currently using cannabis for medical purposes and obtaining significant benefit. The current prohibition does not prevent access to cannabis, but increases cost and degrades quality while transferring massive funds to criminal enterprises. The purpose of the law should be to ensure maximum public benefit. The current prohibitionist regime is a cruel failure whichever way it is assessed. The Commission is encouraged to see the proper way forward as being a rapid reversal of current policies. It is not a matter of relaxing some of the restrictions that were properly put in place to ensure public safety. Cannabis, especially CBD dominant cannabis has an exemplary safety record and is achieving success where all other treatments have failed. The prohibition of

cannabis followed the “Reefer Madness” campaign, an intense media misinformation program initiated by corrupt industrialists and law enforcement agencies in the 1930's. Every credible study and enquiry conducted to date has recommended a reversal of the blanket prohibition of cannabis. As hysteria gives way to fact the truly dramatic effects seen after cannabis treatment in many children and adults can properly inform the future legislative direction.

The most humane and intelligent response to the question of who should have official access to cannabis medicines should be to those who will derive benefit. A more pragmatic response would be for those conditions which currently lack effective remedies using currently available allopathic medicines. There are many conditions where current pharmacology fails patients and these groups should be prioritised for access. This applies strongly to intractable childhood epilepsy. The Commission is encouraged to apply inclusive language when defining those who should have access to cannabis, formulated in a manner most likely to encourage patterns of usage likely to best assist return or preservation of healthy functioning for the afflicted person. Cannabis should not be restricted to certain extreme or terminal cases, when an earlier deployment could preserve health and return function.

Intractable epilepsy, by definition, is the presence of ongoing seizures on a daily basis, despite maximal anti-epileptic medication. Seizure disorders affect many thousands of people with up to 30% being treatment resistant. Current medications are fraught with serious side effects including liver, renal, bone marrow and cutaneous toxicity, as well as severe sedation which limits the capacity of the developing brain to acquire new skills. Further, the benzodiazepine drugs are addictive with the potential for severe rebound seizures on withdrawal. CBD dominant cannabis has shown remarkable effectiveness in controlling seizures across a wide range of previously intractable seizure disorders including Dravet Syndrome, Rubinstein Taybi syndrome and a wide range of congenital and acquired brain abnormalities. CBD has an unparalleled safety profile and appears to be the first therapeutically active substance to display no adverse effects at any dosage level. Many children treated with CBD dominant cannabis have show not only a dramatic reduction in the frequency and intensity of seizures but an accelerated capacity for motor, verbal and social skill acquisition. Clinical details of cases I have treated can be presented to the Commission on request. The reduction of demand on the health infrastructure in terms of ambulance call-outs,

diagnostic tests, consultations, drug costs and inpatient intensive care would see millions of dollars saved.

Crohn's disease is a serious, relapsing disorder of the gastrointestinal tract which has resisted all attempts to elucidate its aetiology and control its symptoms. Current management utilises surgery, steroid medication and more recently immunosuppressive drugs or antibodies. These modalities are only partially effective and associated with a long list of serious side effects and costs. Pilot studies have indicated that cannabis can be highly effective in a significant proportion of patients, including those treatment resistant cases at the more severe end of the disease spectrum. Again, the reduction in demand on the health infrastructure and cost saving would be considerable. Glioblastoma multiforme (GBM) or astrocytoma grade 4 is a generally lethal brain tumour which appears to be increasing in frequency and occurring at younger ages in recent times, with the age of diagnosis from the third decade onwards. Electromagnetic radiation and exposure to volatile organic compounds may have a role in aetiology. The survival interval from diagnosis to death is usually 12-18 months. Surgery has limited effectiveness and the current standard treatment is temozolamide (TMZ). A substantial body of pre-clinical research has indicated responses to cannabinoids in tissue culture, with the potential for synergy with TMZ in inducing tumour cell apoptosis. Given the young age of onset, the rapid clinical deterioration and the disappointing response to standard treatment this area of research should also be a priority. Adenocarcinoma of the prostate is an increasingly common cancer. The role and timing for the PSA screening test, hormonal therapy, surgery, radiation and chemotherapy are all currently controversial. Prostate cancer is recognised as a slowly evolving tumour and in the early stages a policy of watchful waiting is preferred by some clinicians, while others recommend initial surgical intervention or hormonal treatment. Advances in neural sparing robotic surgery have decreased the morbidity of surgery, although impotence and urinary incontinence remain problematic, as does the side effects of anti-androgen therapy. Immunohistochemical examination of prostate cancer tissue can quantify the expression of CB1 and CB2 receptors and the density of these receptors may provide an indicator of a response to cannabis therapy, as well as a fertile area of future research. Cannabis therapy may be applied as an initial treatment in stage 1 when the cancer is confined within the capsule or for the potential control of metastatic disease after failure of conventional therapy. In both instances the administration by suppository is preferred, as this method has

provided indication of enhanced bio-availability and reduced psychotropic side effects.

Spinal injury due to trauma, tumour or congenital lesions is often complicated by painful spasms. Current medications include baclofen and the benzodiazepine drugs, both associated with modest efficacy and significant side effects. Cannabis offers the possibility of increasing the quality of life for these afflicted patients. Dosing regimens can be tailored to suit the individual with the options including oral administration for long acting background levels or vaporising to obtain a rapidly acting and easily titrated delivery. Other condition where current medications are ineffective include neuropathic pain and PTSD, but there are many others.

State and federal legislators in Australia have been slow to embrace the global trend in providing medical cannabis to the needy and suffering. Various models will have been studied by the commission. The language used in reporting on this subject should reflect the facts that cannabis preparations have a range of beneficial effects across a broad range of diseases, with a remarkable lack of toxicity. As previously mentioned progressive legislation should establish a workable, inclusive system. The legislation should not be overly complicated and should allow for three levels of access to medical cannabis. Growing by individual patients and their carers, larger scale proxy growing enterprises on the dispensary model with scientific testing for potency and quality and pharmaceutical preparations such as the UK supplier GW Pharmaceuticals. Apart from providing certifying documents allopathic doctors will only be involved with the prescription of pharmaceutical cannabis. Likewise, TGA oversight and regulation should only apply to this category. An urgent de-scheduling of CBD dominant cannabis from the list of prohibited substances would be a useful step forward and assist in unleashing the healing potential of this remarkable substance.

There have been sufficient numbers of formerly intractable epileptic children in Australia treated to wellness with cannabis extracts to convince any reasonable political body that urgent action is required. Playing politics with the lives of these children and the well-being of their families is reprehensible. If a patient is suffering a cardiac arrest an appropriate response would not be a convene a committee to decide which defibrillator is best, it would be to urgently apply the best available treatment. In cases of intractable epilepsy the best available treatment is cannabis based medicine. Delaying effective treatment by months or years results in progressive brain damage

from the uncontrolled seizures. Cannabis will not be effective against all subtypes of seizure disorder but there is clear evidence that it is effective in a majority. A humane and compassionate political system would devise a means to rapidly identify the responders in pilot studies and provide them with this life saving medicine. As previously stated I will provide the committee with the results of my expertise and experience based on years of research, on request. Many parents have taken the law into their own hands and with our assistance established medical cannabis growing facilities. Their argument that the well being and lives of their children is more important than adhering to a law based on misinformation and corruption is difficult to argue against. A formal direction to police for an immediate moratorium on all small scale cannabis interdictions, especially those with evidence of medical need, would be a useful and productive start. Police resources could then be directed to areas of greater need such as control of ice and other dangerous drugs.

In closing I must express my sincere hope that this committee act with integrity, intelligence and courage. A recommendation for a moratorium on all small cannabis interdictions may seem radical to a conservative mind but this step would immediately free scarce police resource, which could be directed to areas of greater priority, with related saving in court resources. There is clear evidence from multiple jurisdictions that relaxing legal sanctions against cannabis does not lead to increased uptake and use of the drug. Indeed, often the opposite applies. As a matter of urgency I would urge the committee to consider removing CBD dominant cannabis from the schedule of prohibition. CBD has no psychotropic effect and when mixed with THC cannabis has the effect of ameliorating the psychotropic effect. Therefore, the is no potential for black market diversion and no credible argument against taking this step. As mentioned earlier there have been several major inquiries into cannabis law reform including the British study of Indian hemp drugs, the Schafer commission, the UK House of Lords as well as two Australian inquiries. All recommended law reform and that was before the full understanding of the enormous medical application that the hemp drugs possess. It is not being melodramatic to say that this is a matter of life and death for the thousands of Australians, young and old, who could benefit from a long overdue revision of cruel and corrupt legislations.

Dr Andrew Katelaris MD (UNSW)