Letters

Correspondance

Much ado about marijuana

I was intrigued and appalled by *CMAJ*'s recent editorial on marijuana.[1] A disclaimer in the journal states that "all editorial matter in *CMAJ* represents the opinions of the authors and not necessarily those of the Canadian Medical Association" but no authors were identified for the editorial.

There is no scientific evidence to support the statement that recreational marijuana smoking has minimal negative health effects. Rather, the permissive attitude toward recreational drug use in our society is closely connected with the complex factors that lead to addiction.

It is irresponsible to say that the risk of addiction related to marijuana use is "very weak (and perhaps nonexistent)."[1] Perhaps the authors need a lesson in pharmacology and physiology. Marijuana is an addictive hallucinogen.

There may be merit in the proposal that drug possession, which is symptomatic of addiction, be decriminalized. However, decriminalization and medicalization are not the same thing, let alone decriminalization and legalization. Unfortunately, a *CMAJ* editorial like this one only adds smoke to the debate rather than clearing it. The call on the justice minister to decriminalize the possession of small amounts of marijuana for personal use sounds like a personal plea rather than a policy suggestion.

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Reference

1. Marijuana: federal smoke clears, a little [editorial]. *CMAJ* 2001;164(10):1397.

CMAJ has suggested that possession of marijuana should be decriminalized.[1] How incredibly short-sighted. Marijuana use increased by 142% among Dutch children and youths aged 7 to 17 years after Holland instituted a liberal policy.[2] During the time that marijuana use was legal for adults in Alaska but still illegal for young people, the use of marijuana by adolescents was more than twice that seen in the rest of the United States.[3] When several US states decriminalized marijuana in the late 1970s the use of marijuana and other drugs grew at a staggering rate[4] and marijuana-related visits to emergency departments increased.[5]

Harm reduction policies are really harm production policies. Policies should be created that will gain harm prevention and gain harm elimination.

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Thirty years after the publication of the LeDain Commission report,[1] editorial opinion at *CMAJ* has arrived at the same opinion: "the real harm [of marijuana] is the legal and social fallout."[2] In 1995 *The Lancet* editorialized that "the smoking of cannabis, even long term, is not harmful to health."[3] Two years later the *New England Journal of Medicine* called for the reclassification of cannabis under American law[4] and George Annas wrote in the same journal that "marijuana is unique among illegal drugs in its political symbolism, its safety, and its wide use."[5]

It is worth remembering that cannabis was prohibited in Canada only because Emily Murphy managed to create a moral panic around the association of cannabis with Blacks and Mexicans. Cannabis prohibition — as in the Opium Act of 1908 — was from the outset a strategy for the political suppression of selected racial groups.[6]

In the 30 years since the LeDain Commission report was released, thousands of young Canadians have been incarcerated. One of the unintended consequences of incarceration is growing into a full-blown public health catastrophe. In the mid 1990s the Correctional Service of Canada instituted urinalysis testing to enforce a zero-tolerance drug policy. The inmates did the logical thing, from their viewpoint; they migrated to the use of drugs that cleared the body in less time than cannabis. The drugs of choice came to be heroin and cocaine. As a result of needle sharing, our federal prisons have become incubation centres for HIV and hepatitis C.[7] Canada's drug control strategy, a decaffeinated version of the American "war on drugs," produces more pathology than it prevents.[8]

Most inmates eventually get out of prison, and thus the potential for a public health disaster can no longer be denied. Recent events at the Kingston Penitentiary suggest that the Correctional Service of Canada may be looking for a face-saving alternative to its unworkable zero-tolerance drug strategy. Here is an opportunity for the bold stride the *CMAJ* editorial says is needed: *CMAJ* ought to call for the vigorous expansion of harm reduction programs across Canada and in particular within our prisons.

Unfortunately, however, the drug war needs marijuana's prohibited status because without it the "drug problem" collapses from a social crisis involving several million Canadians and requiring more police and more prisons, to a situation involving a handful of hardcore addicts whose sickness can be reduced and confined, as the experience of Holland, Switzerland and Germany demonstrates.[9]

Cannabis in its numerous forms is an efficacious treatment for a number

of conditions, as the Chinese claimed as long ago as 2737 BCE,[1] with considerably fewer side effects for many people than other treatments.[10] Marijuana could compete with established brand medications that are backed by powerful global economic, social and political forces and their legislative allies.

Thus there are at least 2 powerful obstacles to the decriminalization of marijuana, both arising from the vested interests that have grown up and taken hold under prohibition. Still, *CMAJ* is to be congratulated: better late than never.

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I read with interest the recent *CMAJ* editorial on marijuana.[1] The numerous contradictory reports on the effects of smoking marijuana can be easily clarified: marijuana is a crude herb that contains at least 10 psychotropics as well as several hundred long-chain hydrocarbons. Each "joint" has a different chemical makeup.

For the chemicals in marijuana to be approved as medications they would have to be tested by means of the traditional, and only legally approved, methodology: gas chromatographic analysis of the plant and mass spectrometry. Once all of the chemicals were isolated, a large amount of each chemical would have to be synthesized so the appropiate toxicological and pharmacological studies in animals could be carried out.

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Reference

1. Marijuana: federal smoke clears, a little [editorial]. *CMAJ* 2001;164(10):1397.

As an emergency physician who spent 14 years in general practice in a rural area with lots of drug abuse, I am shocked at the ignorance of *CMAJ*'s editors concerning the health effects of marijuana use.[1]

To say that the effects of this substance are "mostly irrelevant" to the users is at the very least irresponsible. What about the serious amotivational syndromes in youth? What about the behavioural changes and family problems created by the drug's effects on the psychoemotional makeup of many users? How can a substance that is more carcinogenic than tobacco products be advocated in such a manner? Maybe you don't know what substances might be contained in burning organic materials, or how marijuana use is accomplished.

For an editor to espouse such an opinion in our major journal is reprehensible. You've either been out of practice so long you're out of touch, or you need to stop smoking up now and clear your vision.

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Reference

1. Marijuana: federal smoke clears, a little [editorial]. *CMAJ* 2001;164(10):1397.

Chemotherapy for older women with node-positive breast cancer

In their recent guideline on adjuvant systemic therapy for node-positive breast cancer, Mark Levine and colleagues state that postmenopausal women with estrogen receptor (ER)-positive tumours gain additional benefit from taking chemotherapy in addition to tamoxifen.[1] I have some concerns about this statement, based on my own analysis of the studies they cite in its support.

In the NSABP B-16 trial 20% of the patients had ER-negative tumours.[2,3] The results may therefore have been influenced in favour of the combined therapy, because these patients would not be expected to derive any benefit from tamoxifen therapy alone.[4,5] A preliminary report of another study showed overall benefit when chemotherapy was added to tamoxifen therapy, but only for ER-negative patients.[6] The Ludwig study also combined patients with ER-positive and ER-negative status and thus had similar limitations.[7]

About 33% of the patients in a study using epirubicin in the chemotherapy arm had ER-negative tumours.[8] Surprisingly, there was no interaction between treatment effect and receptor status (or age). The authors suggested that for the chemotherapy arm to be effective, an anthracycline should be included.

A review of randomized trials showed diminishing benefit with age when postmenopausal women with ER-positive tumours were treated with combination chemotherapy and tamoxifen.[9] Very few patients over 70 years of age have been studied, and they seem to have been adversely affected by combined therapy.

The report by the International Breast Cancer Study Group appears to support the recommendations of Levine and colleagues, but there were small numbers of patients in the relevant study arms and the study included patients who received delayed chemotherapy.[10]