Up in Smoke?

The future of medical marijuana for HIV/AIDS looks hazy.

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Jay Lassiter started smoking pot at age 19, right around the time he learned he was HIV positive. “It was a coincidence,” he says. “Sort of like sex, drugs, and rock ‘n’ roll. It was part of the package.”

When Lassiter was 24 he moved to California, which in 1996 became the first state to legalize medical marijuana. But if he wanted to buy it, Lassiter had to get a letter from a doctor. He could no longer put off making an appointment.

Nearly 20 years later, the now-42-year-old Lassiter credits marijuana with saving his life. “I wanted pot because I liked to smoke pot,” says Lassiter, a political consultant and outspoken advocate of legalized marijuana for all adults, not just those who need it for health reasons.

“I knew that my entry into the world of having access to legalized marijuana was predicated on my HIV status,” he says. “At that point, having access to a drug that I liked to do recreationally provided the incentive for me to face up to this disease and ultimately manage it for a very long time.”
Lassiter, who now lives in New Jersey, says he smokes pot daily, but he really only uses it to help manage HIV symptoms a couple times a month. “I still like smoking marijuana,” he explains, noting that pot does help him sleep and eat better.

When asked if he smokes only legally obtained medical marijuana, Lassiter told this reporter to write that he “smiled sheepishly and had no comment.”

In Maine, Maryland and New Jersey, smoking medical pot is allowed for conditions that might affect people with HIV/AIDS, such as wasting syndrome, pain and nausea, but HIV/AIDS is not specifically cited.

In 19 states and the District of Columbia, smoking medical marijuana is allowed for several conditions, including HIV/AIDS. In New York state, only edible—not smoked—medical pot is allowed for any condition, including HIV/AIDS.

Although Alaska, Colorado, Oregon, Washington state and DC also have legalized recreational marijuana, the federal government still deems pot illegal for any use. As a result, some doctors are reluctant to recommend it, and few scientists have studied its safety and effectiveness in treating people with

HIV/AIDS and other conditions.

Meanwhile, as more and more states legalize medical marijuana, fewer and fewer people with HIV/AIDS need it to relieve symptoms or side effects, thanks to the development of safer, more effective antiretroviral medications.

Search the word “marijuana” on the website for Boston’s Fenway Health, an LGBT health care, research and advocacy organization, and you won’t get a single hit, even though Massachusetts has legalized medical marijuana.

“Because we are a federally qualified and funded health center, we are awaiting federal guidance on this issue and are not currently writing prescriptions for medicinal marijuana,” spokesman Chris Viveiros says.

The AIDS Action Committee of Massachusetts has supported legalized medical marijuana since 1996, says executive director Carl Sciortino, who also pushed for it during his nine years as a state representative. “Our community would have significantly benefited from it in the earlier days of the epidemic.”

But by the time Massachusetts voters approved legalizing medical marijuana in 2012, the percentage of people with HIV who stood to benefit had declined, Sciortino says: “It’s not what it was even 10 years ago.”

Still, AIDS Action’s commitment to the cause never flagged, he says, because the organization wanted to support those with other conditions who had a more pressing need for medical marijuana.

In the early 1990s, when doctors first began thinking that marijuana could relieve symptoms in people with HIV/AIDS, “the whole epidemic was very, very different,” says David Hardy, MD, a Los Angeles infectious disease specialist whose practice tended to attract the sickest patients. “We basically were just slowly staving off the virus. The death and dying was very, very high.”

Two of the most common and debilitating symptoms in that era were wasting and nerve pain, and the best help that doctors could offer was to make patients as comfortable as possible, Hardy says.

They could prescribe anabolic steroids or expensive growth hormone to patients who had lost too much weight, he says, “but unless the person could put the food in their mouth and swallow it, even those very powerful weight-gaining medications did not work.”

So Hardy turned to a pricey prescription medication called Marinol, the brand name for dronabinol, to help patients regain their appetite. Marinol, also used to treat nausea and vomiting caused by cancer chemotherapy, contains synthetic THC, or tetrahydrocannabinol, the compound in marijuana that makes people high and gives them the munchies.

The problem, Hardy found, was that Marinol took as long as two hours to kick in, and the high it produced lasted too long. “What people needed was rapid delivery of appetite-stimulating medication,” he says. And that could be accomplished by smoking marijuana.

Even before California legalized medical marijuana, Hardy began talking about it with the 30 to 40

percent of his patients who needed to pack on pounds. “I would simply ask the patients: Have you ever smoked marijuana before? If they said yes, I’d ask: How did it make you feel?”

If they said, “‘It made me feel like I could eat a side of beef,’” Hardy says, “I would suggest smoking a little marijuana before their meals. I had no qualms about doing that. These were individuals who truly had a terminal disease.”

If patients told him they’d never smoked pot and felt uncomfortable about starting, Hardy says he would not recommend it.

Research suggested that marijuana also could relieve pain in the hands and feet from peripheral neuropathy, a nerve condition caused by HIV infection as well as early antiretroviral drugs that doctors stopped prescribing a decade ago.

Although he has recommended marijuana for peripheral neuropathy pain, Hardy acknowledges that it’s not clear whether patients feel relief because the drug actually reduces pain or whether getting high makes people feel no, or at least less, pain.

Today, Hardy says, fewer than 30 of his 300 HIV-positive patients have peripheral neuropathy, and they include some long-term survivors with intractable pain in their feet. He is reluctant to prescribe narcotic painkillers to them because of the risk for abuse.

And only perhaps three of his patients, all long-term AIDS survivors who nearly died and never regained the weight they had lost, are candidates for smoking marijuana to improve their appetite.

“I have had fewer and fewer requests for medical marijuana,” Hardy says, and he’s increasingly skeptical when patients say they need it.

“You really have to distinguish between the medical use of medical marijuana and the recreational use,” Hardy notes. There are 700 medical marijuana dispensaries around Los Angeles, he says, and most of their clients have no medical need for it.

Nearly 30 percent of the 500 HIV-positive patients in the Norwalk, Connecticut, practice of Gary Blick, MD, use medical marijuana. Half of them had either never smoked pot recreationally or only used it a few times, he says.

Medical marijuana sold at the handful of dispensaries in his state is two to four times as potent as what people can buy on the street, Blick says: “It’s purer.”

He had picked out a space in his office building for a medical marijuana dispensary “when our city said ‘not here.’ Our clients here in Norwalk have to drive pretty much an hour to get medical marijuana.”

Many of them use it as an appetite stimulant because they’ve lost too much weight, says Blick, who regularly smokes it himself to relieve chronic back and nerve pain from spinal stenosis.

His 92-year-old mother, Gloria Blick, started smoking pot in a pipe a couple of years ago, before legal medical marijuana was available in Connecticut, to treat her glaucoma. Now her ophthalmologist recommends it.

Chronic pain from peripheral neuropathy is the main reason Blick's patients use medical marijuana. While pain isn't an approved condition for medical marijuana in Connecticut—an omission Blick hopes to correct—HIV/AIDS is. Another common reason his HIV-positive patients smoke medical marijuana is post-traumatic stress disorder (PTSD) related to pain, anxiety and depression associated with their diagnosis, Blick says.

A 16-year study of nearly 3,000 HIV-positive women found that they used medical marijuana for reasons similar to Blick's patients. In that study, the proportion of women who said they currently used marijuana declined over time, from 21 percent in 1994 to 14 percent in 2010.

"As they aged, there was a pretty substantial decline in marijuana use over time," says lead author Gypsyamber D'Souza, an HIV epidemiologist at the Johns Hopkins Bloomberg School of Public Health. "Recreational drug use is higher among younger women."

But daily use of marijuana increased significantly over that period, from 3.3 to 6.1 percent of all of the women in the study and from 18 to 51 percent of the current marijuana users. For D'Souza, that was the most interesting finding, particularly because it paralleled an increase in the use of modern antiretroviral therapy. Still, she notes, her study can't prove that better HIV treatment caused the increase in daily marijuana use.

In 2009, D'Souza's team asked the women if their marijuana use was medicinal or recreational. Most users reported either purely medicinal use or medicinal and recreational use. The most common reason the women gave for using medical marijuana was relaxation and stress reduction, which, of course, is also why people smoke it recreationally, D'Souza says. Other common reasons were to boost appetite and reduce nausea.

Frequent, long-term marijuana use carries its own risks, though, according to the National Institute on Drug Abuse (NIDA). "Marijuana use may have a wide range of effects, particularly on cardiopulmonary and mental health," according to NIDA's "Drug Facts" publication on marijuana. The drug can irritate the lungs, heightening the risk of infections, and raise the heart rate shortly after smoking, greatly increasing the risk of a heart attack in the following hour, according to NIDA.

Plus, marijuana's effect on HIV progression has been little studied. Because the federal government considers the drug illegal, scientists are reluctant to spend the time and effort needed to clear regulatory hurdles, says Igor Grant, MD, chair of psychiatry at the University of California, San Diego School of Medicine and director of the University of California Center for Cannabis Research.

"To do more cannabis research, the only legal source is the federal government. To get that requires a lot of approvals," Grant says. "In the past, it was just kind of seen as a kooky thing."

Some scientists have turned their focus to Marinol and THC. Although the Food and Drug Administration approved Marinol capsules 30 years ago, there's little scientific evidence to support its effectiveness in treating wasting, and concerns have been raised about the safety of THC in HIV/AIDS, says Patricia Molina, MD, PhD, director of the Alcohol and Drug Abuse Center of Excellence at Louisiana State University. In fact, Molina says, "multiple studies had found that cannabinoids have immunosuppressant effects."

So she decided to study the impact of THC on male rhesus monkeys infected with simian

immunodeficiency virus, or SIV, a primate version of HIV. “The purpose of the study was never to show that THC can treat HIV,” she says. “The main question we wanted to answer was whether or not chronic use of THC would increase viral load or further decrease the CD4-to-CD8 ratio in infected animals.”

But Molina’s study attracted wide media attention because the twice-daily injections of THC the researchers gave the monkeys lowered the risk of early death in the monkeys with SIV, possibly because its anti-inflammatory effects decreased viral replication.

After a follow-up study, Molina’s team published results that didn’t get nearly as much press. The main difference in the design of the second study was that it used female instead of male rhesus monkeys. In contrast to their study of male monkeys, though, the researchers found that THC did not protect the female monkeys from early death or weight loss from SIV.

“We still do not have an explanation for those differences” between the male and female monkeys, Molina says, although she speculates that female hormones play a role.

Meanwhile, she says, “I would never advocate marijuana as a treatment for HIV.” Molina says she studies THC to help HIV-positive individuals “make informed decisions regarding frequency, amount and duration of their consumption or, alternatively, of the need to quit or decrease use.”

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