CANNABIS USE DISORDER

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Cannabis is derived from the hemp plant, Cannabis sativa, which has several varieties named after the region in which it is found (e.g. sativa indica in India and Pakistan, and Americana in America).

Cannabis (street names: grass, hash orhashish, marihuana) produces more than 400 identifiable chemicals of which about 50 are cannabinoids, the most active being Δ-9- tetrahydrocannabinol (Δ-THC). The pistillate form of the female plant is more important in cannabis production. Recently, a Gi-protein (inhibitory G-protein) linked cannabinoid receptor has been found (in basal ganglia, hippocampus and cerebellum) which inhibits the adenylate cyclase activity in a dose-dependent manner.

Cannabis produces a very mild physical dependence, with a relatively mild withdrawal syndrome, which is characterised by fine tremors, irritability, restlessness, nervousness, insomnia, decreased appetite and craving. This syndrome begins within few hours of stopping cannabis use and lasts for 4 to 5 days. However, some health professionals feel that there is no true physical dependence with cannabis. On the other hand, psychological dependence ranges from mild (occasional 'trips') to marked (compulsive use). All the active ingredients are called as marijuana or marihuana. Cannabis can be detected in urine for up to 3 weeks after chronic heavy use.

Acute Intoxication

Mild cannabis intoxication is characterised by mild impairment of consciousness and orientation, lightheadedness, tachycardia, a sense of floating in the air, a euphoric dream-like state, alternation (either an increase or decrease) in psychomotor activity and tremors, in addition to photophobia, lacrimation, and tachycardia, reddening of conjunctiva, dry mouth and increased appetite. There is often a curious splitting of consciousness, in which the user seems to observe his own intoxication as a non-participant observer, along with a feeling that time is slowed down.

Perceptual disturbances are common and can include depersonalisation, derealisation, synaesthesias(sensation in one sensory modality caused by a sensation in another sensory modality, e.g. 'seeing' the music) and increased sensitivity to sound. However, hallucinations are seen only in marked to severe intoxication. These are often visual, ranging from elementary flashes of lights and geometrical figures to complex human faces and pictures.

Mild cannabis intoxication releases inhibitions, which is expressed in words and emotions rather than in actions. 'Flashback phenomenon' has been described, and is characterised by a recurrence of cannabis use experience in the absence of current cannabis use.

Complications

The complications of cannabis use can include:

1. Transient or short-lasting psychiatric disorders: Acute anxiety, paranoid psychosis, hysterical fugue-like states, suicidal ideation, hypo mania, schizophrenia-like state (which is characterised by persecutory delusions, hallucinations and at times catatonic symptoms), acute organic psychosis and, very rarely, depression.

1. A motivational syndrome: Chronic cannabis use is postulated to cause lethargy, apathy, loss of interest, anergia, reduced drive and lack of ambition. The aetiological role of cannabis in this disorder is however far from proven.

Complications

3. ‘Hemp insanity’ or cannabis psychosis: Indian hemp insanity was first described by Dhunjibhoy in 1930. Thereafter, several reports appeared in literature from India, Egypt, Morocco and Nigeria. It was described as being similar to an acute schizophrenia form disorder with disorientation and confusion, and with a good prognosis.
The validity of this specific disorder is currently doubted.

4. Other complications: Chronic cannabis use sometimes leads to memory impairment, worsening or relapse in schizophrenia or mood disorder, chronic obstructive air way disease, pulmonary malignancies, alteration in both the humoral and cell-media ted immunity, decreased testosterone levels, reversible inhibition of spermato genesis, blockade of gonadotropin releasing hormone, and increased risk for the developing foetus (if taken during pregnancy).

Treatment

As the withdrawal syndrome is usually very mild, the management consists of supportive and symptomatic treatment, if the patient comes to medical attention.

The psychiatric symptoms may require appropriate psychotropic medication and sometimes hospitalisation. Psychotherapy and psych education are very important in the management of psychic dependence.