Buspirone, Fluoxetine May Counter Cannabis Use

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MIAMI — Limited access and availability of behavioral therapies aimed at helping cannabis-dependent patients support the search for effective pharmacologic treatments, Dr. Ahmed M. Elkashef said at the American Society of Addiction Medicine.

“We will have better outcomes once we have medications available,” Dr. Elkashef said. Several agents are in development and might be best used in combination with behavioral therapies. In the meantime, varying degrees of success are reported. Some off-label use of existing medications, said Dr. Elkashef, chief of clinical trials at the division of pharmacotherapies and medical consequences of drug abuse, National Institute on Drug Abuse, Rockville, Md.

For example, a pilot study of buspirone showed nearly a 30% decrease in marijuana use, as well as subjective reports of improvement, after 12 weeks, compared with baseline (Am. J. Addict. 2006;15:404).

Investigators did a larger follow-up study and found buspirone gave a significant reduction in positive urines, so it’s promising,” Dr. Elkashef said.

A secondary analysis of a fluoxetine (Prozac) study included 22 depressed, alcoholic, marijuana users (Addict. Behav. 1999;24:11-14). Participants took 20 mg fluoxetine daily or placebo for 12 weeks.

“The Prozac group had about 20 times less marijuana cigarettes smoked versus placebo,” Dr. Elkashef said. “Now a larger study is funded by NIDA.”

Early indications for a drug in development for weight loss,rimonabant (Ziel), show possible efficacy blocking the “high” of smoked cannabis as well, Dr. Elkashef said.

“You may want to think about it like naloxone for alcohol abuse when it gets to the market.”(Sanofi Aventis, maker of Zimulti) withdrew its application for the drug after a Food and Drug Administration panel voted against recommending it for approval because of concerns about the drug’s psychiatric and neurologic side effects.

Researchers assessing naltrexone for cannabis dependence found that 50 mg increased the toxic effects of tetrahydrocannabinol (THC), the psychoactive component of marijuana. “So we don’t think this may be useful as a treatment,” according to Dr. Elkashef.

Subsequently, however, researchers found that 12 mg naltrexone did not potentiate the intoxicating effects of THC.

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“It is the heavy users who tend to benefit,” he added. “All we can say about naltrexone at this point is, avoid the 50 mg and use the 12 mg.”

Ask patients about patterns of use, and if they are heavy users, naltrexone might be useful for them.”

Bupropion SR for marijuana withdrawal made participants feel worse in another study, Dr. Elkashef said. Individuals reported increased irritability, restlessness, and depression, as well as difficulty with sleeping (Psychopharmacology [Berl.] 2001;155:171-9).

“Apparently, you don’t want to use anything that is a stimulant during withdrawal from marijuana.”

In another study, nefazodone (Serzone) improved marijuana withdrawal anxiety and muscle pain, but did not improve other symptoms; patients were “irritable,” “insensible,” or had decreased sleep quality (Psychopharmacology [Berl.] 2003;165:157-65).

Other researchers found divalproex (Depakote). actually worsened mood and cognitive performance during marijuana abstinence (Neuropsychopharmacology 2004;29:158-70).

Regarding the future, selegiline (Emdar), a monoamine-releasing hormone agonist, citrine, lithium, or ondansetron, risperidone (Risperdal), and lofexidine (Ilfotil) are among the agents currently being studied with NIDA funding.

Researchers hope these agents provide greater efficacy to reduce marijuana use or ease symptoms of withdrawal among heavy users.