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SENATE BILL 555 - OPPOSITION TESTIMONY
Senate Federal and State Affairs Committee
March 28, 2024

Chairman Thompson and Members of the Committee:

I appreciate the opportunity to appear before our today in opposition to SB 355. I am here today as a subject matter expert on behalf of the Kansas Medical Society. I also represent the views of The International Academy on the Science and Impact of Cannabis-IASIC in my testimony today.

SB 555 contains dangerous elements and misrepresentations about cannabis (marijuana) that jeopardize Kansans and sets the stage for serious problems with marijuana. Please keep in mind that the net effect of this legislation is to take advantage of sick and suffering Kansans with the false hope of marijuana as a near miracle medicine. Every state that has ultimately legalized marijuana had approved medicinal marijuana first. The form of this ponderous bill, which contains 50 pages of legislation wording, conceals intrinsic risks and facts about marijuana and is a tool toward the full legalization of the drug.

Before outlining some of the many concerns about this proposed legislation, I remind the committee that we already have “medicinal marijuana” with the legally available medication Marinol (the generic is dronabinol -THC). This eliminates the need for impure, unpredictable, toxic forms of cannabis that are proposed in this legislation. Marinol is an FDA approved, Schedule III medicine. It can be prescribed by medical providers and is available. It is pure Delta-9-THC typically available in 5 mg and 10 mg forms.

Below you will find a list of precautions or side effects of Marinol in appendix 1. The cannabinoid medicine, Marinol, is the legal and easily available form of marijuana (cannabis). It is much less potent than most forms of cannabis, and far less potent than the THC content allowed in this proposed legislation.

As a physician, my specific concerns are as follows:

1. The alleged “qualifying conditions" listed below as indications for “medical”” marijuana drastically exceed and overstate any conditions considered legitimate indications for the use of cannabis. The proposed indications are mostly poorly researched or un-researched in the medical literature. Please note that medical studies have demonstrated that the placebo effect with cannabis was a major

element in perceived reduction of pain rather than a true pain reduction from cannabis (JAMA Network Open. 2022; https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799017).

2. None of the other disorders listed in the proposed legislation have solid, rigorous medical research supporting the use of cannabis except for some aspects of pain management. The FDA relies upon rigorous research, usually several large samples of case-controlled studies, rather than small case reports or personal vignettes that the industry relies upon to support its claim of "medical efficacy."

   This is the list of "qualifying conditions" listed in the bill:
   a. Acquired Immune deficiency AIDS
   b. ALS-Amyotrophic lateral Sclerosis
   c. Autism
   d. Cancer
   e. Chronic Traumatic Encephalopathy
   f. Crohn's disease
   g. Epilepsy
   h. Fibromyalgia
   i. Multiple sclerosis
   j. Parkinson's disease
   k. PTSD
   l. Sickle Cell anemia
   m. Spinal cord injury
   n. Traumatic Brain Injury (TBI)
   o. Ulcerative colitis
   p. Chronic pain.

   For this testimony, I reviewed 220 medical studies covering the last 10-15 years in the medical literature, and I found that the only disorder in the list that allegedly benefits from cannabis was chronic pain with particular emphasis on nerve-injury type pain. No study differentiated a benefit of leaf or natural cannabis over pharmaceutical cannabis (Marinol).

3. The allowed THC content for the cannabis by the legislation is 35% which is frankly toxic. The incidence of cannabis psychosis increases with THC content over 10% by weight. Consider that at the proposed THC concentration level, one gram of product such as seen in a typical "joint" would be allowed to contain 350 mg of THC as compared to 5 or 10 mg of Marinol. There is also no THC content limit on cannabis products, and the exact percentage of contents of the cannabis products would need to be analyzed and listed for the provider and patient. This should include both active ingredients and all contaminants and byproducts as we should see in any other "medicine."
4. Increased episodes of psychosis, violence, and opiate overdoses are seen in states that have legalized marijuana. I have attached information from a medical article that demonstrated increased opiate overdoses in states with marijuana legalization as compared to Kansas. The attached graphs from recent medical

publications demonstrate the much lower Kansas opiate overdose rate vs. states that have legalized marijuana.

5. The exemption from liability for physicians in section 20 is absolutely inappropriate and deprives patients of being able to seek a legal cure from illegal, reckless, or unscrupulous providers.
6. Section 44 allows individuals who have “medical” cannabis to also possess other controlled substances such as stimulants, hallucinogenic drugs, steroids etc. This clause creates a de-facto legalization of other drugs of abuse.

I urge you to soundly reject any legislation that increases the potential use of marijuana or other drugs of abuse that risk the health and welfare of Kansas.

Respectfully submitted,

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Internal Medicine, Pain, Addiction Medicine

President and Chairman of the Board, The International Academy on the Science And Impact of Cannabis-IASIC. (See www.iasic1.org)

Dr. Voth is a specialist in Internal Medicine, Pain Management, and Addiction Medicine. He serves as the President and Chairman of the Board of the International Academy on the Science and Impact of Cannabis (IASIC). Dr. Voth is a pioneer in the appropriate prescribing of controlled medications and is recognized as an international authority on drug use, drug policy-related issues, pain management, and appropriate prescribing practices.

He also serves as an advisor on alcohol and drug abuse issues to the Kansas State Board of Healing Arts, is a former member of the National Advisory Committee for the Center for Substance Abuse Treatment of HHS, and is a Clinical Professor of Internal Medicine at the University of Kansas School of Medicine.

Dr. Voth has advised Reagan, Clinton, both Bush, and Obama administrations, and has advised or testified for numerous Congressional offices on drug related issues. He has appeared on or consulted to, numerous other radio media, and has been quoted by numerous international print media.

Appendix 1: From the package information for Marinol (Dronabinol THC)

5 WARNINGS AND PRECAUTIONS

5.1 Neuropsychiatric Adverse Reactions

Psychiatric Adverse Reactions

Dronabinol has been reported to exacerbate mania, depression, or schizophrenia. Significant CNS symptoms followed oral doses of 0.4 mg/kg (28 mg per 70 kg patient) of MARINOL in antiemetic studies.

Prior to initiating treatment with MARINOL, screen patients for a history of these illnesses.

Avoid use in patients with a psychiatric history or, if the drug cannot be avoided, monitor patients for new or worsening psychiatric symptoms during treatment. Also, avoid concomitant use with other drugs that are associated with similar psychiatric effects.

Cognitive Adverse Reactions

Use of MARINOL has been associated with cognitive impairment and altered mental state.

Reduce the dose of MARINOL or discontinue use of MARINOL if signs or symptoms of cognitive impairment develop. Elderly patients may be more sensitive to the neurological and psychoactive effects of MARINOL [see Use in Specific Populations (8.4, 8.5)].

Hazardous Activities

MARINOL can cause and may impair the mental and/or physical abilities required for the performance of hazardous tasks such as driving a motor vehicle or operating machinery.

Concomitant use of other drugs that cause dizziness, confusion, sedation, or somnolence such as CNS depressants may increase this effect (e.g., barbiturates, benzodiazepines, ethanol, lithium, opioids, buspirone, scopolamine, antihistamines, tricyclic antidepressants, other anticholinergic agents, muscle relaxants). Inform patients not to operate motor vehicles or other dangerous machinery until they are reasonably certain that MARINOL does not affect them adversely.

5.2 Hemodynamic Instability

Patients may experience occasional hypotension, possible hypertension, syncope, or tachycardia while taking MARINOL [see Clinical Pharmacology (12.2)]. Patients with cardiac disorders may be at higher risk. Avoid concomitant use of other drugs that are also associated with similar cardiac effects (e.g., amphetamines, other sympathomimetic agents, atropine, amoxapine, scopolamine, antihistamines, other anticholinergic agents, amitriptyline, desipramine, other tricyclic antidepressants). Monitor patients for changes in blood pressure, heart rate, and syncope after initiating or increasing the dosage of MARINOL.

5.3 Seizures
Seizure and seizure-like activity have been reported in patients receiving dronabinol.

Weigh this potential risk against the benefits before prescribing MARINOL to patients with a history of seizures, including those receiving anti-epileptic medication or with other factors that can lower the seizure threshold. Monitor patients with a history of seizure disorders for worsened seizure control during MARINOL therapy.

If a seizure occurs, advise patients to discontinue MARINOL and contact a healthcare provider immediately.

5.4 Multiple Substance Abuse
Patients with a history of substance abuse or dependence, including marijuana or alcohol, may be more likely to abuse MARINOL as well.

Assess each patient's risk for abuse or misuse prior to prescribing MARINOL and monitor patients with a history of substance abuse during treatment with MARINOL for the development of these behaviors or conditions.

5.5 Paradoxical Nausea, Vomiting, or Abdominal Pain
Nausea, vomiting, or abdominal pain can occur during treatment with synthetic delta-9 tetrahydrocannabinol (delta-9-THC), the active ingredient in MARINOL. In some cases, these adverse reactions were severe (e.g., dehydration, electrolyte abnormalities) and required dose reduction or drug discontinuation. Symptoms are similar to cannabinoid hyperemesis syndrome (CHS), which is described as cyclical events of abdominal pain, nausea, and vomiting in chronic, long-term users of delta-9-THC products.
Because patients may not recognize these symptoms as abnormal, it is important to specifically ask patients or their caregivers about the development of worsening of nausea, vomiting, or abdominal pain while being treated with MARINOL. Consider dose reduction or discontinuing MARINOL if a patient develops worsening nausea, vomiting, or abdominal pain while on treatment.

6 ADVERSE REACTIONS
6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The following serious adverse reactions are described below and elsewhere in the labeling.

- Neuropsychiatric Adverse Reactions *[see Warnings and Precautions (5.1)]*
- Hemodynamic Instability *[see Warnings and Precautions (5.2)]*
- Seizures *[see Warnings and Precautions (5.3)]*

Paradoxical Nausea, Vomiting, and Abdominal Pain *[see Warnings and Precautions (5.5)]*

Studies of AIDS-related weight loss included 157 patients receiving MARINOL at a dose of 2.5 mg twice daily and 67 receiving placebo. Studies of nausea and vomiting related to cancer chemotherapy included 317 patients receiving MARINOL and 68 receiving placebo. In the tables below is a summary of the adverse reactions in 474 patients exposed to MARINOL in studies.

Studies of different durations were combined by considering the first occurrence of events during the first 28 days.

A cannabinoid dose-related “high” (easy laughing, elation and heightened awareness) has been reported by patients receiving MARINOL in both the antiemetic (24%) and the lower dose appetite stimulant clinical trials (8%). The most frequently reported adverse experiences in patients with AIDS during placebo-controlled clinical trials involved the CNS and were reported by 33% of patients receiving MARINOL. About 25% of patients reported a CNS adverse reaction during the first 2 weeks and about 4% reported such a reaction each week for the next 6 weeks thereafter.

Common Adverse Reactions

The following adverse reactions were reported in clinical trials at an incidence greater than 1%.

System Organ Class	Adverse Reactions
General	Asthenia
Cardiovascular	Palpitations, tachycardia, vasodilation/facial flush
Gastrointestinal	Abdominal pain*, nausea*, vomiting*
Central Nervous System	Dizziness*, euphoria*, paranoid reaction*, somnolence*, thinking abnormal*, amnesia, anxiety/nervousness, ataxia, confusion, depersonalization, hallucination
* Actual incidence 3% to 10%	

Less Common Adverse Reactions

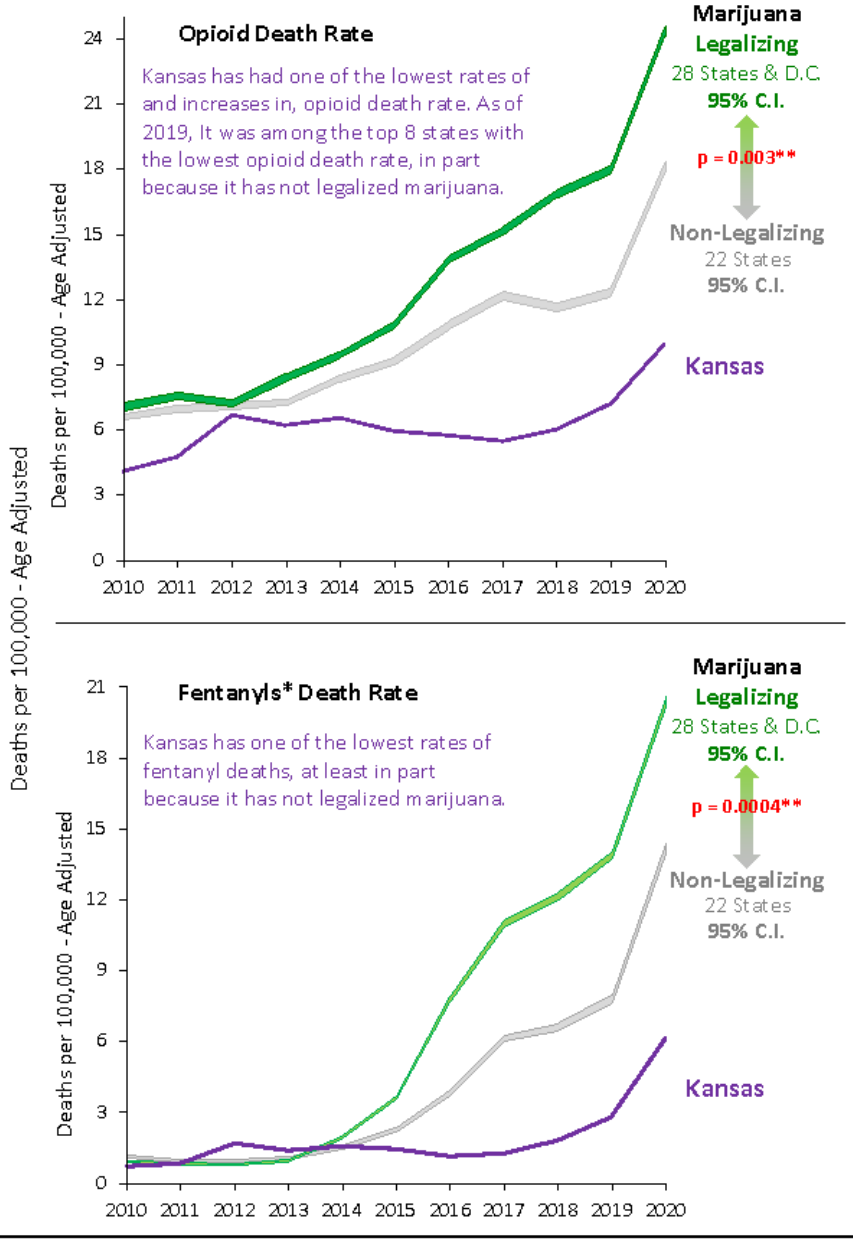
The following adverse reactions were reported in clinical trials at an incidence less than or equal to 1%.

System Organ Class	Adverse Reactions
General	Chills, headache, malaise
Cardiovascular	Hypotension, conjunctival injection *[see Clinical Pharmacology (12.2)]*
Gastrointestinal	Diarrhea, fecal incontinence, anorexia, hepatic enzyme elevation
Musculoskeletal	Myalgias
Central Nervous System	Depression, nightmares, speech difficulties, tinnitus
Respiratory	Cough, rhinitis, sinusitis
Skin	Flushing, sweating
Sensory	Vision difficulties

Annual Opioid and Fentanyls Death Rate, 2010-2020

Comparison of Kansas with 95% Confidence Intervals of Marijuana Legalizing (28 States + D.C.)^ and Non-Legalizing (22 States) Jurisdictions, U.S.

Composite data: Bleyer A, Barnes B, Finn K. *J Natl Med Assoc.* 2022:Online 22 April 2022.
https://www.sciencedirect.com/science/article/abs/pii/S0027968422000529?dgcid=author



^cumulative aggregate *including semi-synthetics **joinpoint pairwise comparison