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LETTERS TO THE EDITOR

Medical Cannabis and AASM Position Statement: The Don't Ask, Don't Tell Wishing Well

Comment on Ramar et al. Medical cannabis and the treatment of obstructive sleep apnea: an American Academy of Sleep Medicine position statement. *J Clin Sleep Med*. 2018;14(4):679–681.

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We were puzzled by the 2018 American Academy of Sleep Medicine (AASM) position statement recommending obstructive sleep apnea (OSA) be struck from the list of medical conditions for state medical cannabis programs on account of unreliable delivery methods and insufficient evidence of treatment effectiveness, tolerability and safety.[1] While positive airway pressure (PAP) will likely remain the gold standard therapy for OSA in the foreseeable future, there should be room for studying and integrating pharmacologic treatment strategies—not just endorsing expensive devices—that can lead to improved and more personalized disease modification. The contrary AASM stance bans members from recommending potential medical alternatives—specifically admonishing cannabis-based therapies—but also implying that failure of PAP in OSA is not an option, even though device nonadherence occurs in roughly half of the patients to whom it is initially prescribed. The AASM stance also implies that AASM affiliates had best be in lockstep with OSA-coupled diagnostic testing and device-driven management at accredited sleep centers because the alternative of ceding the management of patients with OSA who are nonadherent to PAP therapy is not allowed by the position statement authors[1] (including FDA-approved medications [ie, dronabinol] studied for off-label indications).

Carley et al.,[2] in an elegant placebo-controlled randomized clinical trial in patients with moderate or severe OSA found opposite results debunking the criticisms of the AASM's primary assertions including: Epworth Sleepiness Scale scores were *reduced* in the treatment group; the incidence of adverse events was *not significantly different from placebo*; and there was *no evidence of decreased tolerability* as measured by missed doses after 6 weeks of treatment using a 10 mg dose of dronabinol *delivered reliably and safely* in a pill form taken orally 1 hour before bedtime. Moreover, with respect to documenting alleged harms that outweigh benefits for medical cannabis therapies (including synthetic extracts like dronabinol) to justify the position statement, the authors of the AASM position statement[1] fail to cite any relevant evidence to substantiate their ethical claims despite the existing context of ample medical cannabis research reported in humans.[3] This glaring failure may further erode organizational credibility and may be the driving force behind patients with OSA seeking out cannabis program affiliates to discuss alternatives therapies especially when standard treatment is challenged by nonadherence and a nondisclosure policy pertaining to medical cannabis becomes the new norm of accredited sleep centers across the United States.

CITATION

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