South Central Priorities Committees
(Buckinghamshire/Milton Keynes PCTs)

Policy Statement 94: Cannabinoids in the Management of Multiple Sclerosis and Chronic Pain

Date of Issue: March 2009

South Central Priorities Committees have considered the evidence for clinical and cost effectiveness of medicinal cannabinoids in spasticity, chronic pain and other symptoms associated with MS and chronic pain from other causes and consider that the evidence is currently insufficient to support their use for any indication. Priorities Committees recommend that medicinal cannabinoids for these indications should be LOW PRIORITY.

Chronic pain, spasticity and other symptoms in multiple sclerosis and chronic pain from other causes are often inadequately relieved by current therapies and cause considerable morbidity at individual and population level.

Beneficial effects have been reported from smoked cannabis, which is illegal in the UK, and this has led to investigation of medicinal cannabis extracts (cannabinoids). Cannabinoids taken in oral form have highly variable bioavailability. Oro-mucosal cannabinoids (Sativex) may give more consistent results.

Currently, only the oral formulation nabilone is licensed for use in the UK. Its licensed indication is for nausea and vomiting associated with chemotherapy.

Used alone, oral cannabinoids have weak analgesic efficacy, at best only comparable with codeine. There is trial evidence that Sativex and oral cannabinoids as add-on therapy improve pain scores in patients with MS and chronic pain.

Used as add-on therapy, neither oral nor oro-mucosal cannabinoids improved the objective assessment of spasticity using the Ashworth score.

Oral formulations and Sativex as add-on therapy have shown a positive effect on spasticity in patients with MS using subjective patient rating scales. One further trial was negative for this outcome when analysed by intention to treat.

Positive trial outcomes have been measured as small changes in rating scales. Both the clinical and statistical significance of the results has been questioned.

In 2007, the MHRA did not accept evidence on Sativex as sufficiently strong to support a licensing application.

It is possible that the small average effect seen in trials may mask a much larger response in patients who respond well. A further trial, assessing whether such 'responders' can be identified through a short trial of treatment, is due to report in 2009 after which a further licensing application may be made.

There was a weak suggestion of a positive effect on urinary incontinence in one trial of oral cannabinoid but this requires further trial investigation.

NOTES:

1. *Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.*
2. *This policy will be reviewed in light of new evidence or guidance from NICE.*
3. *Buckinghamshire/Milton Keynes Priorities Committee policy statements can be viewed at http://www.miltonkeynes.nhs.uk/default.asp?ContentID=548*