ASCO® Guidelines

Cannabis and Cannabinoids in Adults with Cancer: ASCO Guideline				
Clinical Question	**Recommendation**	**Type**	**Evidence Quality**	**Strength**
Note: In the U.S., the Controlled Substance Act renders cannabis with >0.3% delta-9- THC Schedule I. This status signifies that cannabis has no accepted medical use and a high potential for abuse.[1] The Schedule I designation creates frequent conflicts between federal and state laws, as 38 states now allow medical cannabis use by adults with qualifying conditions. In addition, the Schedule I designation creates challenges for cannabis and/or cannabinoid researchers who face sparse funding opportunities, scarce sources for trial products, regulatory barriers, and procedural obstacles. The designation also generates challenges for clinicians wishing to guide adults with cancer using or considering the use of cannabis and/or cannabinoids: insufficient evidence base, limited federal oversight of non-pharmaceutical cannabinoid product manufacturing, and theoretical legal liability.				
How should clinicians and adults with cancer communicate about cannabis and/or cannabinoids?	**1.1.** Health systems and clinicians, in partnership, should provide adults with cancer unbiased, evidence-based cannabis and/or cannabinoid educational resources to facilitate clinical communication, informed decision-making, and systematized approaches to care.	Good practice statement		
	1.2. Given the high prevalence of cannabis and/or cannabinoid use among adults with cancer, clinicians should routinely and non-judgmentally inquire about cannabis use (or consideration of use), and either guide care or direct adults with cancer to appropriate resources.	Good practice statement		
	Note. Clinicians should remain sensitive to cannabis regulations' disproportionate impacts on marginalized communities and work to omit cannabis-related and other biases (e.g., racial, ethnic, and socioeconomic) from clinical discussions about cannabis and/or cannabinoids. Table 1 (in the full guideline) offers suggestions for cannabinoid history-taking.			
	When adults with cancer use cannabis and/or cannabinoids outside of evidence-based indications or clinician recommendations, clinicians should explore goals, educate, and seek to minimize harm.	Good practice statement		
Does use of cannabis and/or cannabinoids by adults improve cancer-directed treatment?	**2.1.** Clinicians should recommend against use of cannabis and/or cannabinoids to augment cancer-directed treatment unless in the context of a clinical trial.	EB	VL	W
	2.2. Clinicians should recommend against use of cannabis and/or cannabinoids in place of cancer-directed treatment.	IC	VL	S
	Note. Cannabis and/or cannabinoids used as cancer-directed treatment may cause significant clinical (e.g., fatigue, confusion, feeling "high") and financial toxicities without good quality evidence of clinical benefit.			

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Does use of cannabis and/or cannabinoids by adults with cancer reduce treatment-related toxicities, palliate cancer symptoms, or improve QOL?	**3.1.** Adults with cancer who receive moderately or highly emetogenic antineoplastic agents with guideline-concordant antiemetic prophylaxis and experience refractory nausea or vomiting may augment their antiemetic regimen with dronabinol, nabilone, or a quality-controlled oral 1:1 THC:CBD extract.	EB	M for dronabinol and nabilone L for 1:1 THC:CBD extract	W
	Note. Cannabis and/or cannabinoids are one of several pharmacologic options for adults with cancer experiencing refractory nausea and vomiting despite optimal prophylaxis. For such individuals, the 2020 ASCO antiemetics guideline[2] recommends the addition of olanzapine (if not already prophylactically administered); otherwise, the addition of an antiemetic from a different class (e.g., a neurokinin-1 receptor antagonist, dopamine receptor antagonist, benzodiazepine, or synthetic THC).			
	3.2. Outside of a clinical trial, clinicians should not recommend that adults with cancer use 300 mg or more per day of oral CBD to manage symptom burden due to lack of proven efficacy and risk for reversible liver enzyme abnormalities.	EB	L	W
	Note. In adult and pediatric populations without cancer, reversible liver enzyme abnormalities primarily occurred in study participants taking 300 mg or more per day of oral CBD.[3]			
	3.3. Evidence remains insufficient to recommend for or against cannabis and/or cannabinoids in managing cancer treatment-related toxicities or symptoms (including cancer pain), aside from clinical settings addressed in Recommendations 3.1 and 3.2 or within the context of a clinical trial (see Table 2 in the guideline).	N/A	N/A	N/A

Abbreviations. CBD, cannabidiol; EB, evidence based; IC, informal consensus; L, low; M, moderate; N/A, not applicable; QOL, quality of life; S, strong; THC, tetrahydrocannabinol; U.S., United States; VL, very low; W, weak

References. [1] US Drug Enforcement Administration: Drug Scheduling. Available at: https://www.dea.gov/drug-information/drug-scheduling, Accessed July 11, 2023
[2] Hesketh PJ, Kris MG, Basch E, et al: Antiemetics: ASCO Guideline Update. J Clin Oncol 38:2782-2797, 2020
[3] Lo LA, Christiansen A, Eadie L, et al: Cannabidiol-associated hepatotoxicity: A systematic review and meta-analysis. Journal of Internal Medicine 293:724-752, 2023