### Clinical Question

**How should clinicians and adults with cancer communicate about cannabis and/or cannabinoids?**

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.

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.

**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.

### Recommendation

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.

### Clinical Question

**Does use of cannabis and/or cannabinoids by adults improve cancer-directed treatment?**

1. Clinicians should recommend against use of cannabis and/or cannabinoids to augment cancer-directed treatment unless in the context of a clinical trial.

2. Clinicians should recommend against use of cannabis and/or cannabinoids in place of cancer-directed treatment.

**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.
<table>
<thead>
<tr>
<th>Clinical Question</th>
<th>Recommendation</th>
<th>Type</th>
<th>Evidence Quality</th>
<th>Strength</th>
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<tbody>
<tr>
<td>Does use of cannabis and/or cannabinoids by adults with cancer reduce treatment-related toxicities, palliate cancer symptoms, or improve QOL?</td>
<td>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.</td>
<td>EB</td>
<td>M for dronabinol and nabilone</td>
<td>W</td>
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<td>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).</td>
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<td>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.</td>
<td>EB</td>
<td>L</td>
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<td>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)</td>
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<td>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).</td>
<td>N/A</td>
<td>N/A</td>
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</table>

**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.**  