

# Cannabis Finds Its Way into Treatment of Crohn's Disease

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## Key Words

Inflammatory bowel disease · Cannabinoids · Prospective study

## Abstract

In ancient medicine, cannabis has been widely used to cure disturbances and inflammation of the bowel. A recent clinical study now shows that the medicinal plant *Cannabis sativa* has lived up to expectations and proved to be highly efficient in cases of inflammatory bowel diseases. In a prospective placebo-controlled study, it has been shown what has been largely anticipated from anecdotal reports, i.e. that cannabis produces significant clinical benefits in patients with Crohn's disease. The mechanisms involved are not yet clear but most likely include peripheral actions on cannabinoid receptors 1 and 2, and may also include central actions.

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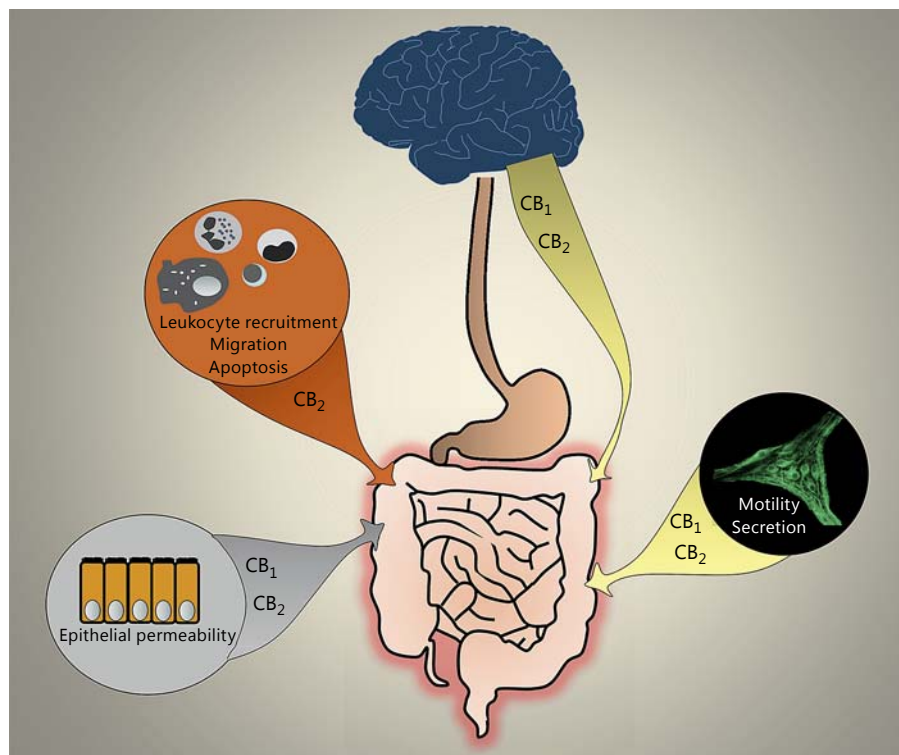
In ancient medicine, cannabis has been widely used to cure disturbances and inflammation of the bowel. A recent clinical study now shows that the medicinal plant *Cannabis sativa* has lived up to expectations and proved to be highly efficient in cases of inflammatory bowel diseases (IBD). In a prospective placebo-controlled study, Naftali et al. [1] have shown what has been largely anticipated from anecdotal reports, i.e. that cannabis produces significant clinical benefits in patients with Crohn's disease. The mechanisms involved are not yet clear but most

likely include peripheral actions on cannabinoid (CB) receptors 1 and 2 (CB<sub>1</sub> and CB<sub>2</sub>), and may also include central actions.

The past 10 years have seen a constant rise in publications dealing with the anti-inflammatory effects of CBs and the potential underlying mechanisms. Preclinical data on the ameliorating effect of synthetic and natural CBs in animal models mimicking features of IBD have been rapidly evolving. The reasonable idea that CBs would also be beneficial in IBD patients was mainly based on results from experiments in CB receptor knockout mice and on data using CB receptor agonists and antagonists. Following a previous publication of a retrospective, observational study by Naftali et al. [2] and a questionnaire performed by a different group in patients with ulcerative colitis and Crohn's disease [3], both revealing symptom relief and improvement after use of cannabis, Naftali et al. [1] have now presented a placebo-controlled prospective study in 21 patients with Crohn's disease unresponsive to standard IBD treatment. Although the primary end point of induction of remission was statistically not achieved, they were able to demonstrate that an 8-week treatment with tetrahydrocannabinol (THC)-rich cannabis caused a decrease in the Crohn's disease activity index in 90% of patients without producing significant side effects. The authors rightfully concluded that a larger patient group is warranted for future studies.

This is the first clinical trial on the effect of cannabis in IBD, and it confirms what has been suggested for a long time from experimental studies, namely that CBs may

**Fig. 1.** Potential targets and mechanisms of CBs involved in the improvement of IBD. Natural and synthetic CBs act via intestinal  $CB_1$  and  $CB_2$  receptors to regulate epithelial permeability, motility, secretion (via the enteric nervous system), as well as leukocyte migration, recruitment and apoptosis. As the site with the highest  $CB_1$  expression (but also some  $CB_2$  expression), the brain may modulate motility, the sensation of pain and unpleasantness, thus positively influencing the inflammatory process.



provide anti-inflammatory effects and symptomatic benefit in patients with IBD. The physiological basis for the beneficial effects of cannabis has been established a while ago and unraveled since then. The discovery of CB receptors and endogenous molecules activating these receptors led to the description of a coordinated network that is inherent to the mammalian organism, the so-called endocannabinoid system. This system consists of the canonical CB receptors ( $CB_1$ ,  $CB_2$ ), their endogenous ligands anandamide and 2-arachidonoyl glycerol (2-AG), also called endocannabinoids, and their synthesizing and degrading enzymes. What capsaicin, the pungent ingredient of chili, is for vanilloid receptors and morphin for opioid receptors is THC, the psychedelic ingredient of cannabis, for CB receptors: the predominant herbal ligand. Thus, THC mimics the actions of anandamide and 2-AG.

The wall of the gastrointestinal tract houses all components of the endocannabinoid system. Recent data show that these components are differentially expressed in human IBD indicating a regulatory role in the disease progression [4]. While anandamide and its synthesizing enzyme display lower levels in ulcerative colitis, expression of  $CB_2$  receptors and enzymes responsible for synthesis and degradation of 2-AG were increased [5]. The findings

indicate that the  $CB_2$  receptor plays a key role in the ameliorating effect of CBs in IBD. The precise mechanism as to how CBs contribute to the improvement of IBD, however, is not clear but by use of experimental models of intestinal inflammation we are able to define a picture on how and at which targets CBs cause improvement of inflammation.

$CB_1$  and  $CB_2$  receptors are located at the colonic epithelium, and a protective effect of THC via epithelial permeability is conceivable (fig. 1). Therefore, CBs could enhance epithelial wound closure in the colon [6]. One of the prominent features of CBs in experimental intestinal inflammation is their effect on immunocytes which mainly express  $CB_2$  receptors. Upon  $CB_2$  activation, T cells undergo apoptosis and decreased proliferation in colitis [7]. Additionally, activation of  $CB_2$  diminishes the recruitment of neutrophils, T cells and macrophages to the inflamed colon [7]. CB receptors are also found in the enteric nervous system (ENS), which controls gut motility and secretion [8].  $CB_1$  receptors present in the ENS represent a break that protects the ENS from hyperstimulation, a situation easily caused by overexpression of inflammatory mediators that activate the ENS during IBD. Therefore, activation of CB receptors by THC may reduce hypermotility associated with the inflammation of the gut

[9]. The reduction of hypermotility may consequently alleviate diarrhea producing beneficial effects for the patient.

It should be emphasized that the brain is the major site of CB<sub>1</sub> expression and that the presence of CB<sub>2</sub> has also been detected in the brainstem [8]. The use of cannabis in improving inflammation could therefore well include central effects, such as a reduction in pain sensation and relief of nausea and feeling of unpleasantness. One report suggests that a full anti-inflammatory response of CBs in gut inflammation includes the central nervous system since a peripherally restricted CB<sub>1</sub>/CB<sub>2</sub> receptor agonist was either not effective or too weak to improve colitis, depending on the experimental model used [10].

In their prospective study, Naftali et al. [1] used THC-free cannabis as placebo with no other CBs present. However, we should consider that also other ingredients of cannabis, such as cannabidiol, cannabigerol and tetrahydrocannabivarin, all of them nonpsychotropic components of cannabis, have proven anti-inflammatory effects in experimental intestinal inflammation [9]. Their actions partly involve non-CB receptor mechanisms via, for instance, peroxisome proliferator-activated receptors

(PPARs) and transient receptor potential cation channels subfamily V receptors (TRPVs) and should be regarded as additive beneficial effects of cannabis in the improvement of colitis in addition to THC-mediated effects.

In summary, in agreement with the ancient use of cannabis in intestinal disturbances and one decade of animal research, cannabis was shown in a clinical trial to reduce symptoms in patients with Crohn's disease. This elegant translation should be followed by larger trials confirming these results and by trials establishing the involved mechanisms to open a promising direction for future treatment of IBD.

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### Disclosure Statement

The authors have no conflict of interest to declare.

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