9-20-2023

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Cannabinoid Hyperemesis Syndrome (CHS) is an uncommon adverse reaction to long-term cannabis use, marked by persistent and prolonged vomiting. With the growing popularity of cannabis among young individuals, CHS cases have been on the rise. Unfortunately, there is presently no known cure for CHS, leaving complete abstinence from cannabis as the only effective remedy. Despite research regarding potential treatments and diagnostic criteria, patients often find it challenging to accept a CHS diagnosis. The qualitative study by Wightman et. al. describes the reasons behind patients' hesitance to acknowledge a CHS diagnosis and the obstacles in providing effective care. One of the primary factors contributing to patients' reluctance in accepting a CHS diagnosis is the absence of a clear and specific test for the condition. CHS diagnosis primarily hinges on the presence of vomiting without any other identifiable cause, along with a history of regular cannabis use. This subjective nature of diagnosis can also give rise to skepticism among patients.

Patients with CHS also may report feeling judged in medical settings, particularly in the emergency department. Judgment by healthcare providers could stem from negative attitudes toward long-term cannabis use or due to a perception that the patient is drug-seeking or has secondary gain from the ED visit. The end-result of this perceived judgment is that healthcare providers may conduct less thorough assessments, further contributing to patients' mistrust in the ultimate diagnosis and treatment.

There is limited availability of data on the causative drivers and preventative measures of CHS. As a result, patients seek information from unreliable sources such as YouTube and Google. This information vacuum can lead to confusion and doubts regarding the diagnosis and proper management of CHS.

In addition, patients often prefer to attribute their vomiting to factors other than cannabis use such as changes in eating habits, specific food consumption, alcohol intake, existing gastrointestinal problems, or stress. Before developing CHS, most patients associated cannabis use with positive benefits, such as anxiety relief or muscle relaxation, leading them to deny any possible association between cannabis and their debilitating symptoms.

Overcoming these challenges requires healthcare professionals who are knowledgeable about the condition and sensitive to the discomfort that their patients are experiencing. Best practices for clinicians include (1) communicating the causal link between cannabis use and CHS in a non-confrontational manner, while also addressing alternative factors that may exacerbate the condition; (2) maintaining a non-judgmental approach to ensure patients feel comfortable discussing their cannabis use and symptoms; and (3) proactively educating patients about CHS, its causes, and the importance of abstaining from cannabis use to manage the condition effectively. Healthcare professionals should prioritize building trust with patients, providing accurate information, and promoting open discussions to facilitate patient acceptance of their CHS diagnosis and improve overall outcomes.

In conclusion, patients' reluctance to accept a CHS diagnosis can be attributed to various factors, including the lack of a specific diagnostic test, perceived judgment from healthcare providers, a scarcity of reliable information, and the preference to attribute symptoms to factors other than cannabis. Addressing these challenges is essential for providing effective care to

patients with CHS. Additionally, further research into CHS and its management is crucial to enhance diagnostic precision and the development of targeted treatments.

The author has no conflicts to report