letters to the editor

BCMJ BC Medical Journal

We welcome original letters of less than 300 words; they may be edited for clarity and length. Letters may be emailed to journal@doctorsofbc.ca, submitted online at bcmj.org/submit-letter, or sent through the post and must include your mailing address, telephone number, and email address. All letter writers will be required to disclose any competing interests.

Re: Cannabis use by adolescents

This article [*BCMJ* 2019;61:14-19] would be the first in the literature to establish different clinical effects from *C. sativa* and *C. indica* strains. While Dr Ocana insists that clinical research supports separating these strains because of their different effects (stimulating vs sedating), the reference he provided does not support this or even use these differing strain names. Recent chemical analysis of cannabis strains from Washington State argues against differences in CBD and THC between these strains.[1] Other cannabis scientists are in agreement that these terms are better suited to marketing than clinical use: "There are biochemically distinct strains of Cannabis, but the sativa/indica distinction as commonly applied in the lay literature is total nonsense and an exercise in futility."[2]

In Dr Ocana's article, results are presented from a cohort interviewed about their experiences with different strains; however, the results should be viewed more as those of the placebo effect in combination with observer bias, especially given the lack of quantification of the cannabis used.

Dr Ocana also states that deaths have increased with cannabis legalization. The cited reference mentions only one death, that of a child who died of myocarditis. This case was controversial enough for the case report's authors to publicly clarify, "We are absolutely not saying that marijuana killed that child."[3]

As Dr Ocana notes, it can be difficult to deal with misinformation; this is magnified when it is published in a medical journal. The three most commonly held misbeliefs among physicians are that cannabis overdose can be fatal, that cannabis is often contaminated with fentanyl, and that there are differences in effect between *C. indica* and *C. sativa* strains.

—Ian Mitchell, MD, FRCP
Clinical Associate Professor, UBC Department of Emergency Medicine
Site Scholar, Kamloops Family Medicine Residency Program

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2. Piomelli D, Russo EB. The cannabis sativa versus cannabis indica debate: An interview with Ethan Russo, MD. Cannabis Cannabinoid Res 2016;1:44-46.
3. Silverman E. The truth behind the 'first marijuana overdose death' headlines. The Washington Post. Accessed 26 February 2019. www.washingtonpost.com/news/to-your-health/wp/2017/11/17/the-truth-behind-the-first-marijuana-overdose-death/?utm_term=.5e8828886558.

Author replies

I thank Dr Mitchell for his opinion and for standing behind the quote, "There are biochemically distinct strains of cannabis, but the sativa/indica distinction as commonly applied in the lay literature is total nonsense and an exercise in futility."[1]

In effect, Dr Mitchell is saying "strain does not matter." I can't say Dr Mitchell is wrong, but it does not align with the data we collected.

Dr Mitchell proposes that my observations should be viewed more as results of the placebo effect in combination with observer bias, especially given the lack of quantification of the cannabis used.

I respectfully disagree. This is not a placebo effect. The data are based on a retrospective chart analysis of a heterogeneous population, in a naturalistic setting, with no exclusion criteria. Even after you remove the noise, our observations remained statistically more likely than expected by chance.

It seems that Dr Mitchell is suggesting that our observations are misinformation, worse because they are published in a peer-reviewed medical journal. Here's why I see it differently:

- Before our study, from reading the medical literature, I didn't even know there were two distinct strains.
- During our study, I was amazed how strong the signal remained, *despite* a possible placebo effect, observer bias, and regardless of the dose. Not only are the strains

different, they are opposites.
- After our study, I shared my observations with every clinician at every conference and everybody said what Dr Mitchell said, "There is no strain difference."

In essence, what our patients consider a self-evident truth, that *sativa* stimulates and *indica* sedates, is based on millennia of trial and error. It should not be a mystery to respected cannabis scientists. But it is. That's why I knew we had to publish it.

Whether this is a random finding or whether it represents the first stone on the scale that measures the weight of evidence, only time will tell.

—A.M. Ocana, MD, CCFP, ABAM
North Vancouver

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1. Piomelli D, Russo EB. The cannabis sativa versus cannabis indica debate: An interview with Ethan Russo, MD. Cannabis Cannabinoid Res 2016;1:44-46.

MyoActivation for the treatment of pain & disability

Chronic musculoskeletal pain is common in our society. One in five people suffer with chronic pain in Canada. We need alternatives to pharmacologic interventions that are cost effective, safe, and available to most patients. Ideally, these alternatives would be covered by MSP. Most importantly, alternative treatments could decrease our reliance on opiates.

I am a retired family physician who underwent right hip replacement surgery in 2018. I was skeptical when a colleague suggested I try myoActivation during my rehabilitation. A compensatory flexion and adduction contracture of my right hip was slowing my recovery. I also had weak hip abductors, hamstrings, and gluteus muscles.

What is myoActivation? It is a refined injection technique that targets damaged fascia, scars, and other trigger points in the body. Using multiple needling with hollow bore cutting needles with minute amounts of normal saline, soft tissue contractures are released.

I am now pain free and back to doing all of the activities I love to do.

Here are some interesting details that I picked up during my visits:
- A detailed history of all past injuries is considered in terms of myofascial contractures and scars.
- A series of standardized movement tests is used to define painful areas.
- The most painful sites are treated first, followed by re-evaluation of movements. Then the next painful area is treated.
- Multiple cycles of injections, followed by evaluation and further injections, are carried out at each appointment.
- Tissue realignment takes place the first few days after treatment, followed by stabilization.

The technique was pioneered by Dr Greg Siren,[1] a family physician with a focused practice in chronic pain in Victoria, BC.

At the time I write this letter, myoActivation is also available in Vancouver at the CHANGEpain Clinic, the Downtown Community Health Centre (Downtown Eastside), and the Complex Pain Service at BC Children's Hospital. It has been shown to be effective in treating chronic pain originating in the soft tissues in the elderly as well as children.

I hope this letter raises awareness about this technique. It can be practically delivered in primary care patient encounters and could be part of a multidisciplinary approach to treatment of chronic musculoskeletal pain.

—Suzanne Montemuro, MD, CCFP
Victoria

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1. Lauder G, West N, Siren G. MyoActivation: A structured process for chronic pain resolution. IntechOpen. Accessed 5 March 2019. www.intechopen.com/online-first/myoactivation-a-structured-process-for-chronic-pain-resolution.

To sleep or not to sleep

One thing that endears me to the *BCMJ* is the editor's page. DRR writes thoughtful, often funny comments about the world around us. His December 2018 editorial, "Sleep, when it no longer comes naturally," [*BCMJ* 2018;60:478] was a bit of a departure from his usually joyful character, and reading it filled me with concern and empathy for him. It revealed his struggle with anticipatory anxiety insomnia, wondering each night if sleep is going to come to him. The last line was: "…if anyone has suggestions for some good book titles, please send them my way."

I asked myself, what would be a good book for someone awake enough in the middle of the night to want to read, but anxious enough to hope to get back to sleep?

I scanned my list of 117 BC physician authors on www.abcbook

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world.com, and looked for diaries, novels, short stories, historical stories, poetry, and theatrical plays published between the early 1800s and recent times. I looked for reading material that was relatively slow paced, interesting but not exciting or anxiety provoking, and long enough to get sleepy—or bored—while reading it.

Here are 10 books I recommend, written by some of our physician colleagues, in alphabetical order by author:

Burris HL. *Medical Saga: The Burris Clinic and Early Pioneers*

Cheadle WB. *Cheadle's Journal of Trip across Canada:1862–1863*

Duncan AC. *Medicine, Madams, and Mounties: Stories of a Yukon Doctor*

Emmott K. *How Do You Feel?* (1992 poetry collection)

Karlinsky H. *The Evolution of Inanimate Objects: The Life and Collected Works of Thomas Darwin (1857–1879)*

Kenyon A. *The Recorded History of the Liard Basin, 1790–1910*

Lee E. *Scalpels and Buggywhips*

Leighton K. *Oar and Sail: An Odyssey of the West Coast*

Swan A. *House Calls by Float Plane: Stories of a West Coast Doctor*

Tolmie WF. *The Journals of William Fraser Tolmie: Physician and Fur Trader*

Dear Dr DRR, have a good read and a good sleep!

—George Szasz, CM, MD
West Vancouver

Thank you for your concern, and I really appreciate your book suggestions.—Ed.

This letter originally appeared as a *BCMJ* blog post. Visit www.bcmj.org/blog to read all of our posts, and consider submitting your own.

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