CANNABIS Y TRASTORNO AFECTIVO BIPOLAR

VANESSA CANTILLANO A.

PSIQUIATRA

PROGRAMA DE AUTOCUIDADO EN DROGAS PARA ESTUDIANTES UNIVERSITARIOS (PADEU) UC

CLÍNICA ALEMANA DE SANTIAGO

SOCHITAB, AGOSTO 2017

EN ESTA PRESENTACIÓN

- **Introducción**
- Aspectos epidemiológicos
- Cannabis e impacto en la salud mental
- Trastornos de ánimo y consumo de cannabis
- Uso de instrumento de screening, CUPIT validado en Chile
- Sugerencias de intervención

Introducción

- Marihuana, droga ilegal más comúnmente usada
- Especialmente prevalente es su uso en adolescentes y adultos jóvenes
- Actual debate respecto de su legalización, autorización de autocultivo, uso medicinal…
- Genera discusiones y debates respecto de libertades individuales
- Como profesional de salud es importante tener una posición frente a crecientes consultas por parte de pacientes y familiares

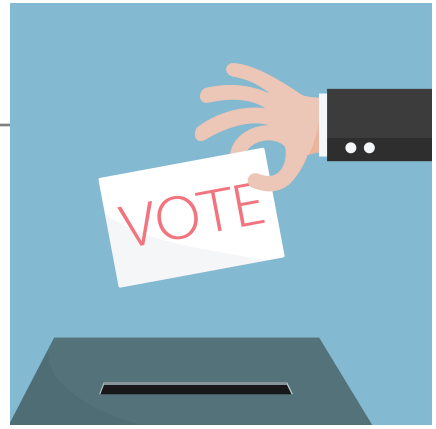
Introducción

- ¿Por qué es importante hablar sobre el consumo de sustancias en pacientes con patología psiquiátrica como el T A Bipolar?
  - Por su frecuencia en la práctica clínica
  - Cannabis y su presencia en opinión pública
  - Porque su presencia está asociada a riesgos específicos
  - ¿Cuáles son estos riesgos?
  - Además están los otros riesgos del cannabis en la salud física y mental…

Preguntas que podemos hacernos como clínicos respecto del consumo de cannabis y el Trastorno Bipolar

- Cuál es la frecuencia de esta co-morbilidad?
- El consumo de cannabis:
  - ¿Agrava el pronóstico del Trastorno Bipolar?
  - ¿Tiene relación con algún tipo de episodio en particular (depresivo, maníaco, mixto)?
  - ¿Altera la evolución: mayor número de episodios, ciclaje rápido?
  - ¿Aumenta el riesgo suicida?
  - ¿Afecta la respuesta a tratamiento?

¿Cuál es la Prevalencia de co morbilidad T A Bipolar y T relacionado con cannabis?



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Cannabis involvement in individuals with Bipolar Disorder

Arpana Agrawal[a], **John I. Nurnberger Jr.**[b], **The Bipolar Genome Study**[c], and **Michael T. Lynskey**[a]

[a]Washington University School of Medicine, Dept. of Psychiatry, 660 S. Euclid, Saint Louis, MO 63110, United States.

[b]Indiana University School of Medicine, Institute of Psychiatric Research, Indianapolis, Indiana 46202-2873, United States.

Abstract

In a study of 471 BD cases and 1761 controls, individuals with BD were 6.8 times more likely to report a lifetime history of cannabis use. Rates of DSM-IV cannabis use disorders in those with BD were 29.4% and were independently and significantly associated with increased suicide attempts, experience mixed episodes and disability attributable to BD.

Agrawal A, Nurnberger JI, Jr., Lynskey MT. Cannabis involvement in individuals with bipolar disorder. Psychiatry research. 2011;185(3):459-61.

RIESGO SUICIDA EN PACIENTES CON PATOLOGÍA PSIQUIÁTRICA

ADDICTION
SSA SOCIETY FOR THE STUDY OF ADDICTION
RESEARCH REPORT
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Associations between substance use disorders and suicide or suicide attempts in people with mental illness: a Danish nation-wide, prospective, register-based study of patients diagnosed with schizophrenia, bipolar disorder, unipolar depression or personality disorder

Marie L. D. Østergaard[1,2], Merete Nordentoft[1,2] & Carsten Hjorthøj[1,2]

Mental Health Centre Copenhagen, Copenhagen University Hospital, Copenhagen, Denmark[1] and The Lundbeck Foundation Initiative for Integrative Psychiatric Research, iPsych, Copenhagen and Aarhus, Denmark[2]

ABSTRACT

Aim To estimate and test associations between substance use disorders (SUDs) and both completed suicides and suicide attempts in a population with severe mental illness. **Design** Register-based cohort study with adjusted Cox regression of substance use disorders as time-varying covariates. **Setting** Denmark. **Participants** People born in Denmark since 1955 with a diagnosis of schizophrenia (n = 35 625), bipolar disorder (n = 9279), depression (n = 72 530) or personality disorder (n = 63 958). **Measurements** Treated SUDs of alcohol and illicit substances identified in treatment registers; suicide attempt identified in treatment registers; and completed suicides identified in the Cause of Death register. Covariates were sex and age at diagnosis. **Findings** Having any SUD was associated with at least a threefold increased risk of completed suicide when compared with those having no SUD. Alcohol misuse was associated with an increased risk of completed suicide in all populations with hazard ratios (HR) between 1.99 [95% confidence interval (CI) = 1.44–2.74] and 2.70 (95% CI = 2.40–3.04). Other illicit substances were associated with a two- to threefold risk increase of completed suicide in all populations except bipolar disorder, and cannabis was associated with increased risk of attempted suicide only in people with bipolar disorder (HR = 1.86, 95% CI = 1.15–2.99). Alcohol and other illicit substances each displayed strong associations with attempted suicide, HR ranging from 3.11 (95% CI = 2.95–3.27) to 3.38 (95% CI = 3.24–3.53) and 2.13 (95% CI = 2.03–2.24) to 2.27 (95% CI = 2.12–2.43), respectively. Cannabis was associated with suicide attempts only in people with schizophrenia (HR = 1.11, 95% CI = 1.03–1.19). **Conclusion** Substance use disorders are associated strongly with risk of completed suicides and suicide attempts in people with severe mental illness.

Ostergaard MLD et al. Associations between substance use disorders and suicide or suicide attempts in people with mental illness: a Danish nation-wide, prospective, register-based study of patients diagnosed with schizophrenia, bipolar disorder, unipolar depression or personality disorder. Addiction (Abingdon, England). 2017;112(7):1250-9.

EN ESTE ESTUDIO TRASTORNO RELACIONADO CON CANNABIS ESTUVO ASOCIADO CON SUICIDIO CONSUMADO, NO CON INTENTOS DE SUICIDIO

Table 3 Cox regression: risk of completed suicide and suicidal attempts in patients with different mental disorders with and without comorbid substance use disorders.

Adjusted for sex, age at diagnosis and calendar year		*Schizophrenia* HR (95% CI), P-value	*Bipolar disorder* HR (95% CI), P-value	*Unipolar depression* HR (95% CI), P-value	*Personality disorder* HR (95% CI), P-value
Suicide attempts					
Any substance use disorder	Current	3.41 (3.23–3.57), $P < 0.001$	3.32 (3.00–3.67), $P < 0.001$	3.50 (3.36–3.64), $P < 0.001$	3.55 (3.43–3.67), $P < 0.001$
	Former	1.83 (1.70–1.96), $P < 0.001$	1.79 (1.53–2.10), $P < 0.001$	1.85 (1.74–1.97), $P < 0.001$	1.77 (1.69–1.86), $P < 0.001$
Alcohol	Current	3.11 (2.95–3.27), $P < 0.001$	3.21 (2.88–3.58), $P < 0.001$	3.38 (3.24–3.53), $P < 0.001$	3.33 (3.20–3.46), $P < 0.001$
	Former	1.76 (1.64–1.89), $P < 0.001$	1.70 (1.44–2.00), $P < 0.001$	1.84 (1.73–1.96), $P < 0.001$	1.78 (1.69–1.86), $P < 0.001$
Cannabis	Current	1.11 (1.03–1.19), $P = 0.006$	0.93 (0.76–1.13), $P = 0.444$	1.05 (0.97–1.15), $P = 0.220$	1.03 (0.97–1.10), $P = 0.324$
	Former	1.23 (1.12–1.34), $P < 0.001$	0.94 (0.75–1.20), $P = 0.636$	1.01 (0.89–1.13), $P = 0.923$	1.03 (0.96–1.12), $P = 0.378$
Other illicit substances (hard drugs)	Current	2.27 (2.12–2.43), $P < 0.001$	2.26 (1.91–2.69), $P < 0.001$	2.15 (2.00–2.30), $P < 0.001$	2.13 (2.03–2.24), $P < 0.001$
	Former	1.61 (1.48–1.76), $P < 0.001$	1.72 (1.41–2.10), $P < 0.001$	1.67 (1.52–1.83), $P < 0.001$	1.54 (1.44–1.64), $P < 0.001$
Completed suicides (deaths)					
Any substance use disorder	Current	2.60 (2.30–2.94), $P < 0.001$	2.33 (1.74–3.11), $P < 0.001$	2.32 (2.02–2.67), $P < 0.001$	3.93 (3.52–4.38), $P < 0.001$
	Former	1.39 (1.10–1.66), $P < 0.001$	1.27 (0.81–2.02), $P = 0.300$	1.19 (0.95–1.49), $P = 0.135$	1.40 (1.20–1.64), $P < 0.001$
Alcohol	Current	2.05 (1.77–2.36), $P < 0.001$	1.99 (1.44–2.74), $P < 0.001$	2.05 (1.76–2.39), $P < 0.001$	2.70 (2.40–3.04), $P < 0.001$
	Former	1.34 (1.11–1.62), $P = 0.003$	1.57 (1.00–2.45), $P = 0.051$	1.28 (1.03–1.60), $P = 0.026$	1.36 (1.17–1.58), $P < 0.001$
Cannabis	Current	1.16 (0.96–1.41), $P = 0.135$	1.86 (1.15–2.99), $P = 0.011$	0.82 (0.58–1.16), $P = 0.261$	0.98 (0.79–1.20), $P = 0.833$
	Former	1.11 (0.90–1.38), $P = 0.331$	1.23 (0.68–2.21), $P = 0.499$	0.75 (0.49–1.14), $P = 0.177$	1.10 (0.91–1.33), $P = 0.312$
Other illicit substances (hard drugs)	Current	2.02 (1.69–2.42), $P < 0.001$	1.50 (0.89–2.55), $P = 0.131$	2.55 (2.05–3.19), $P < 0.001$	3.02 (2.65–3.45), $P < 0.001$
	Former	1.66 (1.35–2.05), $P < 0.001$	1.22 (0.69–2.16), $P = 0.487$	1.53 (1.14–2.05), $P = 0.004$	1.67 (1.41–1.97), $P < 0.001$

HR = hazard ratio.

Ostergaard MLD et al. Associations between substance use disorders and suicide or suicide attempts in people with mental illness: a Danish nation-wide, prospective, register-based study of patients diagnosed with schizophrenia, bipolar disorder, unipolar depression or personality disorder. Addiction (Abingdon, England). 2017;112(7):1250-9.

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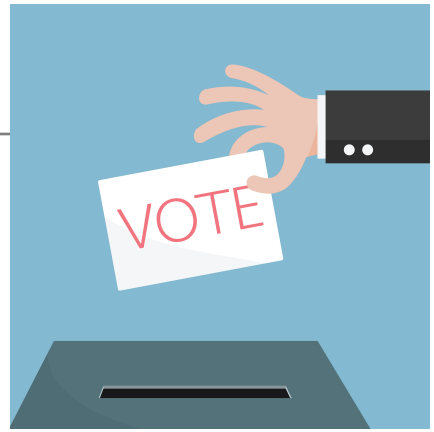
Aspectos epidemiológicos del consumo de cannabis en Chile

- Aumento sostenido de prevalencias de consumo en Chile
- Aumento en población adulta, también y, aún más preocupante, en población adolescente
- Baja sostenida en la percepción de riesgo de consumo de cannabis, especialmente en población escolar
- Discusiones a nivel político (legislación) aparecen como protagónicos
- Menor difusión respecto de la evidencia en los efectos adversos del consumo de cannabis en la salud física y mental

¿Cuál es la Prevalencia de consumo de cannabis en el último en población Chilena de 12 a 64 años (año 2014)?



SENDA. Décimo primer Estudio Nacional de Drogas en Población General

RESULTADOS PRINCIPALES SANTIAGO, CHILE: SERVICIO NACIONAL PARA LA PREVENCIÓN Y REHABILITACIÓN DEL CONSUMO DE DROGAS Y ALCOHOL (SENDA); 2015.

GRÁFICO 1:
Evolución de la prevalencias (%) de consumo de marihuana. Chile, 1994-2014.

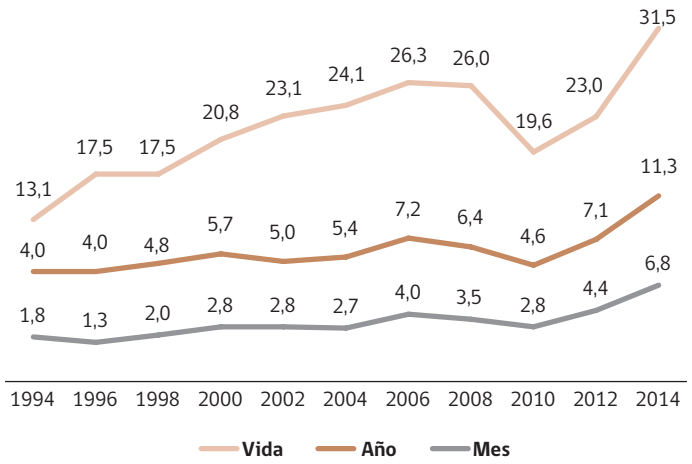


TABLA 12:
Evolución del consumo (%) de tipos de marihuana entre prevalentes en el último año, según sexo, edad y nivel socioeconómico. Chile, 2012-2014.
Porcentaje que declara haber consumido con mayor frecuencia un tipo de marihuana.

Serie	Total	Sexo		Tramos de edad					Nivel socioeconómico		
		Hombre	Mujer	12 a 18	19 a 25	26 a 34	35 a 44	45 a 64	Bajo	Medio	Alto
Marihuana prensada (paraguaya)											
2012	**32,1**	36,4	22,6	42,4	31,9	26,1	26,3	36,2	39,6	36,9	23,7
2014	**15,9**	17,7	12,6	30,9	12,6	14,7	12,1	13,2	25,7	20,4	8,3
Marihuana verde											
2012	**54,4**	50,0	64,1	49,4	50,7	60,5	63,0	55,4	53,8	49,7	58,8
2014	**68,9**	65,7	74,5	54,4	78,3	62,1	73,9	69,0	64,6	70,3	69,8
Marihuana skunk o de alta potencia											
2012	**6,2**	7,4	3,5	2,2	10,2	4,2	4,0	2,7	0,9	4,3	10,8
2014	**5,7**	6,9	3,8	4,4	3,2	13,5	3,0	3,1	1,5	4,2	8,8

SENDA. Décimo primer Estudio Nacional de Drogas en Población General. Resultados Principales Santiago, Chile: Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol (SENDA); 2015.

SENDA. Décimo primer Estudio Nacional de Drogas en Población General. Resultados Principales Santiago, Chile: Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol (SENDA); 2015.

TABLA 11:
Evolución de la prevalencia (%) de consumo de marihuana en el último año, según sexo, edad y nivel socioeconómico. Chile, 1994–2014.

Serie	Total	Sexo		Tramos de edad					Nivel socioeconómico		
		Hombre	Mujer	12 a 18	19 a 25	26 a 34	35 a 44	45 a 64	Bajo	Medio	Alto
1994	**4,0**	6,1	1,9	5,6	8,7	4,7	1,6	0,2	3,6	3,2	5,2
1996	**4,0**	5,9	2,2	6,7	10,6	3,5	1,1	0,2			
1998	**4,8**	7,2	2,4	7,6	12,1	4,8	1,7	0,3	5,4	5,0	4,2
2000	**5,7**	8,5	3,1	8,1	14,7	6,7	2,4	0,4	5,7	4,9	6,6
2002	**5,0**	7,9	2,3	6,2	13,0	6,7	2,0	0,5	5,5	4,3	5,0
2004	**5,4**	7,6	3,2	6,2	14,7	6,5	2,4	0,7	5,0	4,5	7,0
2006	**7,2**	9,7	4,7	7,4	18,5	9,8	3,8	1,3	5,8	6,0	10,3
2008	**6,4**	8,8	4,2	9,1	17,9	6,7	2,8	0,9	7,4	5,6	6,4
2010	**4,6**	7,1	2,1	5,3	12,3	6,7	2,6	0,5	6,1	3,3	5,1
2012	**7,1**	9,8	4,4	6,7	17,5	10,3	4,4	1,9	7,4	6,9	7,1
2014	**11,3**	14,6	8,1	13,5	24,0	17,1	9,0	4,2	10,6	10,4	12,5

TABLA 22:

Evolución de percepción de riesgo (%). Chile, 2000-2014.

Proporción que declara gran riesgo respecto al consumo.

Percepción de riesgo								
	2000	2002	2004	2006	2008	2010	2012	2014
Diario de tabaco	85,5	84,7	82,1	82,0	83,1	83,0	85,6	85,7
De cinco o más tragos de alcohol al día	86,4	85,7	84,9	83,0	85,4	85,3	87,9	86,9
Experimental de marihuana				46,6	51,8	48,1	46,8	34,4
Frecuente de marihuana				88,3	84,2	78,9	79,0	67,2
Experimental de cocaína				69,4	74,5	69,6	74,2	73,7
Frecuente de cocaína				97,2	95,3	94,0	94,8	94,5
Experimental de pasta base				77,2	81,1	78,2	81,6	82,7
Frecuente de pasta base				97,6	96,2	95,3	95,4	95,4

SENDA. Décimo primer Estudio Nacional de Drogas en Población General. Resultados Principales Santiago, Chile: Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol (SENDA); 2015.

TABLA 23:

Evolución de percepción de riesgo (%) en población adolescente (12 a 18 años). Chile, 2000-2014.

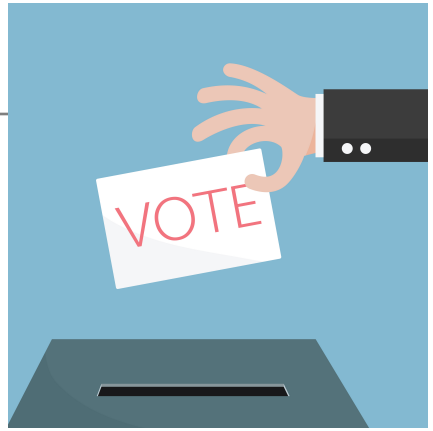
Proporción que declara gran riesgo respecto al consumo.

Percepción de riesgo								
	2000	2002	2004	2006	2008	2010	2012	2014
Diario de tabaco	80,6	75,5	71,9	72,3	73,3	82,2	78,7	79,4
De cinco o más tragos de alcohol al día	80,6	78,6	78,8	76,4	79,3	83,0	82,1	82,5
Experimental de marihuana				42,5	46,4	48,5	46,7	33,8
Frecuente de marihuana				90,3	86,0	80,8	82,5	68,7
Experimental de cocaína				60,2	66,1	67,6	67,1	70,2
Frecuente de cocaína				96,0	94,1	94,5	93,4	92,3
Experimental de pasta base				67,5	73,0	76,1	72,8	76,6
Frecuente de pasta base				96,6	95,7	94,9	94,3	93,2

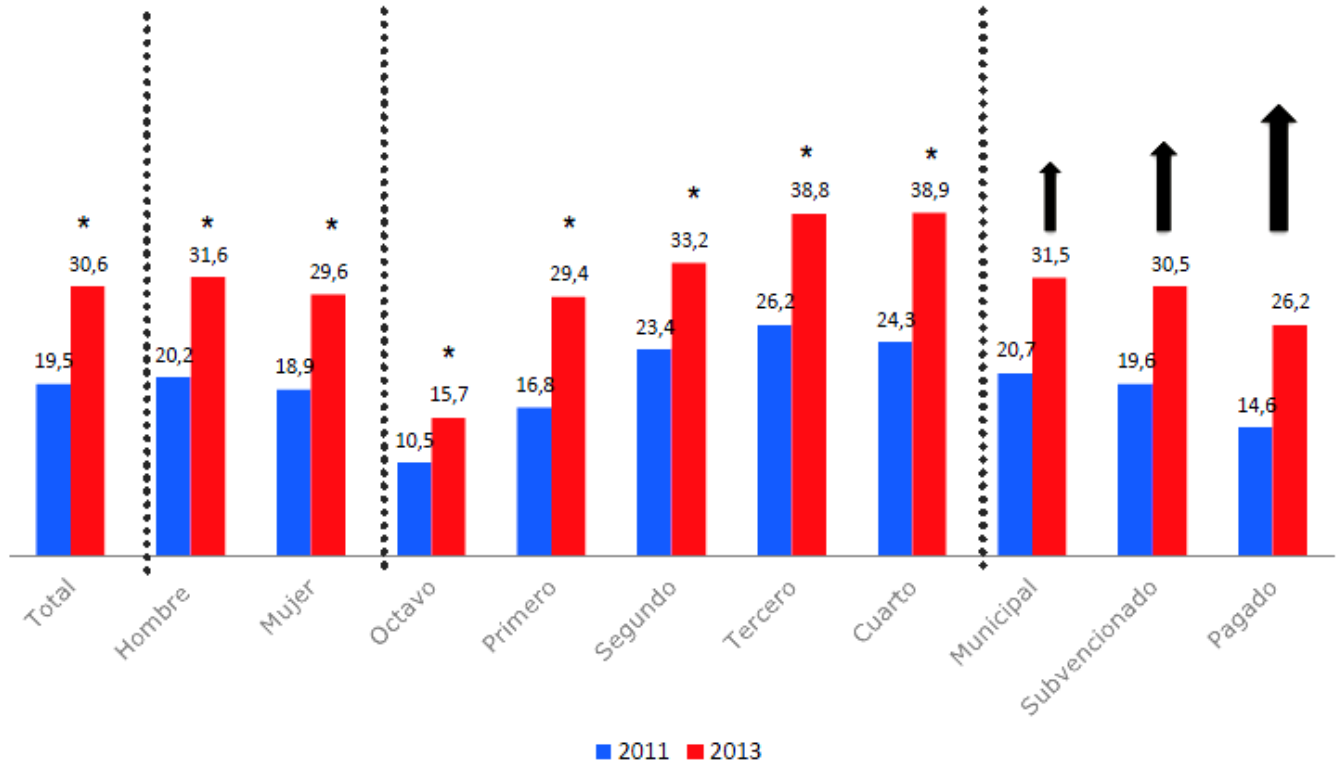
SENDA. Décimo Primer Estudio Nacional de Drogas en Población Escolar

PRINCIPALES RESULTADOS NACIONALES. SANTIAGO, CHILE: SERVICIO NACIONAL PARA LA PREVENCIÓN Y REHABILITACIÓN DEL CONSUMO DE DROGAS Y ALCOHOL (SENDA); 2015.

¿Cuál es la prevalencia de consumo de cannabis de último año en población escolar Chilena (2015)?

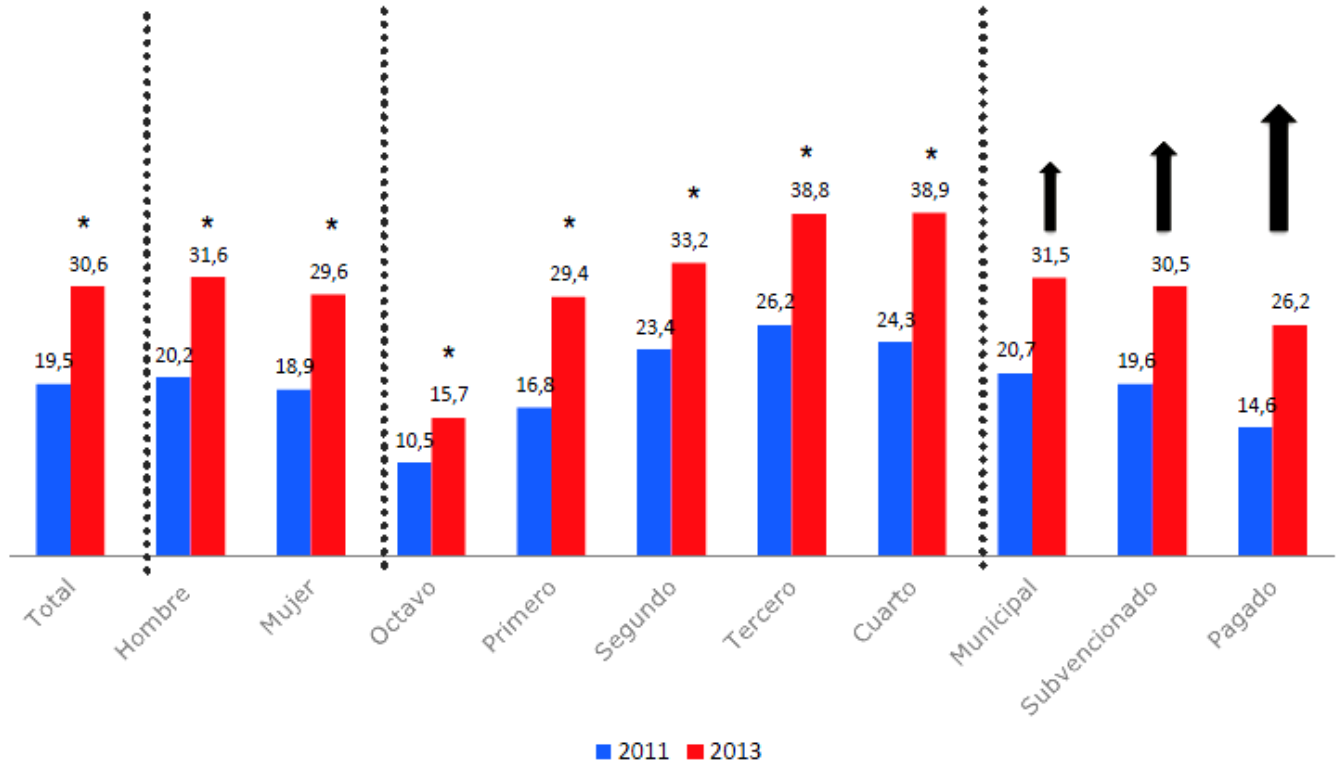


Evolución de la **prevalencia año de consumo de marihuana**, según sexo, curso y dependencia administrativa. Chile, 2011-2013.



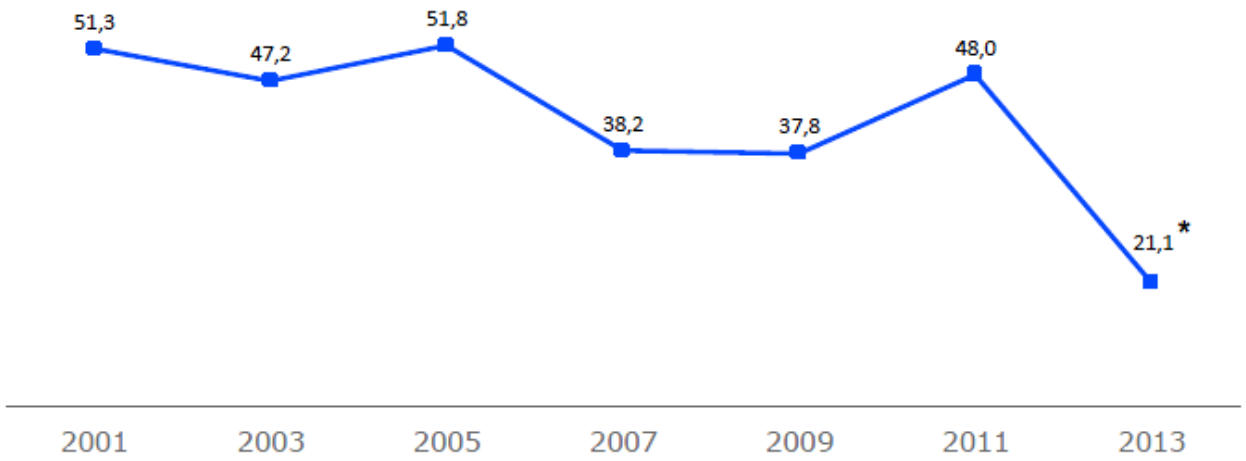
* Variación significativa al 5%

Evolución de la **prevalencia año de consumo de marihuana**, según sexo, curso y dependencia administrativa. Chile, 2011-2013.

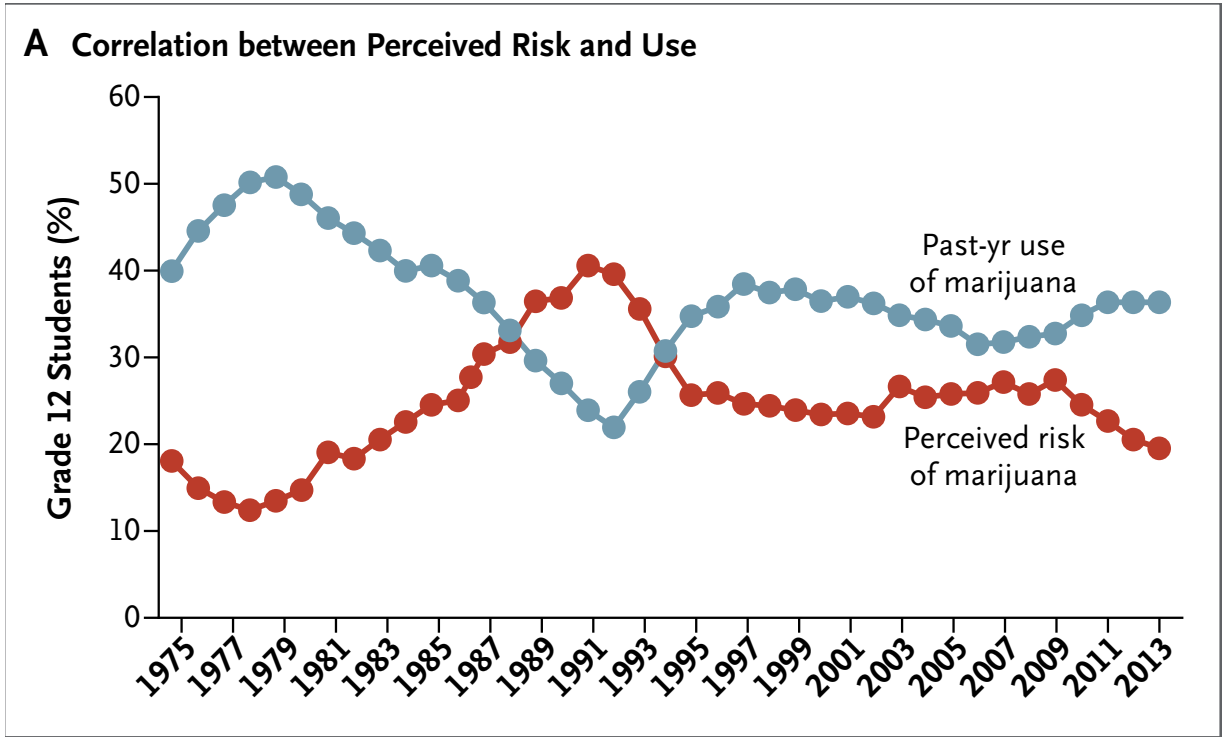


* Variación significativa al 5%

Evolución de la **percepción de riesgo** de consumir marihuana frecuentemente. Chile, 2001-2013.

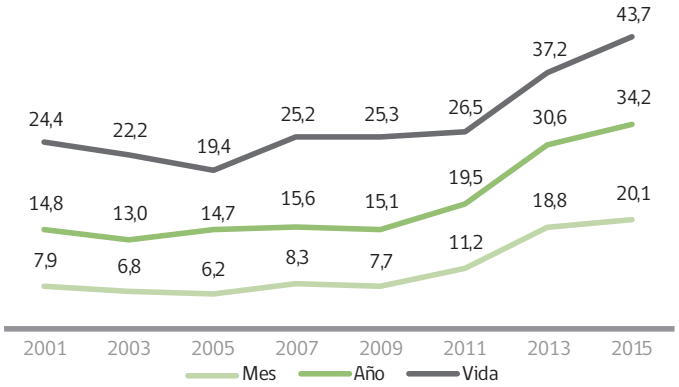


* Variación significativa al 5%



Johnston LD, O'Malley PM, Miech RA, et al. Monitoring the Future: national survey results on drug use, 1975-2013 — overview, key findings on adolescent drug use. Ann Arbor: Institute for Social Re- search, University of Michigan, 2014

GRÁFICO 3:
Evolución de la prevalencia de consumo de marihuana alguna vez en la vida, último año y último mes en Población Escolar.
Chile, 2001-2015.



SENDA. Décimo Primer Estudio Nacional de Drogas en Población Escolar. Principales Resultados Nacionales. Santiago, Chile: Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol (SENDA); 2015.

CUADRO 20:
Evolución de la prevalencia de consumo de marihuana en el último año, según sexo, curso y dependencia administrativa. Chile, 2001-2015.

		Sexo		Curso					Dependencia Administrativa		
Serie	Total	Hombre	Mujer	Octavo	Primero	Segundo	Tercero	Cuarto	Municipal	P. Subvencionado	P. Pagado
2001	14,8	16,2	13,5	5,5	11,1	17,0	20,9	22,5	14,4	15,0	15,4
2003	13,0	14,3	11,7	4,9	9,1	15,2	18,7	21,6	13,0	12,5	14,3
2005	14,7	16,1	13,4	4,8	9,9	16,2	21,2	25,8	15,0	14,3	15,3
2007	15,6	16,7	14,5	5,3	12,1	17,2	21,7	23,6	15,3	15,6	16,2
2009	15,1	15,7	14,5	6,5	11,6	16,7	20,4	22,1	15,9	14,5	14,8
2011	19,5	20,2	18,9	10,5	16,8	23,4	26,2	24,3	20,7	19,6	14,6
2013	30,6	31,6	29,6	15,7	29,4	33,2	38,8	38,9	31,5	30,5	26,2
2015	34,2	34,4	33,9	18,9	28,7	36,4	45,0	45,4	34,4	35,0	28,3

CUADRO 21:

Tipos de marihuana consumida entre prevalentes de último año, según sexo y dependencia administrativa. Chile, 2015 (2013).

		Sexo		Dependencia Administrativa		
Clase de Marihuana	Total	Hombre	Mujer	Municipal	P. Subvencionado	P. Pagado
Prensada	19,9 (31,6)	18,3 (31,0)	21,4 (32,1)	24,0 (33,9)	19,4 (32,0)	5,9 (13,6)
Verde	59,7 (55,4)	56,4 (55,2)	63,1 (55,8)	54,4 (52,2)	61,2 (55,8)	69,5 (70,3)
Verde Transgénica	11,8 (3,8)	16,4 (4,8)	7,2 (2,8)	11,5 (3,2)	11,3 (3,8)	16,7 (7,6)

Nota: Las columnas de la presente tabla no suman 100%. Lo anterior se explica producto de la no respuesta e inconsistencias en las declaraciones de los estudiantes ante la pregunta sobre el tipo de marihuana consumida y la de consumo de último año. Dicha categoría no fue reportada en cada columna, independiente del estrato bajo análisis.

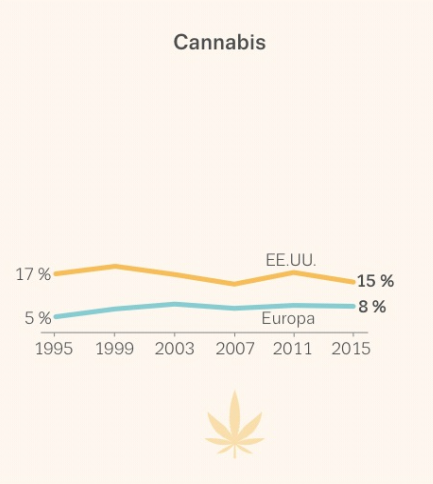
SENDA. Décimo Primer Estudio Nacional de Drogas en Población Escolar. Principales Resultados Nacionales. Santiago, Chile: Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol (SENDA); 2015.

CUADRO 33:
Evolución de la percepción de riesgo.
Chile, 2001-2015.

Sustancia	Indicador	2001	2003	2005	2007	2009	2011	2013	2015
Marihuana	Uso experimental (una o dos veces en la vida)		39,6	39,8	29,6	30,2	17,0	11,7	11,4
	Uso frecuente (una o dos veces por semana)	51,3	47,2	51,8	38,2	37,8	48,0	21,1	21,5
Cocaína	Uso experimental (una o dos veces en la vida)		54,9	49,6	43,8	41,4	27,6	35,6	42,4
	Uso frecuente			68,9	63,9	60,2	58,8	46,1	56,2
Tabaco	Uso frecuente			36,0	42,5	45,0	49,9	48,5	51,5
	Uso diario	66,7	57,7	58,0	68,0	65,3	83,9	85,8	84,7
Alcohol	Abuso (embriagarse algunas veces)			52,9	69,9	69,1	79,8	77,7	76,3
	Uso diario			42,6	44,4	45,8	57,6	58,8	60,5

Percepción de riesgo: Proporción que declara gran riesgo respecto al consumo....
Nota: En el ENPE 2011 se efectúo un cambio de frases para la medición de la percepción de riesgo de consumo experimental de marihuana, cocaína y otras drogas. La pregunta tenía incorporada la frase "una o dos veces en la vida". En el resto de los estudios, incluida la Décima Primera Versión, se hace referencia a "una o dos veces". Por esta razón los datos obtenidos el año 2011 para percepción de riesgo experimental no deben ser analizados respecto a su tendencia.

SENDA. Décimo Primer Estudio Nacional de Drogas en Población Escolar. Principales Resultados Nacionales. Santiago, Chile: Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol (SENDA); 2015.

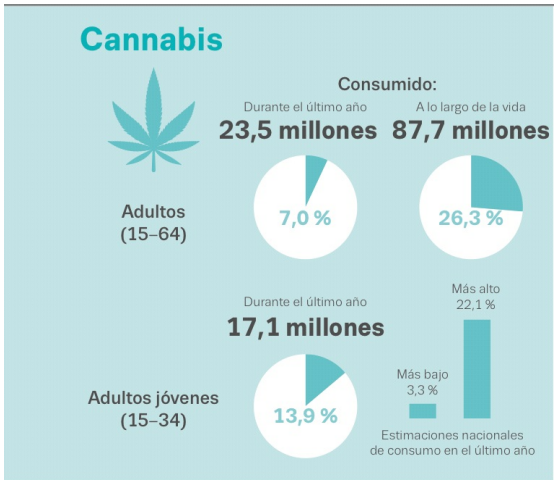


Nota: Tendencias del consumo de sustancias en el último mes entre estudiantes de 15 a 16 años en Europa y EE. UU. Las medias europeas (sin ponderar) se basan en datos de 21 países de la UE y Noruega (fuente: ESPAD). Las medias de EE. UU. se basan en muestras de estudiantes de 15 a 16 años (fuente: Monitoring the Future).

Chile, consumo de último mes de cannabis en población escolar es 20% al año 2015

EMCDDA. Informe Europeo sobre Drogas. Tendencias y Novedades. Luxemburgo: Oficina de Publicaciones de la Unión Europea: Observatorio Europeo de las Drogas y las Toxicomanías 2017.

Prevalencias Europeas de consumo de cannabis adultos y adultos jóvenes



Prevalencias Europeas de consumo de cannabis jóvenes de 15 y 16 años

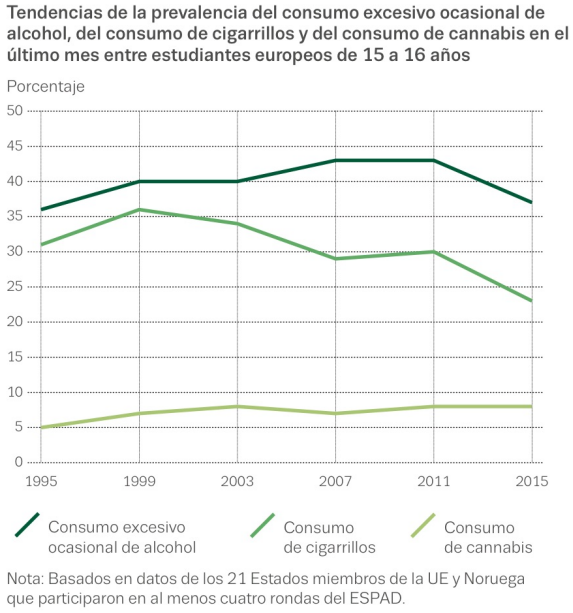
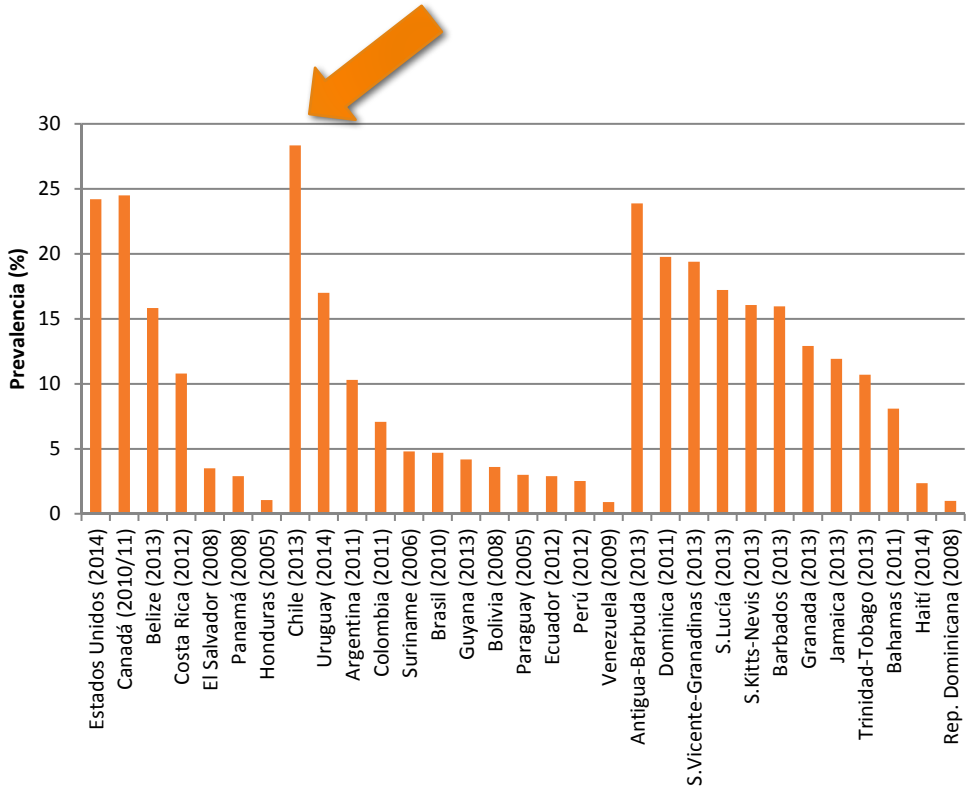


Gráfico 3-1: Prevalencia de último año de consumo de marihuana en estudiantes secundarios de las Américas

Chile en el contexto de América



Informe sobre uso de drogas en las Américas. CICAD OEA 2015

EN ESTA PRESENTACIÓN

- Introducción
- Aspectos epidemiológicos
- **Cannabis e impacto en la salud mental**
- Trastornos de ánimo y consumo de cannabis
- Uso de instrumento de screening, CUPIT validado en Chile
- Sugerencias de intervención

Young adult sequelae of adolescent cannabis use: an integrative analysis

*Edmund Silins, L John Horwood, George C Patton, David M Fergusson, Craig A Olsson, Delyse M Hutchinson, Elizabeth Spry, John W Toumbourou, Louisa Degenhardt, Wendy Swift, Carolyn Coffey, Robert J Tait, Primrose Letcher, Jan Copeland, Richard P Mattick, for the Cannabis Cohorts Research Consortium**

Summary

Background Debate continues about the consequences of adolescent cannabis use. Existing data are limited in statistical power to examine rarer outcomes and less common, heavier patterns of cannabis use than those already investigated; furthermore, evidence has a piecemeal approach to reporting of young adult sequelae. We aimed to provide a broad picture of the psychosocial sequelae of adolescent cannabis use.

Methods We integrated participant-level data from three large, long-running longitudinal studies from Australia and New Zealand: the Australian Temperament Project, the Christchurch Health and Development Study, and the Victorian Adolescent Health Cohort Study. We investigated the association between the maximum frequency of cannabis use before age 17 years (never, less than monthly, monthly or more, weekly or more, or daily) and seven developmental outcomes assessed up to age 30 years (high-school completion, attainment of university degree, cannabis dependence, use of other illicit drugs, suicide attempt, depression, and welfare dependence). The number of participants varied by outcome (N=2537 to N=3765).

Findings We recorded clear and consistent associations and dose-response relations between the frequency of adolescent cannabis use and all adverse young adult outcomes. After covariate adjustment, compared with individuals who had never used cannabis, those who were daily users before age 17 years had clear reductions in the odds of high-school completion (adjusted odds ratio 0·37, 95% CI 0·20–0·66) and degree attainment (0·38, 0·22–0·66), and substantially increased odds of later cannabis dependence (17·95, 9·44–34·12), use of other illicit drugs (7·80, 4·46–13·63), and suicide attempt (6·83, 2·04–22·90).

Interpretation Adverse sequelae of adolescent cannabis use are wide ranging and extend into young adulthood. Prevention or delay of cannabis use in adolescence is likely to have broad health and social benefits. Efforts to reform cannabis legislation should be carefully assessed to ensure they reduce adolescent cannabis use and prevent potentially adverse developmental effects.

Funding Australian Government National Health and Medical Research Council.

Silins E. et al. Young adult sequelae of adolescent cannabis use: an integrative analysis. The lancet Psychiatry. 2014;1(4):286-93.

Young adult sequelae of adolescent cannabis use: an integrative analysis

- Información obtenida de tres cohortes de Australia y N Zelanda
- Se investigó la asociación entre distintas frecuencias de consumo antes de los 17 años y siete resultados evaluados a los 30 años de edad
- Frecuencias de consumo: nunca, menor a mensual, mensual o más, semanal o más, diaria)
- Resultados evaluados: completar educación secundaria, obtener un grado universitario, dependencia de cannabis, consumo de otras sustancias ilícitas, intentos suicidas, depresión, dependencia de los servicios sociales

Young adult sequelae of adolescent cannabis use: an integrative analysis

- Resultados mostraron asociaciones claras y consistentes (relación dosis-respuesta) entre consumo de cannabis en adolescentes y resultados adversos; asociaciones se mantuvieron luego de controlar por posibles confundentes.
- Individuos que habían usado cannabis diariamente antes de los 17 años tuvieron menor probabilidad de completar educación secundaria y obtener un grado universitario comparado con quienes no habían consumido cannabis antes de los 17 años.
- También este grupo presentaron con mayor probabilidad dependencia de cannabis, consumo de otras sustancias ilícitas e intentos suicidas.
- No hubo asociación en el caso de Depresión y dependencia de los servicios sociales

Review

Effects of Cannabis Use on Human Behavior, Including Cognition, Motivation, and Psychosis: A Review

Nora D. Volkow, MD; James M. Swanson, PhD; A. Eden Evins, MD; Lynn E. DeLisi, MD; Madeline H. Meier, PhD; Raul Gonzalez, PhD; Michael A. P. Bloomfield, MRCPsych; H. Valerie Curran, PhD; Ruben Baler, PhD

With a political debate about the potential risks and benefits of cannabis use as a backdrop, the wave of legalization and liberalization initiatives continues to spread. Four states (Colorado, Washington, Oregon, and Alaska) and the District of Columbia have passed laws that legalized cannabis for recreational use by adults, and 23 others plus the District of Columbia now regulate cannabis use for medical purposes. These policy changes could trigger a broad range of unintended consequences, with profound and lasting implications for the health and social systems in our country. Cannabis use is emerging as one among many interacting factors that can affect brain development and mental function. To inform the political discourse with scientific evidence, the literature was reviewed to identify what is known and not known about the effects of cannabis use on human behavior, including cognition, motivation, and psychosis.

JAMA Psychiatry. 2016;73(3):292-297. doi:10.1001/jamapsychiatry.2015.3278
Published online February 3, 2016.

Author Affiliations: Author affiliations are listed at the end of this article.

Corresponding Author: Nora D. Volkow, MD, National Institute on Drug Abuse, National Institutes of Health, 6001 Executive Blvd, Bethesda, MD 20892 (nvolkow@nida.nih.gov).

Autores analizan la evidencia y futuras líneas de estudio acerca de las consecuencias del consumo de cannabis en la capacidad cognitiva, motivación y riesgo de psicosis.
Esto, en el contexto Norteamericano de cambios en la legislación relativa al uso recreacional y médico de esta sustancia en varios Estados.

Volkow ND et al. Effects of Cannabis Use on Human Behavior, Including Cognition, Motivation, and Psychosis: A Review. JAMA psychiatry. 2016;73(3):292-7.

Addiction
MONOGRAPH
doi:10.1111/add.12703

What has research over the past two decades revealed about the adverse health effects of recreational cannabis use?

Wayne Hall[1,2,3]

The University of Queensland Centre for Youth Substance Abuse Research and The UQ Centre for Clinical Research, Herston, Australia,[1] The National Addiction Centre, Kings College London, London, UK[2] and National Drug and Alcohol Research Centre, University of New South Wales, New South Wales, Australia[3]

CONCLUSIÓN: La evidencia de estudios epidemiológicos en los últimos 20 años muestra que el consumo de cannabis aumenta el riesgo de accidentes de tránsito y de desarrollo de una dependencia y que existen asociaciones consistentes entre el consumo regular de cannabis y pobres resultados psicosociales y de salud mental en la adultez.

Hall W. What has research over the past two decades revealed about the adverse health effects of recreational cannabis use? Addiction (Abingdon, England). 2015;110(1):19-35.

RELEVANCIA DEL PROBLEMA

Table 1 Summary of major adverse health outcomes of recreational cannabis use.

	Evidence	*Level of evidence*	*Strength of effect*
Acute effects			
Fatal overdose	+++	No case reports	0
Road traffic crashes	++	Cohort and case control	2-fold
Low birth weight	++	Cohort	
Chronic effects			
Dependence	+++	Cohort studies	1 in 10 among ever users
Educational outcomes	++	Cohort and case control	2-fold in regular users
Cognitive impairment	++	Cohort and case control	Difficult to quantify
Psychosis	++	Cohort studies	2-fold in regular users
Depression	+?	Cohort studies	Probable confounding
Suicide	+?	Cohort studies	2-fold in regular users
Chronic bronchitis	++	Cohort studies	2-fold in regular users
Respiratory impairment	+?	Cohort studies	Mixed
Cardiovascular disease	++	Cohort and case control	3–4-fold for MI
Cancers			
Testicular cancers	++	Case–control	2–3-fold
Respiratory cancers	+?	Case–control	Confounded by smoking

Hall W. What has research over the past two decades revealed about the adverse health effects of recreational cannabis use? Addiction. 2014.

BMJ

RESEARCH

Continued cannabis use and risk of incidence and persistence of psychotic symptoms: 10 year follow-up cohort study

Rebecca Kuepper, research psychologist,[1] Jim van Os, professor,[1] visiting professor,[2] Roselind Lieb, professor,[3,4] Hans-Ulrich Wittchen, professor,[4,5] Michael Höfler, research statistician,[5] Cécile Henquet, lecturer[1]

[1]Department of Psychiatry and Neuropsychology, South Limburg Mental Health Research and Teaching Network, EURON, Maastricht University Medical Center, Maastricht, Netherlands

[2]King's College London, King's Health Partners, Department of Psychosis Studies, Institute of Psychiatry, London, UK

[3]Department of Psychology, Division of Epidemiology and Health Psychology, University of Basel, Switzerland

[4]Max Planck Institute of Psychiatry, Munich, Germany

[5]Institute of Clinical Psychology and Psychotherapy, Technical University Dresden, Germany

Correspondence to: J van Os, Department of Psychiatry and Neuropsychology, South Limburg Mental Health Research and Teaching Network, EURON, Maastricht University Medical Center, PO Box 616, NL-6200 MD, Maastricht, Netherlands
j.vanos@sp.unimaas.nl

Cite this as: *BMJ* 2011;342:d738
doi:10.1136/bmj.d738

Kuepper R et al. Continued cannabis use and risk of incidence and persistence of psychotic symptoms: 10 year follow-up cohort study. BMJ (Clinical research ed). 2011;342:d738.

- Estudio prospectivo en adolescentes y adultos jóvenes
- El consumo de cannabis está asociado con riesgo incrementado de trastorno psicótico (efecto dosis respuesta).
- El consumo de cannabis precede el inicio de los síntomas psicóticos en individuos sin historia de experiencias psicóticas (síntomas se presentan cuatro años después del inicio del consumo de cannabis).
- El consumo de cannabis incrementaría el riesgo de trastorno psicótico impactando en la persistencia de experiencias psicóticas que bajo circunstancias normales (sin exposición a cannabis) habrían permanecido como un fenómeno transitorio.

Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study

Marta Di Forti, Arianna Marconi, Elena Carra, Sara Fraietta, Antonella Trotta, Matteo Bonomo, Francesca Bianconi, Poonam Gardner-Sood, Jennifer O'Connor, Manuela Russo, Simona A Stilo, Tiago Reis Marques, Valeria Mondelli, Paola Dazzan, Carmine Pariante, Anthony S David, Fiona Gaughran, Zerrin Atakan, Conrad Iyegbe, John Powell, Craig Morgan, Michael Lynskey, Robin M Murray

Lancet Psychiatry 2015; 2: 233–38

Summary

Background The risk of individuals having adverse effects from drug use (eg, alcohol) generally depends on the frequency of use and potency of the drug used. We aimed to investigate how frequent use of skunk-like (high-potency) cannabis in south London affected the association between cannabis and psychotic disorders.

Methods We applied adjusted logistic regression models to data from patients aged 18–65 years presenting to South London and Maudsley NHS Foundation Trust with first-episode psychosis and population controls recruited from the same area of south London (UK) to estimate the effect of the frequency of use, and type of cannabis used on the risk of psychotic disorders. We then calculated the proportion of new cases of psychosis attributable to different types of cannabis use in south London.

Findings Between May 1, 2005, and May 31, 2011, we obtained data from 410 patients with first-episode psychosis and 370 population controls. The risk of individuals having a psychotic disorder showed a roughly three-times increase in users of skunk-like cannabis compared with those who never used cannabis (adjusted odds ratio [OR] 2·92, 95% CI 1·52–3·45, p=0·001). Use of skunk-like cannabis every day conferred the highest risk of psychotic disorders compared with no use of cannabis (adjusted OR 5·4, 95% CI 2·81–11·31, p=0·002). The population attributable fraction of first-episode psychosis for skunk use for our geographical area was 24% (95% CI 17–31), possibly because of the high prevalence of use of high-potency cannabis (218 [53%] of 410 patients) in our study.

Interpretation The ready availability of high potency cannabis in south London might have resulted in a greater proportion of first onset psychosis cases being attributed to cannabis use than in previous studies.

Funding UK National Institute of Health Research (NIHR) Specialist Biomedical Research Centre for Mental Health, SLaM and the Institute of Psychiatry at King's College London, Psychiatry Research Trust, Maudsley Charity Research Fund, and th European Community's Seventh Framework Program grant (agreement No. HEALTH-F2-2009-241909 [Project EU-GEI]).

Di Forti M. et al. Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study. The lancet Psychiatry. 2015;2(3):233-8

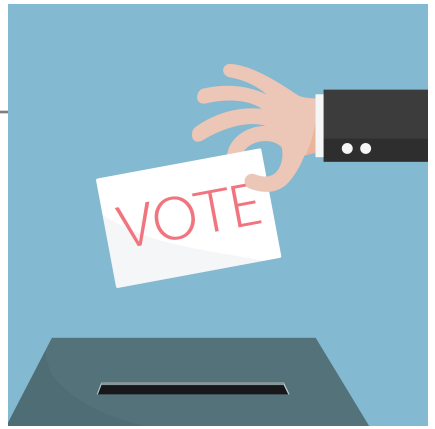
- Usuarios de marihuana de alta potencia ("skunk") tienen tres veces más riesgo de tener un trastorno psicótico comparado con quienes nunca han consumido cannabis (cinco veces en consumidores diarios).

- Se calculó que el consumo de cannabis de alta potencia era responsable del 24% de los nuevos casos de psicosis.

EN ESTA PRESENTACIÓN

- Introducción
- Aspectos epidemiológicos
- Cannabis e impacto en la salud mental
- **Trastornos de ánimo y consumo de cannabis**
- Uso de instrumento de screening, CUPIT validado en Chile
- Sugerencias de intervención

¿El consumo de cannabis en el Trastorno Afectivo Bipolar está asociado a:?



Co-morbilidad entre T Afectivo Bipolar y Trastorno relacionado con cannabis

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Bipolar disorder and co-occurring cannabis use disorders: Characteristics, co-morbidities and clinical correlates

Shaul Lev-Ran [a,b,*], Bernard Le Foll [b,c,d,e], Kwame McKenzie [a,e,f], Tony P. George [e,g,h], Jürgen Rehm [e,i,j]

[a] Social Aetiology of Mental Illness (SAMI) CIHR Training Program, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[b] Addictions Program, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[c] Translational Addiction Research Laboratory, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[d] Departments of Family and Community Medicine, Pharmacology and Toxicology, University of Toronto, Toronto, Ontario, Canada
[e] Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada
[f] Social Equity and Health Research Program, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[g] Schizophrenia Program, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[h] Division of Brain and Therapeutics, Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada
[i] Social and Epidemiological Research Department, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[j] Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

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Bipolar disorder
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ABSTRACT

This study examines rates of co-morbid mental disorders and indicators of the course of illness among individuals with bipolar disorder and cannabis use disorders (CUD). Data were drawn from the National Epidemiological Survey of Alcohol and Related Conditions (NESARC Wave 1, 2001–2002), a nationally representative sample of adults living in the United States. Among individuals with lifetime prevalence of bipolar disorder (N=1905) rates of CUD in the past 12 months were 7.2%, compared to 1.2% in the general population. Logistic regression models adjusting for sociodemographic variables indicated that individuals with bipolar disorder and co-occurring CUD were at increased risk for nicotine dependence (Adjusted Odds Ratio (AOR)=3.8), alcohol (AOR=6.6) and drug (AOR=11.9) use disorders, as well as antisocial personality disorder (AOR=2.8) compared to those without CUD. Among individuals with co-occurring CUD, age of onset of bipolar disorder was significantly lower and median number of manic, hypomanic and depressive episodes per year was significantly greater compared to individuals without CUD. Co-occurring CUD is associated with significant co-morbidities and a more severe course of illness among individuals with bipolar disorder. Comprehensive evaluation of patients with bipolar disorder should include a systematic assessment of CUD.

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Lev-Ran S et al. Bipolar disorder and co-occurring cannabis use disorders: characteristics, co-morbidities and clinical correlates. Psychiatry research. 2013;209(3):459-65.

Presencia de Trastorno relacionado con cannabis en pacientes con T Afectivo Bipolar se asocia a mayores y significativas co morbilidades

Lev-Ran S et al. Bipolar disorder and co-occurring cannabis use disorders: characteristics, co-morbidities and clinical correlates. Psychiatry research. 2013;209(3):459-65.

Table 2
Prevalence of specific co-morbid 12-month DSM-IV diagnosis among individuals with lifetime bipolar disorder with and without 12-month CUD (cannabis use disorders).

	CUD (n=119)	S.E.	No CUD (n=1786)	S.E.	Unadjusted OR	95% CI	Adjusted OR[a]	95% CI
Any anxiety disorder	42.6	5.60	38.1	1.47	1.21	0.77–1.89	1.39	0.87–2.23
Panic disorder	14.4	3.51	13.0	0.93	1.13	0.63–2.04	1.34	0.73–2.46
Social phobia	16.1	3.68	13.3	1.05	1.25	0.73–2.14	1.53	0.86–2.73
Specific phobia	20.4	4.51	21.7	1.17	0.93	0.53–1.63	1.04	0.58–1.87
GAD	14.5	4.07	14.4	1.11	1.01	0.53–1.93	1.34	0.70–2.58
Psychotic disorder	7.9	3.94	3.1	0.45	2.71	0.92–7.99	2.75	0.99–7.64
Nicotine dependence	67.5	5.03	32.7	1.58	4.27	2.66–6.87	3.83	2.21–6.66
Any alcohol use disorder	66.5	5.37	18.0	1.15	9.03	5.35–15.24	6.57	3.84–11.24
Any drug use disorder	71.9	4.81	19.0	1.18	15.64	8.67–28.23	11.90	6.16–22.99
Any PD	80.3	3.74	60.3	1.55	2.68	1.63–4.41	2.36	1.40–3.99
Antisocial PD	49.9	5.31	18.2	1.17	4.49	2.83–7.12	2.75	1.63–4.64
Avoidant PD	21.7	4.61	16.9	1.08	1.36	0.78–2.37	1.46	0.81–2.62
Dependent PD	13.7	4.32	4.0	0.54	3.87	1.78–8.44	2.26	0.73–7.01
Obsessive–Compulsive PD	47.1	5.71	32.8	1.41	1.82	1.14–2.92	2.04	1.21–3.44
Paranoid PD	34.5	5.64	29.7	1.30	1.25	0.76–2.05	1.06	0.61–1.82
Schizoid PD	21.6	4.55	17.3	1.05	1.32	0.76–2.29	1.30	0.73–2.29
Histrionic PD	28.7	5.30	13.2	0.94	2.64	1.53–4.55	2.00	1.12–3.58

Abbreviations: OR=odds ratio; GAD=generalized anxiety disorder; PD=personality disorder.

[a] Adjusted for age, race, educational level, household income, marital status, urbanicity and region.

Lev-Ran S et al. Bipolar disorder and co-occurring cannabis use disorders: characteristics, co-morbidities and clinical correlates. Psychiatry research. 2013;209(3):459-65.

Table 3
Indicators of course of bipolar disorder among individuals with and without 12-month CUD (cannabis use disorders).

Characteristic	CUD ($N=119$)	No CUD ($N=1786$)	P value
Age of onset of first manic or hypomanic episode, mean (S.E.) in years	19.5 (0.81)	25.1 (0.37)	<0.0001
Age of onset of first depressive episode, mean (S.E.), in years	18.5 (0.95)	24.4 (0.37)	<0.0001
No. of depressive, manic or hypomanic episodes per year since onset of disorder, median (quartiles)	1.8 (0.7, 5.8)	0.7 (0.3, 1.7)	0.004
Duration of longest manic or hypomanic episode, in weeks, median (quartiles)	6.9 (1.7, 42.3)	7.6 (1.4, 49.9)	0.57
Duration of longest depressive episode, in weeks, median (quartiles)	25.8 (11.2, 122.7)	24.4 (7.7, 96.1)	0.95
Rapid cycling, % (S.E.)	14.9 (4.92)	5.1 (0.53)	0.06
Ever treated by therapist/counselor/doctor for bipolar disorder, % (S.E.)	49.4 (5.78)	54.3 (1.65)	0.42
Ever stayed overnight in hospital for bipolar disorder, % (S.E.)	18.4 (4.63)	17.6 (1.09)	0.88
Ever went to Emergency Room for help because of bipolar disorder, % (S.E.)	12.6 (3.37)	17.2 (1.21)	0.21
Ever prescribed medications by doctor for bipolar disorder, % (S.E.)	42.3 (6.25)	44.9 (1.77)	0.68
Lifetime suicide attempts, % (S.E.)	21.8 (5.02)	17.5 (1.07)	0.40

Lev-Ran S et al. Bipolar disorder and co-occurring cannabis use disorders: characteristics, co-morbidities and clinical correlates. Psychiatry research. 2013;209(3):459-65.

- Entre los individuos con Trastorno relacionado con cannabis co-mórbido al Trastorno Afectivo Bipolar, la edad de inicio de la Enfermedad anímica fue significativamente más baja.
- Además la media de número de episodios maníacos, hipomaníacos y depresivos por año, fue significativamente mayor, comparado con individuos sin Trastorno relacionado con cannabis co-mórbido.
- También presentaron mayor prevalencia de otros trastornos relacionados con sustancias (alcohol, nicotina y otras sustancias ilegales distinta de cannabis)
- El Trastorno relacionado con cannabis en pacientes con T Bipolar está asociado con significativas co-morbilidades y un curso más severo de la enfermedad anímica.

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Review

Attempted suicide in people with co-occurring bipolar and substance use disorders: Systematic review and meta-analysis

Giuseppe Carrà [a], Francesco Bartoli [b,*], Cristina Crocamo [b], Kathleen T. Brady [c], Massimo Clerici [b]

[a] Division of Psychiatry, University College London, London, UK
[b] Department of Surgery and Interdisciplinary Medicine, University of Milano Bicocca, Via Cadore 48, Monza (MB), Italy
[c] Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina,Charleston, SC, USA

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ABSTRACT

Background: Both individuals with bipolar (BD) and those with alcohol (AUD) and other substance (SUD) use disorders are likely to attempt suicide. Comorbidity of BD and AUD/SUD may increase the likelihood of suicide attempts. We conducted a meta-analysis to estimate the association of comorbid AUD/SUD and suicide attempts in subjects with BD in the literature to date.
Methods: Electronic databases through January 2013 were searched. Studies reporting rates of suicide attempts in people with co-occurring BD and AUD/SUD were retrieved. Comorbid AUD and SUD and suicide attempts rates as well as demographic, clinical, and methodological variables were extracted from each publication or obtained directly from its authors.
Results: Twenty-nine of 222 studies assessed for eligibility met the inclusion criteria, comprising a total of 31,294 individuals with BD, of whom 6308 (20.1%) had documented suicide attempts.

There were consistent findings across the studies included. As compared to controls, subjects with BD and comorbid AUD/SUD were more likely to attempt suicide. The cross-sectional association estimates showed random-effects pooled crude ORs of 1.96 (95% CI = 1.56–2.47; $p < 0.01$), 1.72 (95% CI = 1.52–1.95; $p < 0.01$), and 1.77 (95% CI = 1.49–2.10; $p < 0.01$), for combined AUD/SUD, AUD, and SUD. There was no publication bias and sensitivity analyses based on the highest quality studies confirmed core results.
Limitations: The effects of the number and the type of suicide attempts could not be investigated due to insufficient information.
Conclusions: Comorbid AUD and SUD in individuals with BD are significantly associated with suicide attempts. Individuals with this comorbidity should be targeted for intensive suicide prevention efforts.
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Carra G et al. Attempted suicide in people with co-occurring bipolar and substance use disorders: systematic review and meta-analysis. Journal of affective disorders. 2014;167:125-35.

Table 1
Meta-analyses of the association between different categories of alcohol/substance use disorders and suicide attempts in people with bipolar disorder.

Substance-related disorders	Studies	Participants	OR (95% CI)
AUD and/or SUD			
Lifetime	13	19,062	1.96 (1.56–2.47)
Current	4	3418	1.50 (0.87–2.59)
AUD			
Lifetime	18	10,723	1.72 (1.52–1.95)
Current	1	2088	1.40 (1.07–1.83)
SUD			
Lifetime	13	7952	1.77 (1.49–2.10)
Current	1	2088	1.44 (1.04–1.99)
Cannabis use disorders			
Lifetime	4	3439	1.44 (1.07–1.94)

Abbreviations: AUD = alcohol use disorder, SUD = substance use disorder, OR = odds ratio, CI = confidence interval.

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- En pacientes Bipolares, la presencia de Trastorno relacionados con alcohol y otras sustancias está asociada con conducta suicida, independiente de la edad, género y setting
- Faltan estudios prospectivos para definir mejor la causalidad
- Importancia de la prevención, detección temprana y tratamiento de los trastornos relacionados con alcohol y otras sustancias en paciente Bipolares para reducir suicidalidad.

Original Investigation

Cannabis Use and Risk of Psychiatric Disorders
Prospective Evidence From a US National Longitudinal Study

Carlos Blanco, MD, PhD; Deborah S. Hasin, PhD; Melanie M. Wall, PhD; Ludwing Flórez-Salamanca, MD; Nicolas Hoertel, MD, MPH; Shuai Wang, PhD; Bradley T. Kerridge, PhD, PhD; Mark Olfson, MD, MPH

Supplemental content at jamapsychiatry.com

IMPORTANCE With rising rates of marijuana use in the general population and an increasing number of states legalizing recreational marijuana use and authorizing medical marijuana programs, there are renewed clinical and policy concerns regarding the mental health effects of cannabis use.

OBJECTIVE To examine prospective associations between cannabis use and risk of mental health and substance use disorders in the general adult population.

DESIGN, SETTING, AND PARTICIPANTS A nationally representative sample of US adults aged 18 years or older was interviewed 3 years apart in the National Epidemiologic Survey on Alcohol and Related Conditions (wave 1, 2001-2002; wave 2, 2004-2005). The primary analyses were limited to 34 653 respondents who were interviewed in both waves. Data analysis was conducted from March 15 to November 30, 2015.

MAIN OUTCOMES AND MEASURES We used multiple regression and propensity score matching to estimate the strength of independent associations between cannabis use at wave 1 and incident and prevalent psychiatric disorders at wave 2. Psychiatric disorders were measured with a structured interview (Alcohol Use Disorder and Associated Disabilities Interview Schedule–*DSM-IV*). In both analyses, the same set of wave 1 confounders was used, including sociodemographic characteristics, family history of substance use disorder, disturbed family environment, childhood parental loss, low self-esteem, social deviance, education, recent trauma, past and present psychiatric disorders, and respondent's history of divorce.

RESULTS In the multiple regression analysis of 34 653 respondents (14 564 male [47.9% weighted]; mean [SD] age, 45.1 [17.3] years), cannabis use in wave 1 (2001-2002), which was reported by 1279 respondents, was significantly associated with substance use disorders in wave 2 (2004-2005) (any substance use disorder: odds ratio [OR], 6.2; 95% CI, 4.1-9.4; any alcohol use disorder: OR, 2.7; 95% CI, 1.9-3.8; any cannabis use disorder: OR, 9.5; 95% CI, 6.4-14.1; any other drug use disorder: OR, 2.6; 95% CI, 1.6-4.4; and nicotine dependence: OR, 1.7; 95% CI, 1.2-2.4), but not any mood disorder (OR, 1.1; 95% CI, 0.8-1.4) or anxiety disorder (OR, 0.9; 95% CI, 0.7-1.1). The same general pattern of results was observed in the multiple regression analyses of wave 2 prevalent psychiatric disorders and in the propensity score–matched analysis of incident and prevalent psychiatric disorders.

CONCLUSIONS AND RELEVANCE Within the general population, cannabis use is associated with an increased risk for several substance use disorders. Physicians and policy makers should take these associations of cannabis use under careful consideration.

Blanco C. et al. Cannabis Use and Risk of Psychiatric Disorders: Prospective Evidence From a US National Longitudinal Study. JAMA psychiatry. 2016;73(4):388-95.

Blanco C. et al. Cannabis Use and Risk of Psychiatric Disorders: Prospective Evidence From a US National Longitudinal Study. JAMA psychiatry. 2016;73(4):388-95.

Table 1. Cannabis Use in the Past 12 Months in Wave 1 and Prevalent Psychiatric Disorders in Wave 2 of the NESARC

Prevalent Psychiatric Disorders in Wave 2	Wave 1, % (No.)[a]		OR (95% CI)	Adjusted OR (95% CI)[b]
	Cannabis Use in Past 12 mo (n = 1279)	No Cannabis Use in Past 12 mo (n = 33 364)		
Any disorder	71.5 (892)	31.0 (10 326)	5.6 (4.7-6.6)	2.1 (1.8-2.6)
Any substance use disorder	65.6 (797)	19.3 (6103)	8.0 (6.9-9.2)	2.8 (2.4-3.4)
Any alcohol use disorder	40.2 (475)	8.4 (2663)	7.3 (6.3-8.6)	2.5 (2.1-3.0)
Abuse	17.3 (209)	4.8 (1498)	4.2 (3.4-5.1)	1.8 (1.4-2.3)
Dependence	22.9 (266)	3.6 (1165)	7.9 (6.6-9.4)	2.3 (1.9-2.9)
Any cannabis use disorder	21.4 (261)	0.8 (256)	34.7 (27.5-43.8)	12.4 (8.9-17.2)
Abuse	16.7 (206)	0.6 (172)	34.2 (26.6-44.0)	12.3 (8.9-17.0)
Dependence	4.7 (55)	0.2 (58)	25.3 (15.0-42.7)	9.0 (3.9-20.8)
Any other drug use disorder	8.9 (105)	0.8 (239)	12.5 (9.1-17.4)	3.1 (2.1-4.6)
Abuse	5.2 (61)	0.5 (137)	11.6 (7.8-17.0)	3.0 (1.9-4.7)
Dependence	4.2 (51)	0.3 (114)	12.8 (8.2-20.0)	3.0 (1.7-5.3)
Nicotine dependence	38.2 (470)	12.9 (4039)	4.2 (3.6-4.9)	1.5 (1.2-1.8)
Any mood disorder	18.0 (236)	9.3 (3296)	2.1 (1.8-2.6)	0.9 (0.7-1.2)
Major depressive disorder	6.7 (91)	5.6 (1984)	1.2 (0.9-1.6)	0.8 (0.6-1.1)
Bipolar I disorder	8.9 (112)	2.6 (910)	3.7 (2.8-4.8)	1.1 (0.7-1.5)
Bipolar II disorder	2.3 (31)	0.8 (300)	2.8 (1.7-4.7)	1.0 (0.5-1.7)
Bipolar disorder	11.1 (143)	3.4 (1210)	3.6 (2.9-4.5)	1.0 (0.8-1.4)
Dysthymia	1.0 (13)	0.8 (290)	1.3 (0.6-2.6)	0.7 (0.3-1.7)
Any anxiety disorder	21.0 (262)	12.2 (4298)	1.9 (1.6-2.3)	1.0 (0.8-1.2)
Panic disorder	5.5 (66)	2.5 (884)	2.3 (1.7-3.2)	0.8 (0.5-1.2)
Social anxiety disorder	6.6 (76)	2.4 (869)	2.9 (2.2-4.0)	1.2 (0.8-1.8)
Specific phobia	11.1 (144)	7.4 (2614)	1.6 (1.3-2.0)	0.9 (0.7-1.2)
Generalized anxiety disorder	6.6 (86)	3.7 (1276)	1.8 (1.4-2.5)	1.0 (0.7-1.4)

Blanco C. et al. Cannabis Use and Risk of Psychiatric Disorders: Prospective Evidence From a US National Longitudinal Study. JAMA psychiatry. 2016;73(4):388-95.

- El consumo de cannabis se asoció con prevalencia e incidencia aumentada de un amplio rango de trastornos psiquiátricos (dosis respuesta).

- Sin embargo luego de realizar ajustes estadísticos, el consumo de cannabis (últimos 12 meses) se asoció solo con prevalencia e incidencia aumentada de trastornos por alcohol y otras drogas, incluido dependencia de nicotina

Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes?

Zorrilla I et al. Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes? Acta psychiatrica Scandinavica. 2015;131(2):100-10.

Zorrilla I, Aguado J, Haro JM, Barbeito S, López Zurbano S, Ortiz A, López P, Gonzalez-Pinto A. Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes?

Objective: To examine whether bipolar disorder patients who stop cannabis use during a manic/mixed episode have better clinical and functional outcomes than continued use or never use.
Method: Data from the European Mania in Bipolar Longitudinal Evaluation of Medication (EMBLEM), a 2-year prospective observational study in adults with a manic/mixed episode of bipolar disorder, was used. Three cannabis use groups were: current use (between 12-week and 24-month visits); no current but previous use (during first 12 weeks); and never use. Associations between cannabis use and outcomes were analyzed using regression models.
Results: Of 1922 patients analyzed, 6.9% were current users, 4.6% previous users, and 88.5% never users. Clinical outcomes differed between groups ($P < 0.019$): previous users had highest rates of remission (68.1%) and recovery (38.7%), and lowest rates of recurrence (42.1%) and relapse (29.8%). Logistic regression showed previous users had similar outcomes to never users (all $P > 0.05$), whereas current users had lower recovery ($P = 0.004$) and remission ($P = 0.014$), higher recurrence ($P = 0.014$), greater work impairment ($P = 0.016$), and were more likely not to be living with partner ($P = 0.006$) than never users.
Conclusion: Bipolar patients who stop using cannabis during manic/mixed episode have similar clinical and functional outcomes to never users, while continued use is associated with higher risk of recurrence and poorer functioning.

I. Zorrilla[1], J. Aguado[2], J. M. Haro[2], S. Barbeito[1], S. López Zurbano[1], A. Ortiz[1], P. López[1], A. Gonzalez-Pinto[1]

[1]International Mood Disorders Research Centre, Centro de Investigación Biomédica en Red en Salud Mental (CIBERSAM), Hospital Santiago Apóstol, University of the Basque Country, Vitoria, and [2]Sant Joan De Deu-SSM, Fundació Sant Joan de Déu, CIBERSAM, Barcelona, Spain

Key words: bipolar disorder; cannabis; functioning; remission; relapse

Ana González-Pinto, CIBERSAM G10, Hospital Santiago, Olaguibel 29, Department of Psychiatry, Vitoria, Spain.
E-mail: anamaria.gonzalez-pintoarrillaga@osakidetza.net

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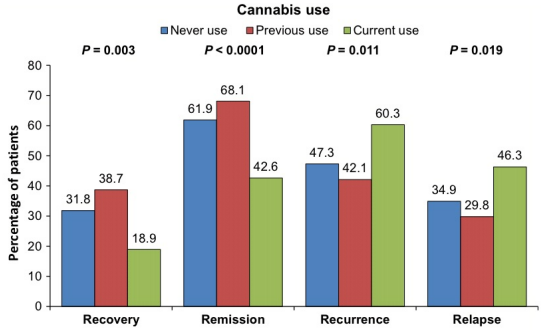
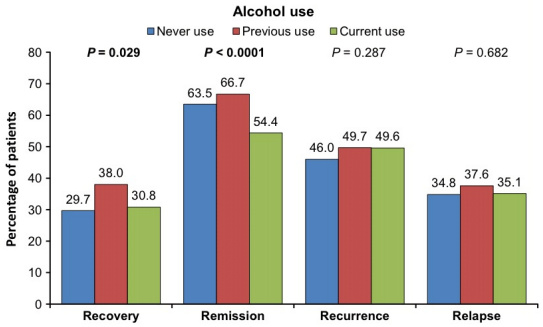
- Estudio de seguimiento EMBLEM study (European Mania in Bipolar Longitudinal of Medication)

- Primer estudio que explora las consecuencias a largo plazo de continuar o cesar el uso de cannabis respecto de la remisión, recuperación, recurrencia o recaída en pacientes con Trastorno Bipolar

- Concluye que una meta importante del tratamiento con los pacientes Bipolares consumidores de cannabis es que suspendan su consumo

Zorrilla I et al. Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes? Acta psychiatrica Scandinavica. 2015;131(2):100-10.





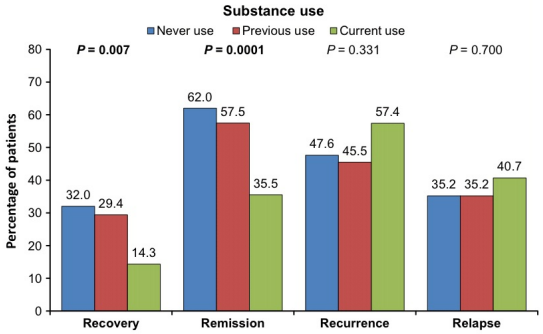
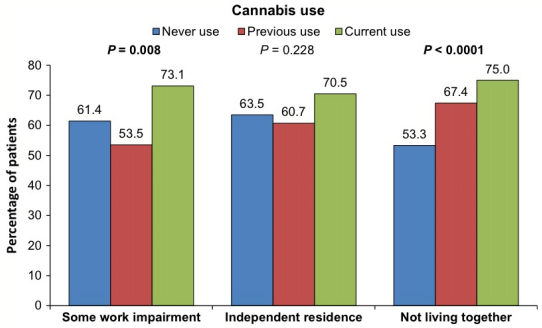
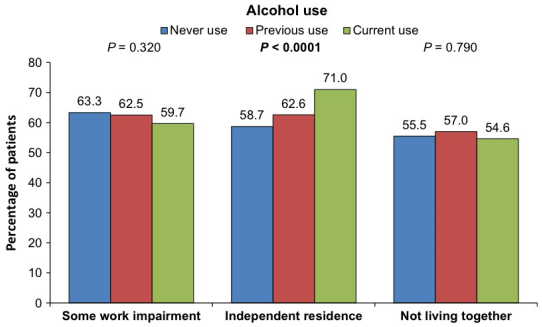


Fig. 2. Clinical outcomes in the cannabis, alcohol, and other substance use groups.

Cannabis





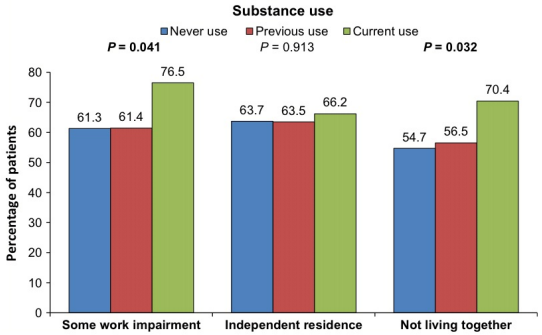


Fig 1 Functional outcomes in the cannabis, alcohol and other substances use groups

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Table 3. Hazard ratios of effect of cannabis use (vs. no use) on times to recovery, remission, recurrence, and relapse (Cox regression analysis)

	M1 model			M2 model*		
	Hazard ratio	95% Wald confidence limits	*P* value†	Hazard ratio	95% Wald confidence limits	*P* value†
Recovery	0.53	0.298–0.959	**0.036**	0.59	0.320–1.076	0.085
Remission	0.69	0.472–1.001	0.050	0.73	0.487–1.101	0.135
Recurrence	1.67	1.206–2.320	**0.002**	1.47	1.030–2.092	**0.034**
Relapse	1.61	1.116–2.316	**0.011**	1.43	0.966–2.121	0.079

*M2 model: alcohol and other substance use included as covariates in the model.

†Bold values indicate significance.

Zorrilla I et al. Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes? Acta psychiatrica Scandinavica. 2015;131(2):100-10.

Table 1. Baseline characteristics of patients by their cannabis use habits during 2 years of follow-up

Variable	Never use (N = 1701)	Previous use (N = 89)	Current use (N = 132)	P value*
Age, years	46.2 (12.9)	35.3 (10.1)	35.8 (9.8)	**<0.0001**
Sex, female, n (%)	981 (59.6)	27 (30.7)	42 (33.3)	**<0.0001**
Body Mass Index (kg/m^2)	26.3 (5.0)	24.9 (4.2)	24.3 (4.6)	**<0.0001**
Number of dependents	0.7 (1.0)	0.4 (0.9)	0.5 (0.9)	**0.001**
Age at onset of bipolar disorder, years	30.5 (11.1)	26.1 (7.0)	24.5 (7.3)	**<0.0001**
Age at first mania, years	32.1 (12.0)	26.7 (7.7)	26.2 (7.7)	**<0.0001**
Number of manic episodes in previous 12 months, n (%)				
1	954 (57.3)	53 (62.4)	60 (45.8)	**0.040**
2	461 (27.7)	21 (24.7)	44 (33.6)	
3 or more	169 (10.2)	9 (10.6)	23 (17.6)	
Number of depressive episodes in previous 12 months (n (%)				
0	749 (44.3)	50 (56.8)	53 (40.5)	0.215
1	581 (34.4)	23 (26.1)	45 (34.4)	
2 or more	250 (14.8)	10 (11.4)	26 (19.8)	
Type of episode, mania/mixed, n (%)	1254 (75.8)/401 (24.2)	71 (80.7)/17 (19.3)	91 (70.0)/39 (30.0)	0.177
In-patient status, n (%)	574 (33.8)	39 (43.8)	60 (45.5)	**0.005**
Number of bipolar disorder-related admissions	0.8 (1.5)	0.9 (0.9)	1.0 (1.3)	**0.008**
Rapid cycler, n (%)	241 (15.7)	12 (15.4)	30 (24.6)	**0.037**
Delusions/hallucinations, n (%)	731 (47.1)	50 (61.7)	75 (62.5)	**<0.001**
Presence of psychosis, n (%)	632 (37.3)	46 (51.7)	72 (54.5)	**<0.0001**
History of at least one suicide attempt, n (%)	116 (7.0)	9 (10.5)	17 (13.3)	**0.021**
Relationship, living together, n (%)	771 (45.4)	21 (23.6)	36 (27.3)	**<0.0001**
Housing conditions, independent residence, n (%)	1020 (60.0)	46 (51.7)	77 (58.3)	0.282
Some social activities, n (%)	1351 (79.7)	76 (85.4)	99 (75.0)	0.168
Some work impairment, n (%)	1396 (87.3)	76 (87.4)	120 (93.0)	0.163
Dissatisfaction with life, n (%)	669 (39.5)	40 (44.9)	72 (54.5)	**0.015**
CBI-BP overall in past year	4.1 (1.3)	4.0 (1.4)	4.6 (1.3)	**<0.0001**
CGI-BP overall	4.7 (1.1)	4.6 (1.1)	5.1 (1.0)	**<0.0001**
CGI-BP mania	4.8 (1.0)	4.7 (1.0)	5.1 (1.0)	**<0.001**
CGI-BP depression	1.9 (1.2)	1.7 (1.1)	2.1 (1.5)	0.153
CGI hallucination and delusions	2.8 (1.8)	3.3 (1.7)	3.6 (2.0)	**<0.0001**
YMRS total	26.0 (9.6)	28.5 (9.5)	30.0 (9.6)	**<0.0001**
HAMD-5 total	3.1 (2.9)	2.7 (2.7)	3.8 (4.1)	0.577
Adherence				
Medication not prescribed	372 (22.1)	26 (29.2)	32 (24.2)	**<0.001**
Almost always adheres	892 (53.0)	37 (41.6)	48 (36.4)	
Adheres half the time	325 (19.3)	18 (20.2)	36 (27.3)	
Almost never adheres	94 (5.6)	8 (9.0)	16 (12.1)	

Data presented as mean (SD) or n (%).

CGI-BP, Clinical global impression bipolar disorder; YMRS, Young mania rating scale; HAMD-5, 5-item version of the Hamilton Depression Rating Scale.

*Bold values indicate significance.

Zorrilla I et al. Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes? Acta psychiatrica Scandinavica. 2015;131(2):100-10.

- Los pacientes que continúan consumiendo cannabis tienen:
  - Peores resultados en general comparado con los que cesan su consumo y con los que nunca han consumido
  - El consumo de cannabis durante la fase de mantención se asoció con bajos índices de remisión y recuperación funcional y con un alto riesgo de recurrencia del Trastorno Bipolar (independiente de las características del paciente al inicio del estudio)
  - El consumo de cannabis se asoció con peores resultados funcionales en los pacientes comparado con quienes nunca habían usado cannabis

Zorrilla I et al. Cannabis and bipolar disorder: does quitting cannabis use during manic/mixed episode improve clinical/functional outcomes? Acta psychiatrica Scandinavica. 2015;131(2):100-10.

- Los efectos negativos del consumo de cannabis en el curso del Trastorno Bipolar desaparecen cuando los pacientes interrumpen su consumo
- Los pacientes que interrumpieron el consumo de cannabis durante un episodio maníaco/mixto tenían resultados, en términos clínicos y de funcionamiento a los 2 años, similares a los de aquellos que nunca habían consumido cannabis.
- Nota: se trata de estudio en población adulta, podrían haber diferencias con consumo de cannabis que se inicia en la adolescencia

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Research report

The association between cannabis use and mood disorders: A longitudinal study

Daniel Feingold [a,b,*], Mark Weiser [c,d], Jürgen Rehm [e,f], Shaul Lev-Ran [b,d,e]

[a] Ariel University, Israel
[b] Addiction Medicine Services, Department of Psychiatry, Sheba Medical Center, Tel Hashomer, Israel
[c] Department of Psychiatry, Sheba Medical Center, Tel Hashomer, Israel
[d] Sackler Faculty of Medicine, Tel Aviv University, Israel
[e] Social and Epidemiological Research Department, Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[f] Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

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ABSTRACT

Background: The association between cannabis use and mood disorders is well documented, yet evidence regarding causality is conflicting. This study explored the association between cannabis use, major depressive disorder (MDD) and bipolar disorder (BPD) in a 3-year prospective study.
Methods: Data was drawn from waves 1 and 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). MDD and BPD were controlled at baseline and defined as meeting full criteria in the 12 months prior to the follow-up. Initiation of cannabis use was defined as any cannabis used by former lifetime abstainers in the time period between baseline and follow-up.
Results: Cannabis use was not significantly associated with increased incidence of MDD (Adjusted Odds Ratio (AOR) for daily use=0.58(0.22–1.51)). Weekly to almost daily cannabis use was associated with increased incidence of BPD ((AOR for weekly to daily use=2.47(1.03–5.92)); daily use was not (AOR=0.52(0.17–1.55)). Baseline MDD was associated with initiation of cannabis use (AOR=1.72(1.1–2.69)). A crude association between baseline BPD and incidence of cannabis use was not maintained in adjusted models (AOR=0.61(0.36–1.04)).
Limitations: Lack of information regarding frequency of cannabis use at follow-up and limitations regarding generalization of the results.
Conclusions: Our findings do not support a longitudinal association between cannabis use and incidence of MDD. Results regarding the association between cannabis use and incidence of BPD are conflicting and require further investigation. Baseline MDD, but not BPD, may be associated with future initiation of cannabis use. This may have implications for clinical, social and legislative aspects of cannabis use.
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Feingold D et al. The association between cannabis use and mood disorders: A longitudinal study. Journal of affective disorders.

- Estudio longitudinal (National Epidemiologic Survey on Alcohol and Related conditions NESARC)
- Autores reportan asociación entre Episodio Depresivo mayor e inicio de consumo de cannabis (esto no se observó en el caso de Trastorno Afectivo Bipolar)
- No se observó asociación entre consumo de cannabis y Episodio depresivo mayor
- Se observó asociación entre consumo semanal a casi diario de cannabis y mayor incidencia de Trastorno Afectivo Bipolar (no en otras frecuencias de uso)

RESEARCH REPORT doi:10.1111/j.1360-0443.2007.01875.x

Does cannabis use predict the first incidence of mood and anxiety disorders in the adult population?

Margriet van Laar, Saskia van Dorsselaer, Karin Monshouwer & Ron de Graaf

Trimbos Institute, Netherlands National Institute of Mental Health and Addiction, Utrecht, the Netherlands

ABSTRACT

Aims To investigate whether cannabis use predicted the first incidence of mood and anxiety disorders in adults during a 3-year follow-up period. **Design and participants** Data were derived from the Netherlands Mental Health Survey and Incidence Study (NEMESIS), a prospective study in the adult population of 18–64 years. The analysis was carried out on 3881 people who had no life-time mood disorders and on 3854 people who had no life-time anxiety disorders at baseline. **Measurements** Life-time cannabis use and DSM-III-R mood and anxiety disorders, assessed with the Composite International Diagnostic Interview (CIDI). **Findings** After adjustment for strong confounders, any use of cannabis at baseline predicted a modest increase in the risk of a first major depression (odds ratio 1.62; 95% confidence interval 1.06–2.48) and a stronger increase in the risk of a first bipolar disorder (odds ratio 4.98; 95% confidence interval 1.80–13.81). The risk of 'any mood disorder' was elevated for weekly and almost daily users but not for less frequent use patterns. However, dose–response relationships were less clear for major depression and bipolar disorder separately. None of the associations between cannabis use and anxiety disorders remained significant after adjustment for confounders. **Conclusions** The associations between cannabis use and the first incidence of depression and bipolar disorder, which remained significant after adjustment for strong confounders, warrant research into the underlying mechanisms.

van Laar M et al. Does cannabis use predict the first incidence of mood and anxiety disorders in the adult population? Addiction (Abingdon, England). 2007;102(8):1251-60.

- Estudio longitudinal basado en información de estudio NEMESIS (Netherlands Mental Health Survey and Incidence Study)
- Se observa que consumo de cannabis aumenta el riesgo de Depresión mayor (actor de 1.6) y de Trastorno Afectivo Bipolar (factor de 5.0)
- Se concluye que 6% de nuevos casos de depresión mayor y 14% de nuevos casos de Trastorno Afectivo Bipolar en un periodo de un año podrían prevenirse asumiendo que cualquier intervención puede remover completamente el consumo de cannabis y que la asociación es de causalidad

Journal of Affective Disorders 171 (2015) 39–47

Contents lists available at ScienceDirect

Journal of Affective Disorders

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Review

Cannabis use and mania symptoms: A systematic review and meta-analysis

Melanie Gibbs [a,1], Catherine Winsper [a,1], Steven Marwaha [a,b,*], Eleanor Gilbert [c], Matthew Broome [d], Swaran P. Singh [a]

[a] Division of Mental Health and Wellbeing, Warwick Medical School, University of Warwick, CV4 7AL, UK
[b] Early Intervention Service, Swanswell Point, Coventry CV1 4FH, UK
[c] Caludon Centre, Coventry and Warwickshire Partnership Trust, CV2 2TE, UK
[d] Warneford Hospital, University of Oxford, OX3 7JX, UK

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Keywords:
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Meta-analysis

ABSTRACT

Background: Whilst cannabis use appears to be a causal risk factor for the development of schizophrenia-related psychosis, associations with mania remain relatively unknown. This review aimed to examine the impact of cannabis use on the incidence of manic symptoms and on their occurrence in those with pre-existing bipolar disorder.
Methods: A systematic review of the scientific literature using the PRISMA guidelines. PsychINFO, Cochrane, Scopus, Embase and MEDLINE databases were searched for prospective studies.
Results: Six articles met inclusion criteria. These sampled 2391 individuals who had experienced mania symptoms. The mean length of follow up was 3.9 years.

Studies support an association between cannabis use and the exacerbation of manic symptoms in those with previously diagnosed bipolar disorder. Furthermore, a meta-analysis of two studies suggests that cannabis use is associated with an approximately 3-fold (Odds Ratio: 2.97; 95% CI: 1.80–4.90) increased risk for the new onset of manic symptoms.
Limitations: We were only able to identify a small number of studies of variable quality, thus our conclusions remain preliminary.
Conclusions: Our findings whilst tentative, suggest that cannabis use may worsen the occurrence of manic symptoms in those diagnosed with bipolar disorder, and may also act as a causal risk factor in the incidence of manic symptoms. This underscores the importance of discouraging cannabis use among youth and those with bipolar disorder to help prevent chronic psychiatric morbidity. More high quality prospective studies are required to fully elucidate how cannabis use may contribute to the development of mania over time.

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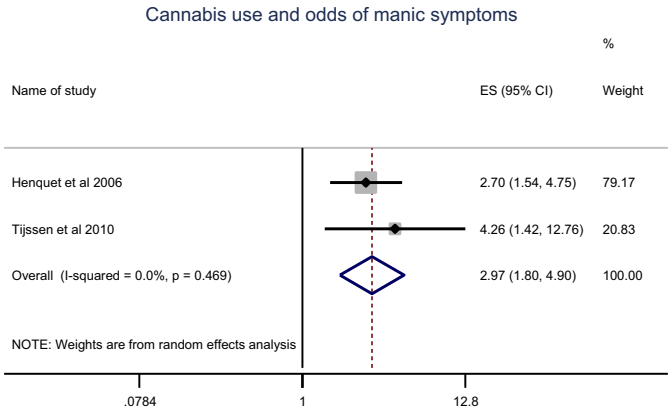

Fig. 2. Cannabis and manic symptoms.

Gibbs M et al. Cannabis use and mania symptoms: a systematic review and meta-analysis. Journal of affective disorders. 2015;171:39-47.

Gibbs M et al. Cannabis use and mania symptoms: a systematic review and meta-analysis. Journal of affective disorders. 2015

- Consumo de cannabis precede el inicio de síntomas maníacos o episodios de manía en individuos con Trastorno Afectivo Bipolar pre-existente
- Se concluye que en población clínica, el consumo de cannabis empeora el pronóstico del Trastorno Afectivo Bipolar incrementando la posibilidad, duración y severidad de los episodios maníacos
- Existe asociación de consumo de cannabis y síntomas maníacos en individuos sin Trastorno Afectivo Bipolar pre-existente (efecto dosis respuesta)
- En población no clínica, el consumo de cannabis se asocia a síntomas maníacos (sub umbral). Para evaluar su relevancia clínica, se requiere de futuros estudios

Journal of Affective Disorders 165 (2014) 103–108

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Review

Cannabis use and first manic episode

Nathalie Bally [a], Daniele Zullino [a], Jean-Michel Aubry [b,*]

[a] Division of Addiction Psychiatry, Department of Mental Health and Psychiatry, Geneva University Hospitals, Switzerland
[b] Mood Disorders Unit, Division of Psychiatric Specialties, Department of Mental Health and Psychiatry, Geneva University Hospitals, 20 Bis, Rue de Lausanne, CH-1201 Geneva, Switzerland

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Keywords:
Cannabis
Marijuana
Bipolar disorders
Onset mania

ABSTRACT

Background: Cannabis is the most commonly abused drug among patients with bipolar disorder. Available data has shown that the risk of psychotic disorders increases with the frequency and intensity of cannabis abuse. The present purpose was to review relevant studies to investigate whether cannabis use can be linked to the onset of mania in bipolar disorder.
Methods: Articles published between 1972 and December 2013 were searched on Medline and PsychInfo using the following keywords: *first manic episode*, or *onset mania*, or *bipolar disorder* and *cannabis*. Relevant papers cited in the references of selected articles were further considered for inclusion into the review.
Results: Lifetime use of cannabis among bipolar patients appears to be around 70% and approximately 30% of patients with a bipolar disorder present a comorbidity of cannabis abuse or dependence. Cannabis use is associated with younger age at onset of first mania and with more frequent depressive or manic episodes, although the evidence is somewhat inconsistent. Likewise cannabis consumption is related to poorer outcome and an increased risk of rapid cycling or mixed episodes. In contrast, neuro-cognitive functioning seems to be positively affected in patients with psychiatric comorbidity. While cannabis use often precedes first manic episodes, the causal direction remains to be determined.
Limitations: Variations in definition of cannabis use/dependence. Lack of controlled studies limiting definite conclusions about a putative causal relationship between cannabis and onset of mania.
Conclusions: Further investigations are needed to clarify the relationships between cannabis use and first manic episode.

Bally N et al. Cannabis use and first manic episode. Journal of affective disorders. 2014;165:103-8.

Bally N et al. Cannabis use and first manic episode. Journal of affective disorders. 2014

- Pacientes que disminuyen la frecuencia o interrumpen el consumo de cannabis luego de una primera hospitalización tienen una mejoría importante de sus síntomas al seguimiento a 1 año, comparado con quienes no realizan cambios en su consumo de cannabis

- Consumo de cannabis precede episodios maníacos o hipomaníacos

- Consumo de cannabis está asociado a una menor edad de inicio del Trastorno Afectivo Bipolar

- Se puede plantear las siguientes hipótesis:
  - ✓ Consumo de cannabis gatilla episodios maníacos
  - ✓ Consumo de cannabis por individuos de alto riesgo, para atenuar síntomas prodrómicos

Entonces…

Cannabis y Trastorno Afectivo Bipolar

- Consumo de cannabis tiene efectos negativos en los síntomas del trastorno Bipolar:
- Parece gatillar episodios maníacos más que depresivos, y síntomas psicóticos
- Podría aumentar la frecuencia de los episodios en un año
- Aumentaría el riesgo de otras co-morbilidades que confieren mayor gravedad al cuadro clínico del paciente
- Se asociaría a peores índices de remisión, mayor recurrencia, peor adherencia a tratamiento y peor funcionamiento de los pacientes

Cannabis y Trastorno Afectivo Bipolar

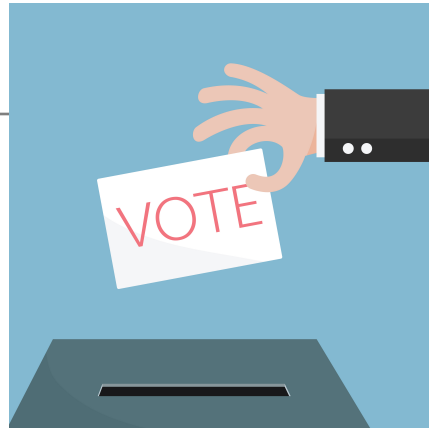
- Investigación futura debiera aclarar cuál es el efecto del cannabis en las características clínicas del cuadro anímico, las que podrían influenciar el riesgo suicida

- ¿Vulnerabilidad compartida para mayores niveles de impulsividad en casos de T Bipolar y suicidio asociado a consumo de cannabis?

EN ESTA PRESENTACIÓN

- Introducción
- Aspectos epidemiológicos
- Cannabis e impacto en la salud mental
- Trastornos de ánimo y consumo de cannabis
- **Uso de instrumento de screening, CUPIT validado en Chile**
- Sugerencias de intervención

¿Cuál sería la utilidad del screening de consumo de cannabis en pacientes con Trastorno Bipolar?



CUPIT

CANNABIS USE PROBLEMS IDENTIFICATION TEST

INSTRUMENTOS DE SCREENING

- El screening en el consumo de marihuana es un paso necesario en la identificación de consumidores que pueden estar en riesgo de desarrollar un consumo problemático.
- Una intervención temprana puede evitar la progresión hacia una dependencia y a daños más serios y crónicos.
- Instrumentos de screening pueden utilizarse en combinación con intervenciones breves.

Copeland, J (2009)
Bashford, J (2010)

CUPIT (CANNABIS USE PROBLEMS IDENTIFICATION TEST)

Addiction

METHODS AND TECHNIQUES

doi:10.1111/j.1360-0443.2009.02859.x

The Cannabis Use Problems Identification Test (CUPIT): development, reliability, concurrent and predictive validity among adolescents and adults

Jan Bashford[1], Ross Flett[1] & Jan Copeland[2]

School of Psychology, Massey University, Palmerston North, New Zealand[1] and National Cannabis Prevention and Information Centre, University of New South Wales, Sydney, Australia[2]

ABSTRACT

Aims To describe the empirical construction and initial validation of the Cannabis Use Problems Identification Test (CUPIT), a brief self-report screening instrument for detection of currently and potentially problematic cannabis use. **Design** In a three-phase prospective design an item pool of candidate questions was generated from a literature review and extensive expert consultation. The CUPIT internal structure, cross-sectional and longitudinal psychometric properties were then systematically tested among heterogeneous past-year users. **Participants** Volunteer participants were 212 high-risk adolescents ($n = 138$) and adults ($n = 74$) aged 13–61 years from multiple community settings. **Measurements** The comprehensive assessment battery included several established measures of cannabis-related pathology for CUPIT validation, with DSM-IV/ICD-10 diagnoses of cannabis use disorders as criterion standard. **Findings** Sixteen items loading highly on two subscales derived from principal components analysis exhibited good to excellent test–retest (0.89–0.99) and internal consistency reliability (0.92, 0.83), and highly significant ability to discriminate diagnostic subgroups along the severity continuum (non-problematic, risky, problematic use). Twelve months later, baseline CUPIT scores demonstrated highly significant longitudinal predictive utility for respondents' follow-up diagnostic group membership. Receiver operating characteristic (ROC) analysis identified a CUPIT score of 12 to be the optimal cut-point for maximizing sensitivity for both currently diagnosable cannabis use disorder and those at risk of meeting diagnostic criteria in the following 12 months. **Conclusions** The CUPIT is a brief cannabis screener that is reliable, valid and acceptable for use across diverse community settings and consumers of all ages. The CUPIT has clear potential to assist with achievement of public health goals to reduce cannabis-related harms in the community.

Bashford J, Flett R, Copeland J. The Cannabis Use Problems Identification Test (CUPIT): development, reliability, concurrent and predictive validity among adolescents and adults. Addiction. 2010;105(4):615-25.

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Short communication

Psychometric properties of the Spanish version of the Cannabis Use Problems Identification Test among Chilean university students: A validation study

Vanessa Cantillano[a,*], Paloma Del Villar[b], Lorena Contreras[a], Daniel Martínez[a], M. Soledad Zuzulich[c], Claudia Ramírez[a], Carmiña Pons[a], Jan Bashford[d]

[a] Prevention program in student's drug and alcohol use, Students' Health Center, Pontificia Universidad Católica de Chile, Chile
[b] Sociology Institute, Pontificia Universidad Católica de Chile, Chile
[c] Pontificia Universidad Católica de Chile, Chile
[d] School of Psychology, Massey University, Palmerston North, New Zealand

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University
Students

ABSTRACT

Background: In Chile, concerns mount about escalating cannabis use. Thus, it is important to have tools for early identification of at-risk users. The Cannabis Use Problems Identification Test (CUPIT) is a useful screening tool, and the aim of this study was to examine the psychometric properties of its Spanish version among Chilean university students.

Methods: The CUPIT was translated into Spanish, pre-tested in a focus group (n = 8), and then tested through an online survey (n = 3798, 28% response rate). Of the 1061 respondents, 578 reported 12-month cannabis use. Internal reliability, internal structure, and concurrent validity (using the Cannabis Abuse Screening Test [CAST]) were obtained. Test–retest reliability was calculated (n = 150) at 3–4 weeks (30% of attrition rate). Discriminative validity was evaluated comparing CUPIT subscales and four DSM-IV diagnostic groups. Receiving operator characteristic (ROC) curve analysis assessed sensitivity and specificity.

Results: Test–retest Pearson correlation between total CUPIT scores of 0.90 ($p < 0.001$), and highly significant Kendall Tau-b coefficients for individual items ($p < 0.001$) indicated excellent reliability. Concordance between the CUPIT and CAST (Pearson correlation 0.73, $p < 0.001$) indicated good concurrent validity. ANOVA revealed significant differences in CUPIT scores between the four DSM-IV diagnostic groups ($p < 0.001$), indicative of good discriminative validity. ROC analysis (gold standard: DSM-IV abuse/dependence) yielded an AUC value of 0.72, indicating acceptable discriminative capability.

Conclusions: The Spanish CUPIT is reliable, valid, and accepted by the university population studied, and, thus, a potentially useful tool for identifying both problematic and at-risk users.

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Cantillano V, Del Villar P, Contreras L, Martinez D, Zuzulich MS, Ramirez C, et al. Psychometric properties of the Spanish version of the Cannabis Use Problems Identification Test among Chilean university students: A validation study. Drug and alcohol dependence. 2017;170:32-6.

CUPIT

- ✓Instrumento de screening breve confiable, válido y aceptable para uso en distintos contextos sanitarios y en consumidores de todas las edades
- ✓Tiene un claro potencial para ayudar a reducir los daños relacionados con el cannabis en la Comunidad
- ✓Permite clasificar en forma confiable a los consumidores en portadores de un problema actual o en riesgo de desarrollar un problema en los próximos doce meses.

CUPIT

Sus 16 preguntas miden el concepto tridimensional (Clasificaciones DSM IV /CIE 10) de consumo riesgoso (preguntas 1 y 2), dependencia/conducta de consumo (preguntas 3 a 10) y problemas de salud y sociales (preguntas 11 a 16).

Las preguntas se puntúan de la siguientes forma: Pregunta 1: 1 a 8 puntos; pregunta 2, de 0 a 8 puntos; pregunta 3, de 1 a 6 puntos; pegunta 4, de 0 a 6 puntos; pregunta 5, de 0 a 5 puntos; pregunta 6, de 0 a 4 puntos; pregunta 7, de 1 a 9 puntos. Las preguntas 8 a 16 puntúan de 0 a 4, con excepción de la pregunta 9 cuyo puntaje es inverso.

CUPIT versión validada

MARIHUANA - AUTODIAGNÓSTICO

Algunas personas pueden usar marihuana sin desarrollar problemas serios. Otros pueden experimentar problemas de salud u otra clase de problemas. Responder este cuestionario puede ayudarte a clarificar si estás teniendo problemas con tu consumo de marihuana o no. No existen preguntas correctas o incorrectas. Selecciona la respuesta que se acerque más a tu consumo de marihuana de los **últimos 12 meses.**

Cantidad y frecuencia

1. ¿Cuántos días has consumido marihuana en los últimos 12 meses? (Si no hay un patrón para tu consumo de marihuana, por favor realiza tu mejor estimación)

1 - 6 días (menos de un día al mes) **1 pto.**	7 - 12 días (un patrón promedio de un día al mes) **2 ptos.**	13 - 36 días (un patrón promedio de 2 - 3 días al mes) **3 ptos.**	37 - 52 días (un patrón promedio de un día a la semana) **4 ptos.**	54 - 104 días (un patrón promedio de 2 días a la semana) **5 ptos.**	Hasta 208 días (un patrón promedio de 3 - 4 días a la semana) **6 ptos.**	Hasta 312 días (un patrón promedio de 5 - 6 días a la semana) **7 ptos.**	Hasta 365 días (consumo diario/ la mayoría de los días) **8 ptos.**

2. Ahora piensa acerca de tu consumo reciente de marihuana. ¿Cuántos días has consumido marihuana en los últimos 3 meses (90 días)?

Ningún día **0 pto.**	1 - 2 días (menos de un día al mes) **1 pto.**	3 - 4 días (un patrón promedio de un día al mes) **2 ptos.**	5 - 9 días (un patrón promedio de 2 - 3 días al mes) **3 ptos.**	10 - 15 días (un patrón promedio de un día a la semana) **4 ptos.**	16 - 26 días (un patrón promedio de 2 días a la semana) **5 ptos.**	27 - 52 días (un patrón promedio de 3 - 4 días a la semana) **6 ptos.**	53 - 78 días (un patrón promedio de 5 - 6 días a la semana) **7 ptos.**	79 - 90 días (consumo diario/ la mayoría de los días) **8 ptos.**

3. En los últimos 12 meses: Pensando en un día en que consumes marihuana, ¿cuántas veces lo haces al día? (Nota: al menos una hora entre cada nuevo "consumo")

Una vez **1 pto.**	Dos veces **2 ptos.**	3 - 4 veces **3 ptos.**	5 - 6 veces **4 ptos.**	7 - 9 veces **5 ptos.**	10 o más veces **6 ptos.**

4. ¿Con qué frecuencia has consumido marihuana a primera hora de la mañana?

Nunca **0 pto.**	Una ó dos veces **1 ptos.**	Menos que mensualmente **2 ptos.**	Mensualmente **3 ptos.**	Un día a la semana **4 ptos.**	Varios días a la semana **5 ptos.**	Diariamente / siempre **6 ptos.**

5. En los últimos 12 meses: Pensando en un día en que consumes marihuana, ¿Cuánto tiempo en el día lo pasas o te sientes "volado"?

0 horas **0 pto.**	1 - 2 horas **1 ptos.**	3 - 4 horas **2 ptos.**	5 - 6 horas **3 ptos.**	7 - 8 horas **4 ptos.**	9 ó más horas **5 ptos.**

6. ¿Qué tan difícil sería para ti dejar de consumir o estar sin consumir marihuana?

Nada difícil **0 pto.**	Un poco difícil **1 pto.**	Algo difícil **2 ptos.**	Muy difícil **3 ptos.**	Imposible **4 ptos.**

7. ¿Cuánto es el tiempo más largo en que no has consumido marihuana?

6 meses ó más **1 pto.**	3 - 5 meses **2 ptos.**	1 - 2 meses **3 ptos.**	2 - 3 semanas **4 ptos.**	Una semana **5 ptos.**	4 - 6 días **6 ptos.**	2 - 3 días **7 ptos.**	Un día **8 ptos.**	Ningún día **9 ptos.**

CUPIT versión validada

PONTIFICIA UNIVERSIDAD CATÓLICA DE CHILE

CATEGORÍAS CUPIT

- **Trastorno actual (Puntaje de 20 a 82):** Trastorno relacionado con cannabis (abuso/dependencia)
- **Riesgo de Trastorno (Puntaje de 12 a19):** en riesgo de desarrollar un trastorno en los próximos 12 meses
- **Bajo riesgo (Puntaje de 0 a 11):** de Trastorno relacionado con cannabis

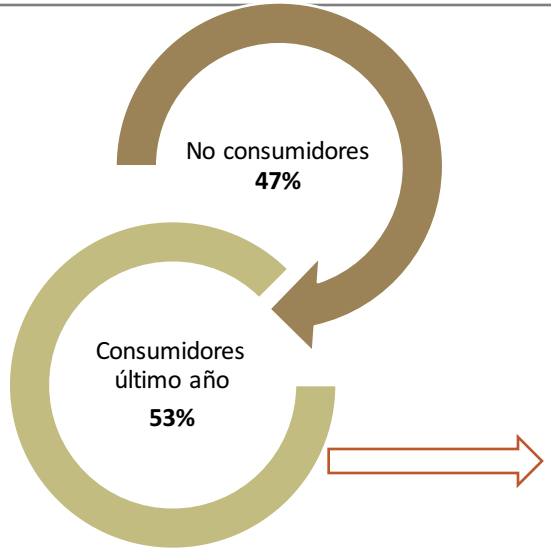
0 – 11 puntos: representa un **RIESGO BAJO** de presentar un abuso o dependencia a marihuana. El consumo intermitente presenta otros riesgos para la salud mental: crisis de angustia y/o pánico y cuadros psicóticos (pérdida del juicio de realidad). La mejor manera de disminuir tus riesgos es no consumir marihuana ni otras drogas. Si consideras que requieres apoyo o necesitas información adicional puedes contactarnos en Salud Estudiantil.

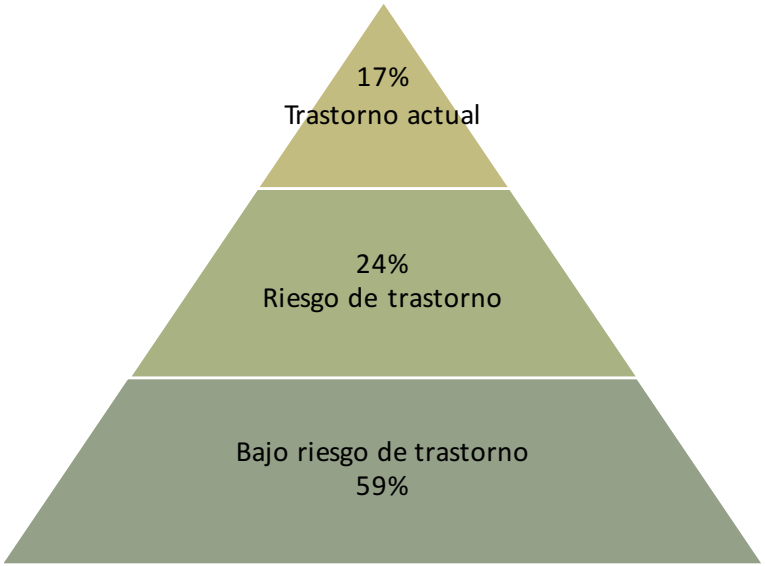
12 – 19 puntos: representa un **RIESGO INTERMEDIO** de desarrollar un Trastorno por el consumo de marihuana en los próximos 12 meses, lo que significa que la forma en que consumes ahora está afectando tu salud física y mental, lo que incluye riesgo de desarrollar Abuso o Dependencia de Marihuana. Además, esta pauta de consumo tiene riesgos adicionales, como los cuadros ansiosos, depresivos, y psicóticos (pérdida del juicio de realidad). La mejor manera de disminuir tus riesgos es no consumir marihuana ni otras drogas. Te recomendamos buscar apoyo solicitando una hora de atención en Salud Estudiantil.

20 – 82 puntos: representa un **RIESGO ALTO** en el consumo de marihuana; constituye una sospecha de estar cursando en la actualidad un "Trastorno por el uso de marihuana", es decir un Abuso o Dependencia y problemas serios en tu salud física y mental. Te recomendamos suspender o disminuir el consumo de marihuana y, para ello, puedes recibir ayuda profesional. Los profesionales de Salud Estudiantil, pueden realizar una evaluación adecuada y recomendarte la la estrategia más adecuada.

TEST CUPIT

Riesgo de trastorno por abuso o dependencia a Cannabis





VI Estudio sobre uso de tabaco, alcohol y otras sustancias entre alumnos de la UC (2015)

- ✓ **Entre quienes consumieron marihuana en los últimos 12 meses, un 17% poseería un trastorno por abuso o dependencia (41 % trastorno o riesgo). No se observan cambios significativos desde 2013**

Base: prevalentes año (N 2015: 1863)

PROCESO DE VALIDACIÓN

Traducción y retraducción

Pretest (8 estudiantes) y focus group

Se realizan pequeños ajustes al instrumento

Se seleccionaron 13 carreras de la UC con mayor prevalencia de consumo de marihuana

Envío de invitación electrónica a participar utilizando el programa "Survey Analytics" a muestra de un 30% (3798 alumnos)

VALIDACIÓN

Tasa de participación de un 28%

Muestra total de 1061 alumnos

De la muestra se consideró a aquellos que habían consumido marihuana el último año (**578 casos**)

Los análisis de validez y confiabilidad de la traducción del CUPIT al español se realizaron con esta muestra.

Se estudió:Confiabilidad Test-Retest, Estructura factorial y consistencia interna o fiabilidad, Validez concurrente y validez discriminativa

Equipo de trabajo

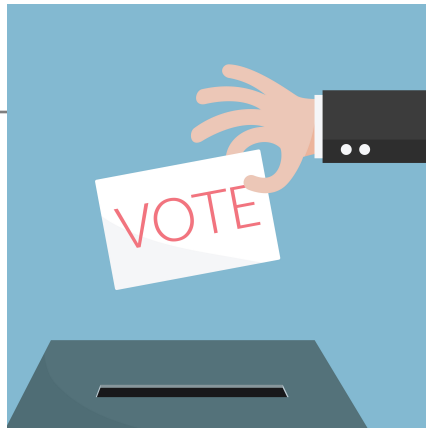
M. Soledad Zuzulich
Lorena Contreras
Vanessa Cantillano
Carmiña Pons
Claudia Ramírez
Programa de Autocuidado en Drogas para Estudiantes Universitarios
SERVICIO DE SALUD ESTUDIANTIL

Paloma Del Villar
Eduardo Valenzuela
Dirección de Estudios Sociales UC
INSTITUTO DE SOCIOLOGÍA

EN ESTA PRESENTACIÓN

- Introducción
- Aspectos epidemiológicos
- Cannabis e impacto en la salud mental
- Trastornos de ánimo y consumo de cannabis
- Uso de instrumento de screening, CUPIT validado en Chile
- **Sugerencias de intervención**

¿En relación a las Intervenciones breves,qué sería más efectivo?



SUGERENCIAS PARA CONVERSAR CON EL PACIENTE ACERCA DE SU PUNTAJE

Microhabilidades ENTREVISTA MOTIVACIONAL

- Realizar Preguntas abiertas
- Realizar Afirmaciones
- Reflejar
- Realizar resúmenes
- Entregar información con permiso

Miller WRR, S. Motivational Interviewing Helping people change. New York: The Guilford Press; 2013.

Algunas estrategias útiles…

- Conversar con el paciente de acuerdo a lo que a él/ella le es más relevante, se entrega un menú de opciones.

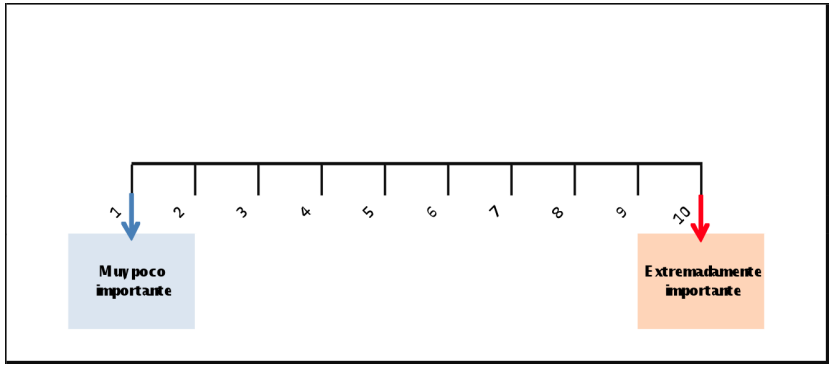
- Preguntar por “lo bueno” y lo “no tan bueno” (del consumo de marihuana)

- Usar las scalas de importancia y de confianza

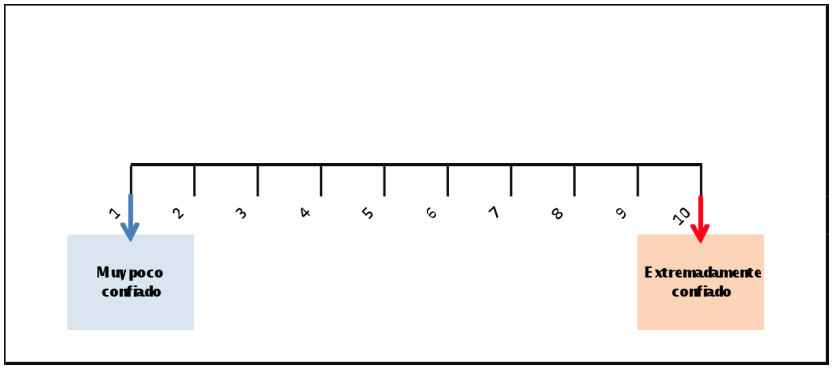
Rollnick S, Butler CC, Kinnersley P, Gregory J, Mash B. Motivational interviewing. BMJ. 2010;340.

Escala de Importancia y Confianza

¿Qué tan importante es para ti ….disminuir/suspender el consumo de marihuana?



¿Qué tanta confianza tienes en que puedes… disminuir/suspender el consumo de marihuana?



Usando las escalas efectivamente…

- Cuando tu paciente diga “6” de importancia/confianza, tu siguiente respuesta debería ser con un número menor (¿por qué no un 4 ó un 5…?

- Después de que tu paciente ha respondido, puedes reflejar y resumir

Algunas estrategias útiles…

- Intercambio de información a través de estrategia CHECK-CHUNK-CHECK:
  - Chequear lo que conoce el (la) paciente
  - Entregar un pedazo de información
  - Chequear lo que ha entendido el paciente y su opinión al respecto

Rollnick, S. et al. Motivational interviewing. BMJ. 2010 January 1, 2010;340

CHECK-CHUNK-CHECK

CHECK

- ¿Qué es lo que sabes acerca de los efectos de la marihuana en la salud mental (en tu trastorno del ánimo)…?
- ¿Qué has pensado/ Qué piensas acerca de tu consumo actual de marihuana…?

CHUNK

- Quienes consumen marihuana tienen un riesgo mayor de…
- Los resultados de tu evaluación CUPIT indican…

CHECK

- ¿Qué piensas de esto..?
- ¿Cómo crees tú que podrías disminuir tu riesgo…?

COMENTARIOS

go raibh maith agat
gracias
merci
obrigado
danke
thank you
teşekkür ederim
bedankt
dziękuję
mochchakkeram
ngiyabonga
kop khun krap
dakujem
takk
terima kasih
спасибо
sukriya
sagolun
arigatô
tapadh leat
謝謝
grazie
mauruuru
dank je
taiku
hvala
мерси
ありがとう
ευχαριστώ