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EXECUTIVE SUMMARY

The circumstances under which veterinary clinicians encounter cannabis-derived products are quite varied. A classic scenario is that of a patient exposed to marijuana plant material intended for the owner's recreational use; in recent years, products such as edibles, concentrates, or vaping devices may also be involved.¹ However, unintentional exposures of recreational products represent only one aspect of cannabis in veterinary medicine. As the potential therapeutic benefits of cannabis continue to be examined for people, veterinarians are encountering cannabis-derived products intended for use in companion animals. The scientific and regulatory landscapes continue to rapidly evolve, so this report represents a snapshot in time with the intention for regular updates.

Passage of the [2018 Agricultural Improvement Act](#) (2018 Farm Bill) removed “hemp” from the definition of “marihuana” in the [Controlled Substances Act](#) (CSA), and descheduled it, although it left authority for scheduling hemp-derived products for therapeutic purposes intact.^{2,3} Descheduling hemp removed significant barriers for medical research, so the body of knowledge regarding the chemical constituents of cannabis is now growing more rapidly.

Terms used when discussing cannabis and its derivatives are not uniformly applied. Depending on the subject matter, the intended use of the product, and historical conversational use, we note that the same term may be interpreted quite differently. Therefore, for this report, we define “cannabis,” “marijuana,” and “hemp,” as follows:

“Cannabis” refers to plants that are further defined as either “hemp” or “marijuana,” depending on their Δ^9 -tetrahydrocannabinol (THC) concentration. Cannabis is a genus of flowering plants in the family Cannabaceae, of which *Cannabis sativa* is a species, and *Cannabis indica* and *Cannabis ruderalis* are subspecies. Cannabis refers to any form of the plant for which the THC concentration on a dry weight basis has not yet been determined prior to further categorization as hemp or marijuana.⁴

“Marijuana” is defined as cannabis that has a THC concentration exceeding 0.3 percent so remains classified as a Schedule I controlled substance regulated by the DEA (as of the date of this publication).³

“Hemp” is defined in the 2018 Farm Bill as the plant species *Cannabis sativa* L. and any part of that plant, including the seeds and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a Δ^9 -tetrahydrocannabinol concentration of not more than 0.3 percent on a dry weight basis.²

Investigations of the therapeutic role of cannabis-derived products in modern medicine for humans and “other” animals are in their infancy, so many questions remain to be asked, much less answered. Although we recognize there is considerable interest in both hemp and marijuana for therapeutic purposes, the scope of this report is limited primarily to hemp and hemp-derived articles for dogs and cats.

We provide a bit of history, an introduction to the endogenous endocannabinoid system, a synopsis of manufacturing quality, a review of animal clinical studies exploring efficacy and safety, information about potential adverse effects (including data around exposures and toxicoses from poison control centers), and a description of the current regulatory landscape.

Information is likely to evolve rapidly, so the AVMA will work to stay abreast of scientific and legal developments so that we can continue to keep veterinarians informed of the potential role of cannabis in veterinary medicine and responsibilities around its use.

SECTION 1

HISTORICAL PERSPECTIVE ON CANNABIS IN THE UNITED STATES

Understanding the historical role of cannabis-derived therapies facilitates understanding of their potential integration into current medical practice. This history also provides the context for different approaches to medicinal cannabis evident in various cultures. Cannabis has been part of recreational, religious, and medical activities for more than 5,000 years. Although the first evidence of cannabis cultivation for recreational and industrial use appears to be in China in 4000 BC, cannabis appears not to have been used for medicinal purposes until 2700 BC.⁵ Reported in 1993, the first direct evidence of medicinal use is based on the presence of cannabis material in the remains of an Egyptian mother who died during childbirth in 400 AD.⁶ Medical indications are recorded in the world's oldest pharmacopeia (0-100 AD) and Avicenna's *Canon of Medicine* (980-1037 AD), and cannabis is known to have been used in both Arabic (900-1400 AD) and South American medicine (1500s).^{7,8,9} Analgesic, anticonvulsant, anti-inflammatory, and antibiotic effects were among its diverse medical indications. Cannabis first appeared in Western Europe in the 1830s as treatment for muscle spasms associated with tetanus and rabies. Its use rapidly spread among physicians in Europe and North America.

Common use of cannabis in the United States was evident by its inclusion in the 1850 United States Pharmacopeia.¹⁰ In 1860, the Committee on Cannabis Indica of the Ohio State Medical Society reported on medical successes of cannabis for multiple indications.⁷ By 1924, more than 100 papers describing therapeutic benefits had been published. Cannabis continued to be considered an acceptable intervention and was a common ingredient of over-the-counter pharmaceuticals used to treat a variety of diseases and conditions.

Efforts at regulatory control began emerging in the early 1900s. In 1906, the [Pure Food and Drug Act](#) regulated labeling of patent medicines containing *Cannabis indica*.⁷ However, in the 1930s, other medical advances—including the development of the hypodermic needle, vaccines, analgesics such as aspirin, and synthetic drugs such as opioids—led to a general decline in attention paid to medicinal cannabis. Although local laws put some restrictions around the use of cannabis as early as 1860, the reduced importance of cannabis for medicinal use and a continued interest in its recreational use made medical cannabis vulnerable to political manipulation. While it is beyond the scope of this document to address the impacts of the politicization of cannabis, understanding the political path that led to its prohibition—despite efforts of the medical communities to retain medical access—is important in acknowledging the potentially important role cannabinoids could have had, and may still have, in medicine.

The efforts of the first commissioner of the Federal Bureau of Narcotics in the U.S. Treasury Department, Harry Anslinger, led to enactment of the [Uniform State Narcotic Act \(1925\)](#).¹¹ This act mandated that marijuana be regulated as a drug and granted states the authority to seize illicit drugs. The [Marijuana Tax Act of 1937](#) was the first national regulation pertaining solely to cannabis products.¹² To deter the purchase of these products, which were assumed to be highly toxic despite suggestions to the contrary from the American Medical Association, the act criminalized the purchase of cannabis if a tax was not paid. Two committees, the Indian Hemp Drugs Commission of 1893-94 and the LaGuardia Committee of 1944, contradicted the U.S. Treasury Department's claims that marijuana use led to insanity and other adversities. Because payment of the tax required an admission of purchase, and because the tax targeted physicians and pharmacists, amongst others, this act effectively brought medical use of cannabis and much of the research related to

it to a halt. In 1941, medical cannabis was removed from the United States Pharmacopeia. The [Marijuana Tax Act](#) was struck down in 1969 because it violated the Fifth Amendment, and, by then, the increase in recreational cannabis use in the 1970s put marijuana back in the spotlight, leading to changes in regulation. The [Marijuana Tax Act](#) was almost immediately replaced with the [Controlled Substances Act \(CSA\) of 1970](#), which established the Drug Enforcement Agency and the National Commission on Marijuana and Drug Abuse³ (see [Section 6: Regulatory overview of the use of cannabis-derived products in animals](#)).

Despite the CSA, increased recreational use of marijuana in the 1960s and 70s reinvigorated interest in research on the use of cannabis in medical practice. Although several cannabinoids had been isolated, a pivotal event was the 1965 synthesis of Δ^9 -tetrahydrocannabinol (THC) and cannabidiol (CBD) by Raphael Mechoulam, the “Father of Cannabis”.¹³ Early research primarily focused on the neurologic or psychotropic effects of cannabinoids, particularly THC. Use of dogs in that research, which served the role of a bioassay in the 1970s and 80s, was followed by use of rodents. These bioassays were critical for describing adverse effects, including tolerance and physical dependence.

The second pivotal event that led to improved understanding of the mechanisms of cannabinoid action was the discovery of cannabinoid receptors in the 1980s. This discovery allowed investigators to relate the structure of cannabis-derived compounds to their potency and efficacy. Localization of the receptors using radioligand binding studies, identifying the receptors as membrane G-protein coupled, and cloning the receptors have markedly advanced medical knowledge. The final pivotal event, which occurred in the 1990s, was the discovery and description of endocannabinoids, the endogenous compounds that bind to cannabinoid receptors.

Subsequent to this work, medical access to marijuana was approved in several states. For example, in 1996, California passed the [Compassionate Use Act](#), which was in opposition to the federally mandated prohibition of marijuana and provided for medical use of marijuana by humans.¹⁴ Many other states have now followed suit. Laws and regulations, however, vary from state to state. Many states stipulate specific conditions under which medical marijuana is allowed.¹⁰

The science around medical use is not clear. Although insufficient evidence might exist for some indications, therapeutic benefits have been clearly demonstrated for others, such as the FDA-approved drugs for treatment of epilepsy, anorexia, and nausea.¹⁵ Among phenomena associated with increases in medical marijuana use has been the emergence of medical marijuana dispensaries, or pharmacies, and the manufacture and marketing of products containing medical cannabinoids as dietary supplements. Many veterinary patients are being exposed to these products marketed as dietary supplements, despite that such a category for animal use does not exist under the [Federal Food, Drug, and Cosmetic Act \(FDCA\)](#)¹⁶ (see [Section 6: Regulatory overview of the use of cannabis-derived products in animals](#)). Accompanying decriminalization of marijuana at the state level during the last two decades has been an increased exposure of both consumers and the medical communities to a plethora of information regarding the potential medical benefits of cannabinoids. However, discriminating science from testimony can be difficult.

For veterinarians and pet owners, results of recent investigations in companion animals emphasize the need for controlled clinical trials as contrasted to case studies and anecdotal reports. Such controlled studies may provide much needed clarity for veterinary practitioners and shape the future of cannabis-derived products for veterinary use.

SECTION 2

CANNABIS PHARMACOLOGY AND THE ENDOCANNABINOID SYSTEM

Cannabis species (*Cannabis* spp.) are pharmacologically diverse plants with three cultivars: *Cannabis sativa*, *Cannabis indica*, and *Cannabis ruderalis*. *Cannabis ruderalis* flowers independent of photoperiod and yields low cannabinoid content, making it a poor choice for commercial growth.¹⁷

Cannabis spp. contain at least 480 distinct compounds, the presence and concentration of which vary within and among species and subspecies (cultivars). *Cannabis* spp. contain approximately 90 different terpenophenolic compounds known as cannabinoids—with the remaining compounds being other terpenoids and phenylpropanoids.^{18,19} Cannabinoids are lipophilic, low-weight (300 Da) molecules.²⁰ There are three types of cannabinoids, two of which are naturally-occurring: phytocannabinoids, derived from *Cannabis* spp. plants, and endocannabinoids, found in animals. The third type is synthetic cannabinoids designed for therapeutic or illicit recreational use.

Phytocannabinoids are derived from the carboxylated (CBGA) form of cannabigerolic acid (CBG) or cannabigerovarinic acid (CBGVA).²¹ Determining the most medically important phytocannabinoids will take some time, but, currently, Δ^9 -tetrahydrocannabinol (THC), cannabidiol (CBD), cannabichromene (CBC), and cannabigerol (CBG) are most commonly cited.¹⁹ THC, CBD, and CBC are formed as the carboxylic acids tetrahydrocannabivarin carboxylic acid (THCVA), cannabidiolic acid (CBDA), and cannabichromene carboxylic acid (CBCA), respectively, when processing via drying, heating, or aging decarboxylate phytocannabinoids in the plant.²¹

Of these cannabinoids, THC is the most understood because its psychogenic effects have been of considerable interest. However, CBD is less psychotropic and has many therapeutic effects similar to THC, so it is also emerging as a commonly studied cannabinoid.²² Cannabinol (CBN) is important as the primary product of the metabolism of THC, and it has been used to predict the age of marijuana plants. Because CBG is rapidly metabolized to THC, CBD, and CBC, very low concentrations of CBG exist in the plant.²³

In addition to phytocannabinoids, cannabis contains approximately 140 different terpenoids or terpenes. Terpenes share a precursor molecule with phytocannabinoids and are not unique to *Cannabis* spp. They are responsible for a variety of pharmacologic effects, such as taste and scent, and are often targets for *Cannabis* spp. hybridization. Prominent cannabis-derived terpenes include limonene, myrcene, α -pinene, linalool, β -caryophyllene, caryophyllene oxide, nerolidol, and phytol.²¹ Other components in the cannabis plant include nitrogen-containing compounds; carbohydrates, such as common monosaccharides (e.g., fructose, glucose, mannose), selected disaccharides (e.g., sucrose, maltose), and several polysaccharides (e.g., cellulose, pectin); as well as several sugar alcohols (e.g., mannitol, sorbitol, glycerol). Flavonoids and fatty acids are also present. An advantage of having this number and variety of compounds in the cannabis plant is the potential for an “entourage effect” in which negative aspects of one cannabinoid (e.g., anxiousness induced by THC) is offset by the effects of another (e.g., anxiolytic effects of CBD).

The presence and concentration of compounds (cannabinoid and non-cannabinoid) in cannabis cultivars vary, and multiple strains have been genetically modified or hybridized to preferentially generate specific cannabinoid or other substance content.²⁴ This hybridization includes differences in the proportions of both cannabinoids and terpenes.

The cannabinoid constituents of cannabis or their synthetic analogs are available in approved drugs. These include THC ([dronabinol](#), Schedule II) approved for use as an appetite stimulant in patients with AIDS or cancer; a synthetic THC ([nabilone](#), Schedule II) approved for use as an antiemetic in patients undergoing chemotherapy, but also used under extralabel guidelines as an analgesic; and the most recent approval of CBD ([Epidiolex](#)[®], descheduled in 2020) for treatment of refractory epilepsy in children.²⁵ The DEA indicates the descheduled status for Epidiolex[®] is for that drug only because other CBD products have not been demonstrated to be safe. In the UK, nabiximol is a combination of THC and CBD (1:1) undergoing investigation for treatment of spasticity associated with multiple sclerosis, and a synthetic CBD analogue is undergoing phase one clinical trials for treatment of pediatric epilepsy. Synthetic forms of CBD are currently being investigated as cheaper and more effective alternatives to natural products.²⁶

The products in the previous paragraph that are FDA-approved are available for legal use in humans and legal extralabel use in veterinary patients ([see Section 6: Regulatory overview of use of cannabis-derived products in animals](#)). However, far more publicly accessible are a plethora of cannabis-derived products that, due to their intended use, meet the definition of an unapproved drug. Such products are often marketed as supplements or food products to which cannabinoids have been added. Despite their prevalence, such products have not been evaluated or approved by the FDA, which has initiated enforcement action against many manufacturers ([see Section 6: Regulatory overview of use of cannabis-derived products in animals](#)).

The structural characterization of THC and CBD has informed synthesis of cannabinoids that vary in their agonist effect on cannabinoid or related receptors. While several pharmaceutical synthetic cannabinoids have been developed for medicinal use, as is the case for previously mentioned nabilone and dronabinol, most have been synthesized for illicit recreational use.^{27,28}

For many illicit synthetic cannabinoids, the chemical structure has been modified to preserve the psychotropic effects while rendering the molecules more difficult to detect with standard assays. Because these synthetic analogues are structurally different from THC and CBD, some testing methods that might otherwise be used to determine cannabinoid exposure may not be effective ([see Section 5: Cannabis toxicosis in companion animals](#)).

Congress passed the [Drug Abuse Prevention Act of 2012](#) making these unapproved recreational synthetic cannabinoid products illegal and empowering the DEA to take enforcement action. However, these products continue to be both a human and animal safety risk.^{1,29}

THE ENDOCANNABINOID SYSTEM

Pharmacodynamics

The presence of the endocannabinoid system has only been recognized for about three decades, so new information continues to emerge. We currently understand that the endocannabinoid system comprises endocannabinoid receptors and endogenous cannabinoid ligands, with the latter referred to as endocannabinoids.^{30,31} The discovery and description of the effects of THC on one of the primary endocannabinoid receptors paralleled that of the discovery of opioid receptors leading to the discovery of the endogenous cannabinoid system. The neuromodulatory function of the endocannabinoid system is widespread throughout the CNS, contributing to synaptic plasticity and response to both endogenous and nervous stimuli.³² The system is frequently cited for its importance in neuroprotection.³³

Receptors

Two major endocannabinoid receptors (CBR) have been described: CB₁R and CB₂R. Similar to opioid receptors, endocannabinoid receptors are G protein-coupled cell-membrane receptors (GPCR). They are distributed throughout the body, playing critical roles in most tissues.³¹

CB₁R are highly conserved in vertebrates. They are the most common metabotropic receptors (act through a second messenger) and are one of the most abundant GPCR in the brain. However, they are distributed in certain cell types in selected areas, specifically the basal ganglia nuclei, hippocampus, cortex, and cerebellum. CB₁R largely inhibit neurotransmitter release, neuronal excitability, and synaptic plasticity.^{31,34}

Neurotransmitters reported to be modulated by CB₁R include glutamate, gamma-amino butyric acid (GABA), acetylcholine, noradrenaline, and serotonin.³⁴ Localization of CB₁R in the brain reflect their control of motor function, cognition, memory, and analgesia.³¹ Classic CB₁R-mediated responses include hypolocomotion, analgesia, catalepsy, and hypothermia.³⁵ However, the dopaminergic reward pathway is also stimulated by CB₁R, contributing to overeating, smoking, and substance use disorders.

CB₁R are also located within cells and in peripheral tissues. Mitochondria are one of the most common CB₁R-labeled organelles.³⁴ CB₁R are also expressed in lower concentrations in the periphery, primarily in circulating immune and hematopoietic cells, including microglia.³⁴ Organ and cell locations include the spleen, tonsils, thymus, lungs, testes, macrophages and leucocytes.

Activation of CB₂R does not cause mentation effects typical of CB₁R activation. Along with CB₂R, CB₁R are up- or down-regulated during immune responses. Their expression increases in the CNS in selected disease states, particularly inflammation, immune suppression, and cancer.³¹

That CB₁R and CB₂R are GPCR indicates their importance in normal physiology. Interactions between ligand and GPCR can occur in a variety of ways, resulting in a variety of signals, thus allowing for complicated drug-dose-response relationships that interface with other physiologic signals.³⁶ The receptors have at least two sites at which ligands can bind: the site in which endogenous ligands bind (orthostatic) or at a site distant from the orthostatic site (allosteric). Allosteric binding allows modulation of the effects of endocannabinoids. Ligands can interact at the orthostatic site as agonists, partial or mixed agonists, inverse agonists, or antagonists. Interestingly, while many agonists demonstrate minimal selectivity for either CB₁R versus CB₂R, antagonists tend to be highly selective for one CBR compared with the other.³¹

The manner in which ligands interface with either cannabinoid receptor can also differentially modulate β -arrestin, which regulates the number of CBR on the membrane surface. These changes can lead to desensitization or a diminished response that might occur with repeated administration of an exogenous cannabinoid (e.g., phytocannabinoids or synthetic cannabinoids). Rapid desensitization results in tachyphylaxis, whereas a more gradual desensitization results in tolerance, physical dependence (and thus withdrawal signs) and, potentially, drug resistance.³⁷

Cannabinoid tolerance may develop due to either biochemical or cellular changes.³¹ Although mechanisms have not been fully elucidated, changes in CBR binding due to down-regulation and desensitization have been proposed. β -arrestin is likely to regulate CB₁R signaling and adaptation. In humans, the amount of CB₁R downregulation can be positively correlated with the number of years of (THC) smoking and is reversible when smoking is discontinued. CB₂R also down-regulate in response to agonists. The manner in which ligands

bind to the receptor may influence the degree of down-regulation. For example, allosteric modulation of CB₁R provides analgesia but not tolerance or dependence.³⁸

GPCR are capable of dimerization; i.e., monomers of GPCR can bind with one another. Dimerization of cannabinoid receptors has been demonstrated to allosterically modulate opioid receptor activity. As such, cannabinoids have the potential of influencing opioid and other GPCR.³⁹ An additional complicating factor is the existence of GPCR that are not CB₁R or CB₂R but nonetheless interface with cannabinoids.⁴⁰ The importance of these orphan (receptors with no identified endogenous ligand) GPCR is being investigated.

Endocannabinoids

Endogenous cannabinoids are lipophilic-signaling molecules synthesized on demand from cell membrane phospholipids. Like neurotransmitters, they are released in response to increased calcium concentrations following post-synaptic depolarization or activation of metabotropic glutamate receptors.⁴¹

Although many endocannabinoids have been described, the most prevalent and most studied in mammals are 2-arachidonoyl glycerol (2-AG) and anandamide (AEA). These two endocannabinoids are particularly prevalent in the brain but also are distributed throughout the body. Interestingly, AEA concentrations are higher in plasma than serum.

Most endocannabinoid effects occur through CB₁R and CB₂R.⁴² Although not yet totally clear, their binding affinities to CBR differ. 2-AG is currently thought to bind with moderate affinity to both CB₁R and CB₂R as a full agonist, whereas AEA is currently thought to bind with high affinity to CB₁R as a partial agonist.^{41,43} AEA is about tenfold more potent than 2-AG, but concentrations are very low.⁴¹ Binding of both AEA and 2-AG is competitive. The differential binding of the two major endocannabinoids allows for modulation of different functions.

The metabolism (formation and degradation) of these two endocannabinoids also varies, potentially paving the way for differential pharmacologic manipulations.³² Arachidonic acid is contained in both AEA and 2-AG, but the pathway to AEA synthesis is complex compared to 2-AG. Four pathways of AEA formation have thus far been proposed.³² The importance of understanding these pathways reflects the role AEA is suspected to have in disease.³² The degradation of both 2-AG and AEA to arachidonic acid is rapid. The impact of COX-2 inhibitors, including certain non-steroidal anti-inflammatories, on AEA formation is still being investigated, but ultimately COX-2 inhibitors selective only for AEA or prostaglandins may be developed.

The basic physiologic effects of the endocannabinoid system have been substantially reviewed elsewhere.^{35,42} Briefly, endocannabinoids appear to influence every major body system and have important roles in metabolism (e.g., food or energy intake, body adiposity, exercise, and energy expenditure), cell regulation (e.g., sleep and wakefulness), and systemic inflammation and stress. Interestingly, circulating AEA concentrations are inversely related to measures of anxiety and depression and are altered in human patients with post-traumatic stress disorder. Memory and cognition are also influenced by AEA through CB₁R.⁴² The role of endocannabinoids in addictive behaviors and reward is less clear, but 2-AG, in particular, is associated with reward.

Endogenous cannabinoids increase in response to a variety of pathologic situations. The role of AEA and 2-AG in pain is also an area of research, with higher concentrations of AEA and 2-AG, for example, being associated with chronic pain syndromes.⁴² It is beyond the scope of this report to describe the known and presumed physiologic effects of AEA and 2-AG; however, reviews are available focusing on energy

metabolism;⁴⁴ epilepsy;⁴⁵ pain (including neuropathic);⁴⁶ inflammation;^{46,47} cancer;⁴⁸ and the central nervous,⁴⁹ cardiovascular,⁵⁰ gastrointestinal,^{51,52} immune,⁵³ skin,⁵⁴ lower urinary,⁵⁵ musculoskeletal,⁵⁶ and reproductive systems.^{57,58}

Cannabinoid receptors and phytocannabinoids

The endocannabinoid system interacts differentially with phytocannabinoids; THC, CBD, CBC, and CBG are illustrative.³⁵ THC binds as a partial agonist at both CB₁R and CB₂R in nanomolar concentrations. As a partial agonist, THC either directly activates CB₁R or attenuates the tone of endogenous cannabinoids. Although most of the physiologic effects of THC can be attributed to CBR binding, it may also interface with orphan GPCR cannabinoid receptors.³⁵

On the other hand, CBD has very low affinity for cannabinoid receptors, with weak antagonist activity at CB₁R and inverse agonist activity at CB₂R.^{35,59} However, CBD may act indirectly as an agonist at both receptors by inhibiting AEA hydrolysis.³⁵ Interestingly, CBD exists naturally as the negatively charged enantiomer, which does not bind to CB₁R; however, the synthetic positively charged enantiomer has been shown to bind both CB₁R and CB₂R.⁶⁰ As early as the 1960s, CBD began to be used as an anticonvulsant, with effects similar to phenobarbital.⁶⁰

CBC is another non-psychotropic cannabinoid. It exhibits strong anti-inflammatory effects by indirect activation of CB₁R, through inhibition of endocannabinoid inactivation.⁶¹ Most recently, CBC was determined to normalize intestinal motility in a mouse experimental intestinal inflammation model, but not alter the rate of transit in control animals.⁶²

Even though little CBG occurs in *Cannabis* spp., it has been studied nonetheless. It appears to be a partial agonist/antagonist at both CB₁R and CB₂R.²³ Interestingly, it is also an agonist at alpha-2 adrenoreceptors, and thus 5HT-1a receptors, interfaces with select transient receptor potential channels, and inhibits cyclooxygenases 1 and 2, although the clinical relevance of these *in vitro* studies, if any, is not clear. Theoretically, modulation of inflammation is anticipated.

Tolerance to phytocannabinoids has been described in humans.^{31,37} Tolerance and rapidly diminishing clinical response have also been documented with chronic THC use (e.g., dronabinol [Marinol®]).⁶³ Tolerance to cardiovascular and selective adverse CNS effects developed within 12 days of initiating therapy, but not to appetite stimulation, the approved indication. A withdrawal syndrome was reported when dronabinol was abruptly discontinued, indicating physical dependence had occurred.⁶³ In contrast, CBD did not induce physical dependence after 28 days of therapy.⁶⁴ Although tolerance is not described for CBD (Epidiolex®), users are warned to gradually withdraw the drug to minimize the risk of status epilepticus (package insert [PI]).⁶⁴

Pharmacokinetics of the major phytocannabinoids

The lipophilic nature of phytocannabinoids contributes to potentially complicated pharmacokinetics. Care must be taken to not assume the disposition of one cannabinoid can be used to predict others. Also, in humans, the pharmacokinetics of THC from inhaled marijuana is different from that from orally administered products. This review focuses on oral administration. The pharmacokinetics of other routes of administration for humans have been reviewed elsewhere.^{65,66}

Because both THC (as a synthesized form, dronabinol [Marinol®]) and CBD (Epidiolex®) are available as FDA-approved human drugs, quite a bit of human pharmacokinetic information is available.

In humans, THC (Marinol®—dosed at 2.5 mg every 12 hours, with gradual titration as needed up to a maximum dose of 10 mg divided every 12 hours)—is almost completely absorbed, but about 10 to 20% reaches systemic circulation.⁶³ However, at least one of the major metabolites, 11-OH-Δ-THC, is active and is present in plasma in concentrations equal to THC. Concentrations peak anywhere from 30 minutes to four hours after oral administration. Pharmacokinetics are largely dose-dependent at 2.5 to 10 mg (total dose), although proportionality increases at higher doses (**Table 1**). Although food increases the area under the curve (AUC) by approximately threefold, it also delays the time to maximum concentration by four hours. Elimination follows two compartments with an initial half-life of four hours, then a longer one of 25 to 36 hours. First pass metabolism is extensive, with bile being the major route of elimination and only 10 to 15% of a dose being recovered in urine. Enterohepatic circulation may result in low but detectable concentrations in urine and feces for as long as five weeks or more. THC is metabolized primarily by CYP2C9 and CYP3A4. The impact of other drugs that induce or inhibit these enzymes has not been reported.⁶³

The package insert for CBD as Epidiolex®—dosed at 2.5 mg/kg every 12 hours, with titration up to 20 mg/kg/day total dosing—does not report bioavailability.⁶⁴ By seven days of dosing, the AUC of the active metabolite is 38% of the parent and continues to contribute to bioactivity. Oral absorption is largely concentration-dependent at doses of 5 to 20 mg/kg but the proportionality declines with higher doses. Its maximum serum concentration and AUC are markedly impacted by a high fat meal, with both increasing five- and fourfold, respectively. The elimination half-life of CBD is 56 to 61 hours in humans. It is metabolized primarily in the liver, with some GI tract metabolism. Elimination occurs primarily through the bile and feces. The package insert indicates that neither CBD nor its active metabolite interact with most clinically relevant transporters.⁶⁴

Drug interactions

Drug interactions involving cannabinoids might occur at the level of transporter proteins, including influx and efflux proteins (e.g., P-glycoprotein), blood albumin, or at the level of elimination. Of these three, elimination and, specifically, metabolism have been most studied. After understanding that phytocannabinoids are metabolized by CYP450, concern for drug interactions involving these enzymes became a focus of research.⁶⁷

Two areas of concern regarding interactions involving CYP450 include the impact of phytocannabinoids on other drugs by virtue of their ability to induce or inhibit metabolism, and the impact of other drugs known to be inducers or inhibitors of CYP450 on THC and CBD metabolism. Current drug interaction data have been systematically reviewed.⁶⁷ Although *in vitro* studies have demonstrated potential CYP450 drug interactions to date, clinically relevant reports have been limited to a case report of CBD-associated increase in the concentrations of a clobazam ([see Section 5: Cannabis toxicosis in companion animals](#)).⁶⁸

Other sources of information regarding drug interactions come from the package inserts for Marinol® (dronabinol) and Epidiolex® (CBD).^{63,64} According to the package inserts for Marinol® (dronabinol) and Epidiolex® (CBD), potential drug interactions involving CYP450 have not been established, but caution is recommended when using phytocannabinoids with drugs metabolized and known to inhibit CYP3A4 (e.g., imidazole antifungals, including ketoconazole, itraconazole) or CYP2C9 (e.g., amiodarone or imidazole antifungals, including fluconazole).⁶³ Pharmacodynamic interactions of concern listed for THC involve additive CNS or cardiac effects. Although competition for protein binding sites may be of concern for THC, displacement has not been confirmed *in vitro*.

The package insert for Epidiolex® (CBD) indicates it has the potential to inhibit CYP2C8, CYP2C9, and CYP2C19 and induce CYP1A2 and CYP2B6 at clinically relevant concentrations.⁶⁴ Although, as previously

Species	Units	Human		Dog						Cat
		CBD	THC	THC	CBD	CBD	CBD	CBD	CBD	CBD
Author		Epidolex® PI; Taylor 2018	Marinol® PI; Taylor 2018	*Garrett 1977	Samara 1988	Barner 2018	Gamble	*Boothe	Deabold 2020	Deabold 2020
Preparation		Synthetic, Pure	Pure	Pure	CB in 70% EtOH	Oil	Oil	Oil	Soft Chew	Soft Chew
Dose	mg/kg (or TD)	1500 mg TD	2.4-10 TD	0.1 to 2	45 / 90 (1.9 to 5.6 mg/kg)	10 to 20	2 to 8	2	2	2
Route		PO	PO	IV	IV	PO	PO	PO	PO	PO
N				3 (Mongrel)	6 (Mongrel)	5 (Beagles)	4 (Beagles)	8 (Beagles)	8 (Beagles)	8 (DSH)
Parameter										
Cmax	ng/ml	334±81.3	1.32±0.62 to 7.9±4.54	NA	NA	625±164 to 845±262	102 (61- 132) to 591 (389-905)	110±61 (*289±127)	*272±130	301±63 (SEM)
Tmax	hr	2.5 to 5	0.5 to 4	NA	NA		1-5 to 2.0	2.0±4.0 (*2.3±0.7)	*0.7±2.0	1.4±0.2 (SEM)
AUC	ng/mL/ hr	1987	2.88±1.47 to 15.2±5.52		2706±519 /6095±1741	135±46 to 297±112 ug/ml/ min	367(183- 437) to 2568 (1753- 3048)	1672±2535 (*1292±579)	*1100±379	1297±210 (SEM)
Clearance	L/hr/kg	1111	0.2	0.53±0.16; 17±2.95	0.85±0.17 /0.795±0.2					
Half-life	hr	56 to 61	25 to 36	1.2 DAYS 8.2+ 0.23 DAYS	6.8±2.7/9.3±3.3	3.3±0.9 to 2.1±0.5	4.2 (3.6- 6.8) to 4.2 (3.8-4.8)	6.4±3.3 (*6.3±1.7)	8.1±2.0	1.0±0.2 (SEM)
MRT	hr				7.0±3.5 / 7.5±2.7	217±46 to 298±43	5.6(4.2- 9.1) to 5.6 (5.1-7.0)	39±76 (*7.0±0.8)	*8.1±2.0	1.4±0.3 (SEM)
Protein binding	%	94	97							
Volume of Distribution	L/kg	20963 to 42849	*10 L/kg	0.064	8.4±2.3/ 10.5±4	NA	NA		NA	NA
Bioavailability			10-20%		15	108±10				
Comments		1,6, 14	2-5,13	16, 19, 20	12, 15,17	7	10,11,19	10,11,19		

- 1 Cmax increased by 5 fold and AUC by over 4 fold when administered with high fat/high calorie meal
- 2 THC is 90-95% absorbed but first pass metabolism reduces oral bioavailability
- 3 THC is metabolized to an active metabolite (11-hydroxy-delta 9 THC)
- 4 AUC is 0 to 12 hrs
- 5 Cmax not significant increased but AUC increased by 3 fold when administered with high fat/high calorie meal
- 6 2.5 to 20 mg/kg/day is recommended dose
- 7 median and range
- 9 AUC = Area under the curve; MRT = Mean Residence Time; TD = total Dose; SEM = standard error of the mean
- 10 Unpublished data
- 11 *Fed
- 12 *AUC is in mcg/hr/liter
- 13, 14 Volume of distribution reported out as ratio to bioavailability
- 15 74% hepatic extraction
- 16 based on average weight of 14 kg
- 17 Based on average weight of 20 kg
- 18 *Based on radioactive labeling, thus reflects THC and metabolites
- 19 The shorter half-life is the "best" estimate for THC; the longer half-life reflects THC and radiolabeled metabolites
- 20 Clearance of bound (124±38 ml/min)) versus unbound (4131± 690 ml/min) drug
- 21 Clearance is based on total body weight, not per kg

Table 1. A summary of pharmacokinetics for two major cannabinoids (THC and CBD) reported for humans, dogs and cats.

indicated, drug interactions at the level of transporters are not of concern for either CBD or its active metabolite, the inactive 7-COOH metabolite does interact with P-glycoprotein. Because this metabolite (in humans) achieves an AUC 40-fold higher than THC, a potential risk of competition for P-glycoprotein may exist.⁶⁴

CANNABINOIDS IN ANIMALS

Currently, the most information regarding cannabinoids' actions in domestic animals is available for dogs, but even that is limited. Initial studies in the 1970s and 80s that used dogs as a model focused on the impacts of THC and, to a lesser degree, CBD on humans. Early studies provide some evidence that dogs may respond to cannabinoids in unique ways.

Pharmacodynamics

Receptors

In 1975, tritium-labeled Δ^9 -THC (0.5 mg/kg IV) radioactivity was demonstrated to be distributed throughout the canine cerebellum and cerebral cortex, with increased concentrations in grey matter as compared with white matter, and up to 50% of the signal reflected metabolites.⁶⁹ Peripherally, radioactivity occurred in all organs except vitreous humor. Peripheral tissues with the highest relative concentrations included bile, adrenal glands, liver, heart, renal cortex, and pancreas. Lowest concentrations were found in fat, trachea, and testes. More recent studies in dogs have demonstrated CB₁R in the cells of parotid and mandibular salivary glands.⁷⁰ Dogs have high concentrations of CBD receptors in the cerebellum, where they appear to control motor movement, contributing to a static ataxia that may be unique to dogs.⁷¹ Using radiolabeled studies, THC (-) and, to a lesser degree, THC (+) are much more potent in the dog compared to cannabidiol. More recently, Freundt-Reveille, et al. confirmed the unique cerebellar distribution of the CB₁R in dogs, and distribution similar to other species in the central and peripheral nervous system.⁷² In other studies, both CB₁R and CB₂R were demonstrated in the canine epidermis and dermis; both receptors appear to increase in atopic dogs.⁷³ Finally, the recently cloned and characterized canine CB₂R reveal 76% homology with that of other species.⁷⁴

Endocannabinoids

Information regarding endocannabinoids in dogs is limited. Freundt-Reveille, et al. measured AEA and 2-AG in the CSF of normal dogs and dogs with spontaneous steroid-responsive meningitis-arteritis following natural spirocercosis infection.⁷⁵ These authors demonstrated higher concentrations of AEA and 2-AG in both CSF and serum prior to glucocorticoid treatment and a decrease in both after treatment.

Tolerance to CBD has been reported for dogs. Dogs developed tolerance to the static ataxia associated with intravenous CBD administration as soon as three days after intravenous administration of 0.5 mg/kg THC, which was no longer evident by seven days after administration.⁶⁹ In a related study, the intravenous dose of THC necessary to induce ataxia in dogs increased from 0.5 mg/kg to 161 mg/kg after 80 days of dosing every eight days. Tolerance was still present 23 days after the last dose.⁷⁶ Tolerance has also been demonstrated to the analgesic effects within eight days in dogs subjected to tooth pain.⁷⁷

Pharmacokinetics

Limited THC and CBD pharmacokinetic data are available for dogs. For THC, although it has been administered intravenously to dogs in several studies, pharmacokinetics on the parent compound are not

available. Although tissue disposition of radiolabeled THC and its metabolites has been described for dogs, separating parent compound from metabolites is difficult.^{78,79} A best terminal half-life of 1.24 days was reported for THC, as compared with 8.2 ± 0.23 days for all radiolabeled activity.⁷⁹ The longer half-life reflects the parent compound and the many metabolites, whose pharmacologic activity is not known. THC undergoes enterohepatic circulation in dogs, prolonging its half-life. (**Table 1**)

Several recent studies have provided limited tissue disposition information for CBD-based products in dogs. Very early studies provide limited data on intravenous administration (**Table 1**). Single-dose CBD disposition (n=six dogs) after 2 to 5 mg/kg IV (prepared in 1.5 ml of 70% alcohol) revealed a large volume of distribution and a mean half-life of seven to nine hours, indicating the compound does not appear to accumulate over time.⁸⁰ The elimination half-life reported after intravenous administration is similar to that reported for orally-administered CBD in oil or soft chews.^{81,82,83,84} Recent studies also indicate that feeding enhances absorption, although not as substantially as in humans.⁸⁵

One study describes the pharmacokinetics and potential adverse effects of CBD administered orally in fish oil to eight cats for three months.⁸¹ The pharmacokinetics reported are similar to those reported for dogs with respect to timing and half-life. Monthly CBC and serum biochemical analyses were performed, and one cat did have an elevated ALT concentration, with no changes in any other parameters. However, the study provides limited information because CBD was not readily bioavailable ([see Section 3: Clinical research investigating therapeutic potential and pharmacokinetics in companion animals](#)). An unpublished pilot study using soft chews indicates improved oral absorption in cats using an emulsified preparation. Dogs metabolize cannabinoids differently than humans, and it is not known which metabolites are, and are not, active. Differences in metabolites contribute in part to the unknown relevance of human test kits for detecting cannabinoids in animals. One study has demonstrated that kits that detect cannabis exposure in people were not effective detecting exposure in dogs⁸⁶ ([see Section 5: Cannabis toxicosis in companion animals](#)).

A report in abstract form reveals marked variability in the serum concentrations of CBD and THC in dogs (n=183) receiving CBD products marketed as dietary supplements⁸⁵ ([see Section 6: Regulatory overview of the use of cannabis-derived products in animals](#)). CBD concentrations ranged from non-detectable to greater than 1,000 ng/ml, with a median of 13.7 ng/ml, while THC ranged from nondetectable to 87.4 ng/ml (median of 0.6 ng/ml). More than 40 different oil- or capsule-based products were represented. This variability suggests that therapeutic drug monitoring of phytocannabinoids might be prudent in clinical patients.

A recent study in dogs explored the dose-concentration relationship of THC and its active metabolite 11-OH- Δ -THC and CBD and its metabolite 7-COOH-CBD (which, in humans, is inactive, according to the Epidiolex[®] package insert). The dose escalation was tenfold, resulting in approximately 49 mg/kg THC and 62 mg/kg CBD.⁸⁷ Notably, the incidence of significant adverse events was rare, but when they did occur they occurred primarily with THC administration alone or with CBD administered alone (serum concentrations of THC associated with adverse events were 785 ng/ml or 133-296 CBD and 99-361 ng/ml THC combined).⁸⁷ [See Section 5: Cannabis toxicosis in companion animals.](#)

SECTION 3

CLINICAL RESEARCH INVESTIGATING THERAPEUTIC POTENTIAL AND PHARMOCOKINETICS IN COMPANION ANIMALS

This section provides an overview of the clinical evaluations of cannabidiol (CBD), including preclinical pharmacokinetic data and potential adverse effects of CBD-rich hemp products reported in limited peer reviewed literature. When appropriate, this review also addresses the acid derivatives of CBD and Δ^9 -tetrahydrocannabinol (THC), cannabidiolic acid (CBDA), and tetrahydrocannabinol acid (THCA), as these cannabinoids have been examined and may have biological value. Low-THC (< 0.3%) *Cannabis sativa*-derived products are referred to as CBD-rich hemp products throughout this section. Data derived primarily from studies of dogs are summarized because well-controlled clinical studies for other species are sparse.

PHARMACOKINETIC STUDIES INVOLVING ADMINISTRATION OF ISOLATED CBD OR CBD-RICH HEMP PRODUCTS TO DOGS

Prior to embarking on clinical investigations to determine the therapeutic potential of cannabinoids, researchers looked to previous preclinical pharmacokinetic studies examining canine bioavailability of cannabinoids that were conducted primarily in the late 1980s ([see Section 2: Cannabis pharmacology and the endocannabinoid system](#)). However, such studies provide minimal data to help determine an appropriate dose for clinical investigations. Several recent pharmacokinetic evaluations have been completed to more accurately define canine bioavailability based on oral administration of cannabinoids (particularly of CBD), as well as potential adverse effects associated with their administration.

One such preclinical pharmacokinetic examination was conducted by Bartner et al. in 2018.⁸³ This study examined 30 dogs in six cohorts (five dogs per experimental group) that received either 10 mg/kg/day or 20 mg/kg/day of CBD from a hemp extract containing small amounts of other cannabinoids and terpenes, corresponding to a 75 mg dose of CBD every 12 hours or a 150 mg dose of CBD every 12 hours, respectively. During the 12 hours following the first dose, CBD plasma concentrations were measured eight times to determine the relative half-life of three different formulations: a CBD-rich infused oil, microencapsulated beads, and a transdermal cream. Briefly, plasma concentrations during the first 12 hours as well as at two, four, and six weeks showed greater absorption and retention from CBD-rich infused oil than from microencapsulated beads or transdermal cream. For dogs given doses of 10 mg/kg/day of CBD-infused oil and 20 mg/kg/day of CBD-infused oil, their plasma mean maximal concentrations were 649 and 903 ng/mL, respectively⁸³ ([see Section 2: Cannabis pharmacology and the endocannabinoid system](#)).

Adverse events associated with the six-week exposure period were subsequently reported.⁸⁸ Weekly examinations were performed by a veterinarian and bi-weekly complete blood counts (CBC), serum biochemical analyses, urinalyses, and before-and-after bile acid concentrations were obtained. The most prevalent adverse effect regardless of CBD dose was diarrhea. Erythematous pinnae were also observed exclusively in the groups of dogs receiving transdermal applications. Urinalyses and CBC revealed no differences over time, while serum biochemical analyses indicated increased concentrations of alkaline phosphatase (ALP) in 36% of dogs (11 of 30). A significant rise of twofold or more of ALP was observed in dogs with higher elevations in the microencapsulated bead group than the infused oil group. Elevations in ALP were not observed for dogs given the transdermal formulation.⁸⁸

As part of a clinical osteoarthritis study (which is also discussed in the next section, Clinical investigations in canine osteoarthritis and epilepsy), 24-hour pharmacokinetic analyses were also performed for four beagles receiving two different doses one week apart.⁸² This study revealed that serum maximal concentrations after an intended total oral CBD dose of 2 mg/kg (CBD dose of 1 mg/kg and cannabidiolic acid or CBDA dose of 1 mg/kg) and 8 mg/kg (CBD dose of 4 mg/kg and cannabidiolic acid or CBDA dose of 4 mg/kg), were approximately 100 ng/mL and 600 ng/mL, respectively, with half-lives of approximately four hours in fasted dogs fed two hours after oral dosing. However, we now know that CBDA was not converted to CBD in the body. Hence, in hindsight, the CBD measured in the blood was actually from a total CBD dose of 1 and 4 mg/kg.⁸²

A subsequent CBD/CBDA study with similar dosing (1 mg/kg each of CBD and CBDA) using a soft chew evaluated eight beagle dogs in a contract research laboratory setting.⁸¹ Twenty-four-hour pharmacokinetics in fasted dogs revealed a serum C_{max} of approximately 300 ng/mL at one to two hours and a half-life of two to three hours. More importantly, this study included twice daily dosing of dogs over a period of three months to determine whether there were any abnormalities detected on physical examination or altered blood work parameters. No significant changes in blood counts, serum chemistry values, or physical examination abnormalities were detected, implying the relative safety of this product in these younger, healthy beagle dogs for that duration of administration.⁸¹

Differences in absorption between the soft chew formulation and oil tincture with and without feeding were further elucidated for eight dogs receiving three sequential treatments with a seven-day washout period between treatments. In this study, administration of 2 mg/kg of CBD in an oil tincture resulted in a similar C_{max} and a slightly longer half-life (about four hours) when compared with results of the soft chew study using CBD/CBDA.^{81,89} These data were instrumental in understanding that feeding when administering CBD likely enhances its absorption by approximately threefold^{81,89} ([see Section 2: Cannabis pharmacology and the endocannabinoid system](#)).

More recent studies that are yet to be published involved the use of three different oral formulations and one transdermal product.^{90,91} The first looked at CBD, its native acidic form CBDA, THC, and THC's acidic form THCA. Each dose was designed to deliver 1 mg/kg of CBD and 1 mg/kg of CBDA, and less than 0.04 mg of THC and 0.04 mg of THCA every 12 hours. Twenty-four-hour pharmacokinetics and one- and two-week steady state evaluations of these products six hours after a morning dose were reported. Products were formulated as a sesame oil base with either 25% medium chain triglycerides or 25% sunflower lecithin, or as a soft chew. All dogs were fed 100 grams of wet food when dosing to promote absorption. Results of 24-hour pharmacokinetics revealed that CBD and CBDA were absorbed equally, and one- and two-week serum concentrations indicated equal absorption and retention of CBD and CBDA (75-100 ng/mL of each), except for the 25% lecithin base product where CBDA concentrations were higher (125-200 ng/mL). THC retention (less than 10 ng/mL) appeared to be lower than THCA retention (15-30 ng/mL) across all oral forms. Although the psychotropic metabolite of THC, 11-OH-THC, was examined, its concentrations were close to the lower limit of detection so conclusions across groups could not be made.⁹⁰ Finally, the retention of CBDA (15 to 30 ng/mL) resulting from administration of the transdermal formulation aurally was approximately twofold higher than that of CBD at weeks one and two of a 4 mg/kg twice-a-day application in dogs⁹¹ ([see Section 2: Cannabis pharmacology and the endocannabinoid system](#)).

CLINICAL INVESTIGATIONS OF CANINE OSTEOARTHRITIS AND EPILEPSY

An owner survey of CBD-rich hemp product use in dogs and cats revealed pain management, seizures, neoplasia, quality of life, and anxiety or other behavioral issues as the top reasons that owners opted to use these products.⁹² Unfortunately, few clinical studies evaluating long-term clinical effects including benefits and adverse events are available at the time of this review. Four studies—three osteoarthritis pain management studies and one seizure management study—did look at these aspects.

Two publications report on the clinical effects of CBD-rich hemp on osteoarthritis. The first was a placebo-blinded, randomized cross-over clinical trial in which veterinarians and owners were unaware of treatment groups.⁸² The study looked at CBD-rich hemp in an olive oil base that contained <0.3 percent THC/THCA and an equal mix of CBD and CBDA. The CBD/THC ratio in this study was approximately 25:1. The dosage provided in this publication was 2 mg/kg of total cannabinoids (approximately 1 mg/kg of CBD and 1 mg/kg of CBDA) administered every 12 hours with food. The working solution of the oil contained approximately 50 mg/mL of CBD and CBDA combined. Sixteen dogs randomized into groups completed the study of one month's treatment, two weeks of washout, then cross-over to the second treatment. Dogs could concurrently receive fish oil, glucosamine supplements, non-steroidal anti-inflammatory drugs (NSAIDs), or a combination thereof for minimally four weeks prior to enrollment. No changes in treatment were allowed during the trial. Twenty-two dogs were originally enrolled, but six were ultimately excluded due to having a diagnosis of osteosarcoma, gastric torsion (placebo oil), prior aggression issues (CBD oil), pyelonephritis/kidney insufficiency (CBD oil), recurrent pododermatitis (placebo oil), or diarrhea (placebo oil).⁸²

Owners and veterinarians performed assessments. All owners completed the canine brief pain index and Hudson scales to assess pain and activity at zero, two, and four weeks.^{93,94} Veterinarians assessed pain, lameness, and weight bearing every two weeks during the study. CBC and serum biochemical analyses were also performed every two weeks. Assessments performed by owners indicated a significant reduction in pain scores and increase in activity scores when the dogs received CBD-rich hemp oil compared to placebo. In addition, the two veterinarians evaluating these dogs reported reductions in pain indices at weeks two and four for dogs receiving CBD-rich hemp treatment compared to placebo. However, there were no significant changes in veterinarians' physical examination findings for gait and weight bearing. Results of CBC did not differ but serum biochemical analyses revealed an increase in ALP at week four for dogs in the treatment compared to placebo group (nine of 16 dogs had an increase over their initial measurements). Dogs were allowed to remain on NSAIDs during the trial. An association with increased ALP when using CBD in combination with NSAIDs was not reported. Overall, assessments of pain relief by owners and veterinarians were positive.⁸²

A more recent study of osteoarthritis involved 37 enrolled dogs, 32 of which completed the 90-day trial with no placebo control group.⁹⁵ This was a dose escalation study starting at 0.25 mg/kg every 12 hours with food after three days of once-daily dosing with 13:1 CBD/THC in hemp seed oil containing 30 mg/mL CBD. CBD dose escalations of 0.5 to 0.75 mg/kg approximately every 12 hours were prescribed at each reassessment until the patient's pain score on palpation was zero to one, with zero indicating the least pain and ten indicating the greatest pain. THC systemic exposure was likely greater in this study as compared to the study previously described due to the higher potency of CBD used. Dogs were withdrawn from the study for several reasons, including scheduling compliance (n=1), advanced hepatic/renal disease (n=1), and neoplasia (n=3).⁹⁵

In this study, dogs could receive concurrent gabapentin, but not NSAIDs, and concurrent acupuncture or electroacupuncture, nutraceuticals, polysulfated glycosaminoglycan, or a combination thereof. Physical examination by veterinarians and owner assessments were done every two weeks using the [Cincinnati Orthopedic Disability Index](#). Changes in supplements, physical therapy, or other integrative modalities were not allowed, but owners were allowed to lower gabapentin dose based on owner comfort. CBC and serum biochemical analyses were assessed prior to and three months after the study began. A veterinarian performed a gait speed assessment, pain palpation (zero to ten scale), and physical examination, which occurred every two weeks. If the veterinarian's palpation pain index score did not show improvement, CBD-rich hemp dose was increased from 0.5 to 0.75 mg/kg until a palpation score of zero to one was achieved. If palpation pain index scores decreased, a reduction in gabapentin dose was attempted. This study reports that two of the 32 dogs did not respond during the 90-day study, with their overall pain scores remaining at one out of ten. The final dose for these two non-responding dogs was 2 mg/kg. CBD-rich hemp treatment appeared to be effective within the CBD dosing range of 0.3 to 4.12 mg/kg every 12 hours. Most of the patients enrolled required 1 to 2 mg/kg of CBD-rich hemp product to achieve a palpation score of zero to 1, with zero indicating the least pain and ten indicating the greatest pain. Initial average veterinary pain index was 3.2 ± 2.2 then significantly decreased to 1.0 ± 0.8 by the end of the study. Unfortunately, data for the owner's assessment using the Cincinnati Orthopedic Disability Index was not reported other than to indicate that 94% of owners felt the treatment positively impacted the dog's quality of life. Of the 23 dogs that were also on gabapentin for pain mitigation, use was completely discontinued for ten dogs and daily dose was reduced for 11 dogs. The average initial dose of gabapentin was $1,846 \pm 1,756$ mg/day which reduced to $710 \pm 1,112$ mg/day by the end of the study. Considerable variability is noted, and reporting may have been more useful as mg/kg per day.⁹⁵

With respect to CBC and serum biochemical analyses prior to and after the trial, only serum ALP concentrations showed a significant increase; changes in serum alanine amino transferase (ALT) were not observed. Neither the owners nor veterinarians reported evidence of adverse effects from the treatment. Owners felt their dogs slept less and interacted more with family while on the CBD-rich hemp product.⁹⁵

A more recent study investigated the therapeutic potential of CBD for osteoarthritis, using both CBD in fractionated coconut oil and lecithin-liposomally-encapsulated CBD in a four-week, randomized, placebo-controlled, double-blinded study in a spontaneous canine model of osteoarthritis.⁹⁶ This pilot study included 20 dogs with an average weight of 41 ± 15 kg divided into four groups (n=5/group). They were given placebo fractionated coconut oil, 20 mg/day CBD or 50 mg/day CBD in fractionated coconut oil, or 20 mg of sunflower lecithin-liposomally-prepared CBD daily, with no information on whether the treatment was provided with a meal or not. Before study initiation and at day 30, and using a five-point scale, a veterinarian assessed walking, running, and assuming a standing position from both a sitting and lying down position. Owners also evaluated dogs before treatment, at week four of treatment and then again at week six (two weeks after discontinuing the treatment) using the [Helsinki Chronic Pain Index](#), a validated, 11-item assessment of treatment response in dogs with osteoarthritis pain. Veterinary examinations and owner evaluations indicated no significant difference in response between dogs given a placebo or 20 mg/day coconut oil-based CBD, but significant improvement was noted for all sitting to standing and lying to standing transitions for dogs that received 50 mg/day CBD in coconut oil and 20 mg/day liposomal CBD. Dogs receiving 50 mg/day of CBD in coconut oil also showed improvement in walking when pre- and post-treatment assessments were compared.⁹⁶

In addition to these studies of canine osteoarthritis, results of a study on seizure management were reported by McGrath and colleagues at Colorado State University.⁸⁴ Although it involved a small cohort of dogs, it was a randomized, blinded, placebo-controlled evaluation of idiopathic epilepsy cases refractory to traditional management.⁸⁴

This study included dogs currently being given the anti-epileptics potassium bromide, phenobarbital, levetiracetam, zonisamide, or a combination thereof, without other comorbidities. Dogs were randomized to receive either chicken-flavored placebo hemp oil or CBD-rich hemp oil containing 100 mg/mL CBD with other trace cannabinoids. Dogs were given doses of 2.5 mg/kg every 12 hours and continued on their existing anti-epileptics throughout the 12-week trial. Bloodwork was performed every four weeks to assess CBC, serum biochemical parameters, serum bromide and phenobarbital concentrations, and plasma CBD concentrations. Owners recorded in diaries the number, type, and length of seizures on a monthly basis. The mean monthly frequency of seizures for 16 weeks prior to initiating the study provided the reference for determining a significant response. A significant response was defined as a 50% or greater reduction in seizures. Behavioral assessments were conducted at week zero and 12.

Twenty-six dogs met the criteria for enrollment; 12 were allocated to the CBD-rich hemp oil group and 14 to the placebo oil group. Seventeen of the 26 dogs completed the study; nine in the CBD-rich hemp oil group and eight in the placebo oil group. Dogs were withdrawn from the study due to anti-epileptic drug alterations during the protocol (three in the placebo group), euthanasia due to status epilepticus (one in the CBD group), and ataxia (two in the CBD group). After data were collected, one dog in the placebo oil group was found to have been given CBD oil by its owner during the protocol period, resulting in nine dogs in the CBD-rich hemp oil group and seven dogs in the placebo oil group that continued to meet the study criteria. The 26 dogs were on a vast array of anti-epileptic drug combinations, which were maintained during the study. The median seizure number per month prior to study initiation averaged four and decreased to 2.7 for dogs in the CBD-rich hemp oil group, while dogs in the placebo group remained at two per month prior to and after study initiation. Two dogs in each group met the 50% or more reduction in seizures objective during the three-month trial. The only change in blood work was a significant rise in serum concentration of ALP of approximately 400 U/L with one dog having a serum concentration as high as 1,450 U/L.⁸⁴

Concentrations of CBD in plasma were measured at each of the four-week visits so the mean concentrations for each patient could be assessed against the percent seizure reduction. Plasma concentrations ranged between 150 and 975 ng/mL for the nine patients given CBD-rich oil. Regression analysis suggested a significant association between plasma CBD concentration and seizure reduction. Additionally, serum assessments did not detect alterations in phenobarbital concentration for the seven such patients in the CBD-rich oil group. Significant differences in aggression, fear, anxiety, trainability, excitability, or energy were not reported for dogs in the treatment group. The results of this study suggest promise for this CBD-rich hemp oil product, and further studies in which dose is increased to that mimicking what is used in human seizure control studies are worth pursuing.⁸⁴

PRECLINICAL SAFETY STUDIES OF CBD IN DOGS

Several of the previously-mentioned pharmacokinetic and clinical studies (see “Pharmacokinetic studies involving administration of isolated CBD or CBD-rich hemp products to dogs” and “Clinical investigations of canine osteoarthritis and epilepsy”) have described the profile of adverse effects noted in their study participants. However, these observations have not adequately addressed safety, including the potential toxicity resulting from long-term use of CBD or CBD-rich hemp products for dogs ([see Section 5: Cannabis toxicosis in companion animals](#)). Preclinical safety studies performed prior to FDA approval of two CBD products, Sativex® and Epidiolex®, indicate no observable adverse effects level (NOAEL) of 100 mg/kg BW of CBD.⁹⁷ Reported side effects associated with 10, 50, or 100 mg/kg daily administrations included hepatocellular hypertrophy and weight loss, which were most common in dogs dosed at 100 mg/kg.⁹⁷

For dogs, investigations of toxicity were performed in 20 purpose-bred beagle dogs, examining CBD, THC, and an equal mix of CBD and THC in a dose escalation trial with at least three days between escalating doses.⁸⁷ Administration of THC and CBD/THC oils resulted in obvious neurological side effects for one dog in the THC group when the dose of THC reached 254 mg. Two dogs given the equal mix of THC/CBD also showed neurological side effects when CBD and THC doses reached 105 mg and 72 mg, respectively. CBD-rich hemp oil treatment (18.3 mg/mL CBD oil) given at an escalating dose every three days resulted in no apparent adverse events that were different from occasional gastrointestinal side effects that occurred at a similar frequency in the placebo group when CBD was given at approximately 62 mg/kg⁸⁷ ([see Section 5: Cannabis toxicosis in companion animals](#)).

CLINICAL INVESTIGATIONS OF CBD IN HORSES

Peer-reviewed publications describing the administration of CBD-rich hemp to horses were not identified. A single case report suggests CBD-rich hemp helped alleviate a mechanical allodynia problem.⁹⁸ A recent abstract describing a study at Murray State conducted by Porr et al. reports administration of a hemp-infused pellet providing approximately 250 mg CBD per horse (typical 400 to 500 kg horses) results in similar pharmacokinetics as found in dogs; however, peak serum CBD concentrations ranged between 1 and 6 ng/mL in serum at two hours after administration. These data suggest it may be possible to deliver CBD to horses, but the amount of CBD or the formulation in which it is delivered will need to be dramatically altered to achieve pharmacologically meaningful concentrations.⁹⁹

SECTION 4

ANALYTICAL TESTING AND QUALITY CONTROL IN THE CANNABIS INDUSTRY

In recent years manufacturers of cannabis-derived products have marketed an increasing variety of new cannabidiol (CBD) products, despite a lack of regulatory evaluation and approval of their safety or efficacy. In a study reported in 2019, 13 commercially available CBD oils intended for use in animals were analyzed and determined to have inaccurate label information compared to the actual chemical contents of the products.¹⁰⁰ This study also reported that 12 of the 13 products had greater than Canada's acceptable level of Δ^9 -tetrahydrocannabinol (THC) in hemp (<10 ppm).¹⁰⁰ Similarly, analyses by ConsumerLab and a report in the *Journal of the American Medical Association (JAMA)* revealed that many available CBD products contain different amounts of cannabinoids than indicated on their labels.^{101,102}

The purpose of this section is to briefly identify the substances evaluated in cannabis and cannabis-derived products to help ensure their safety and to describe the quality control (QC) measures that should be in place for laboratories that conduct analytical testing of cannabis-derived products. Reliable testing procedures will help ensure label accuracy.

Current areas of interest in testing the quality of cannabis are the concentration of intended chemical constituents, such as cannabinoids, flavonoids, and terpenes; as well as the concentration of undesirable contaminants, such as residual solvents, pesticides, herbicides, heavy metals, bacteria, and mycotoxins. When veterinarians are presented with cannabis-derived products it is valuable to inquire with manufacturers regarding which of these chemical constituents they test for and the analytical methods used to quantify them. **See Table 2** for a list of examples of the chemical constituents that may be found on the product label for which veterinarians should inquire with manufacturers.

QUALITY CONTROL OF ORGANIC COMPOUNDS IN CANNABIS

Hundreds or perhaps thousands of organic compounds can be found in cannabis plants. In this report, we describe the intended and unintended chemical constituents of cannabis-derived products and consider the relative merits of various analytical techniques in meeting the needs of potential consumers, including veterinary clinicians and pet owners who desire products of known safety and efficacy. Several contract testing laboratories across the United States serve a growing need for chemical analysis of cannabis-derived products. Considerable interstate inconsistency has emerged with respect to analytical processes as each state has adopted unique regulations, so we also consider which modern analytical technologies are preferred for the chemical analysis of the different constituents of cannabis and its many derived products.

Mass spectrometry

Mass spectrometry is the technique of choice for quality control within the pharmaceutical, food safety, and environmental industries. Mass spectrometry can play a critical role as both a sensitive and selective analytical technique for the accurate determination of intended and unintended compounds in cannabis. Although liquid chromatography-mass spectrometry (LC/MS) and gas chromatograph-mass spectrometry (GC/MS) techniques are used in some cannabis applications (*vide infra*), other less definitive techniques, such as liquid chromatography-photometric diode array (LC/PDA), gas chromatography-flame ionization detector (GC/FID), and near infrared spectroscopy are popular techniques in some laboratories.^{105,106} The following chemical

Certificate of Analysis: Substances of Interest		
Cannabis Constituents	Cannabinoids	Δ^9 -tetrahydrocannabinol (THC) cannabidiol (CBD), cannabichromene (CBC), cannabigerol (CBG) and cannabinol (CBN) tetrahydrocannabinolic acid (THCA) cannabidiolic acid (CBDA)
	Terpenes	limonene, myrcene, α -pinene, linalool, β -caryophyllene, caryophyllene oxide, nerolidol, and phytol.
Cannabis Contaminants	Residual Solvents	hexane, ethanol, butane, propane, chlorinated solvents
	Pesticides	azoxystrobin, bifentazate, etoxazole, imazalid and imidacloprid
	Heavy Metals	lead, cadmium, mercury, arsenic, magnesium, copper, chromium, and cobalt
	Bacteria	Salmonella, Shiga toxin producing E. Coli,
	Fungi	<i>Aspergillus flavus</i> , <i>Aspergillus parasiticus</i> .
	Mycotoxin	Aflatoxins B1, G1, G2, G21, OA

* This list is not meant to be exhaustive of all possible substances that may be found on a CoA of a cannabis derived product.

Table 2

constituents should be evaluated by reliable analytical techniques to help veterinarians interpret a product's certificate of analysis (CoA).

POTENCY: CANNABINOIDS

Eleven different phytocannabinoids (cannabinoids derived from plants) can be measured in cannabis plant material, including THC, CBD, cannabichromene (CBC), cannabigerol (CBG), and cannabinol (CBN), and the list grows constantly ([see Section 2: Cannabis pharmacology and the endocannabinoid system](#)).¹⁰⁷ Potency generally refers to the percentage of THC, CBD, or both in the plant material. However, tetrahydrocannabinolic acid (THCA), cannabidiolic acid (CBDA), and CBN are also measured routinely. **Figure 1** shows the structures of these and several related cannabinoid compounds.

Cannabis strains, or cultivars, may have varying compositions. Each cultivar contains a wide variety of chemical constituents present in different relative ratios.¹⁰⁸ At least 480 compounds have been identified in *Cannabis sativa* plants, including 90 phytocannabinoids and 120 terpenes.²⁰

A key component of accurate and precise analyses is specificity, or the selectivity of the detector used. Unfortunately, most current analytical methods used for phytocannabinoid potency testing involve high-performance liquid chromatography-photometric diode array (HPLC/PDA) and a calibration curve approach that is contrary to modern accepted regulated bioanalytical techniques in the pharmaceutical

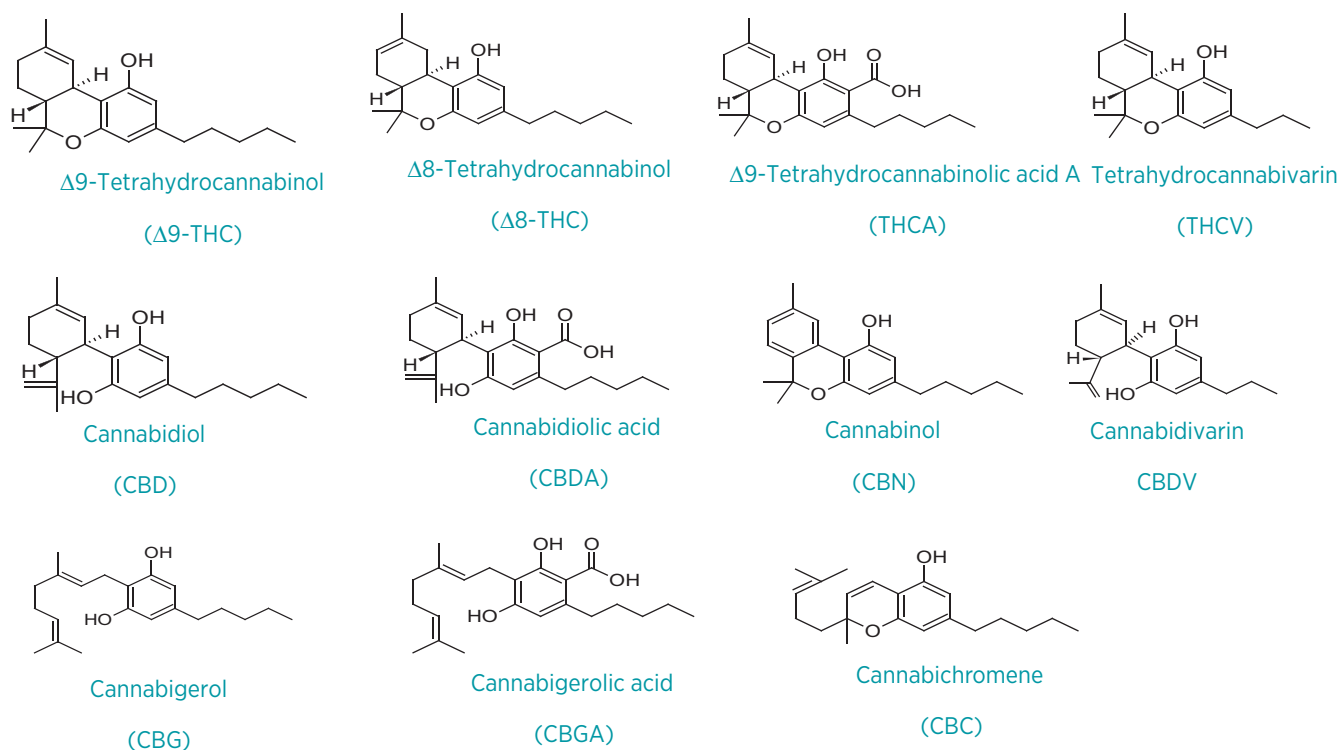


Figure 1. Chemical structures for 11 common cannabinoids found in cannabis plant materials.

and environmental industries. Use of HPLC/PDA for potency determination has the potential for a variety of errors.^{109,110}

TRICHOMES AND TERPENES

Trichomes are plant hairs that have glands that can secrete terpenes. Trichomes are important for the biosynthesis of botanical chemicals and are important in cannabinoid synthesis.¹¹¹ Fresh cannabis plants owe their familiar smell in part to terpene-related compounds.¹¹¹ Although terpenoids are not unique to cannabis, cannabis plants produce unique terpene profiles that, in combination with unique cannabinoid ratios, may determine some of their physiological (including medicinal) effects.¹⁰⁴ The quantitative analysis of terpenes is perhaps best done by either GC/MS or LC/MS/MS.

Terpenes commonly found in cannabis plants include limonene, myrcene, α -pinene, linalool, β -caryophyllene, caryophyllene oxide, nerolidol, and phytol. See **Figure 2** for representative terpene structures. ([See Section 2: Pharmacology and the endocannabinoid system.](#))

PESTICIDES

Pesticide residues rank high on the list of quality concerns in cannabis and cannabis-derived products, and can be challenging for manufacturers to control because cannabis growers often feel they need to use pesticides to mitigate damage by insects, mold, etc.¹¹² Cannabis samples from retail facilities in various states

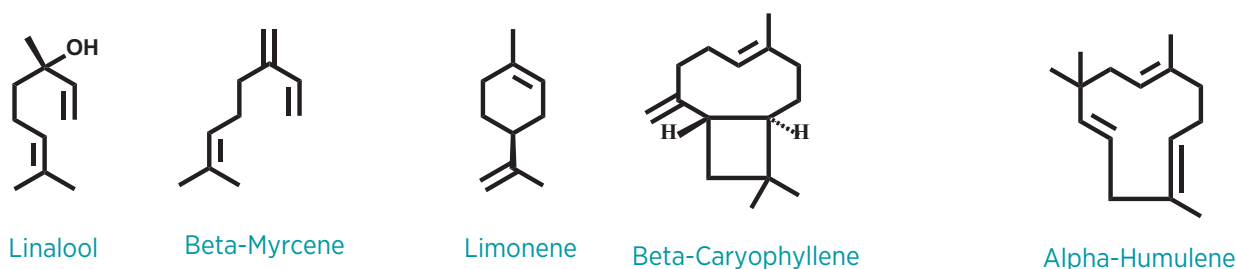


Figure 2. Representative terpene structures

where the sale of recreational marijuana has been legalized have reported contamination with insecticides, fungicides, rodenticides, and other pesticide compounds.¹¹³ Even though some cannabis is grown indoors with careful light, humidity, and temperature control, a variety of insect and bacterial pests can adversely affect the growth and quality of the plant before harvest. As a result, growers are tempted to use pesticides to control these problems; however, very few [pesticide products are registered for use on hemp](#).¹¹⁴ Extralabel use of pesticide products is not lawful under the [Federal Insecticide Fungicide and Rodenticide Act \(FIFRA\)](#), so if the pesticide is not approved for cannabis its use is likely illegal. Recalls of cannabis products in multiple states and Canada highlight the need for regulatory control.^{115,116,117}

Pesticide levels and cannabis product quality, in general, are particularly important if cannabis products are to be used for patients with already compromised health. Pesticides of interest include azoxystrobin, bifenthrin, etoxazole, imazalid, and imidacloprid.¹¹³ However, many pesticides are in use, and states have their own lists of those pesticides that must be monitored in cannabis samples. California, for example, currently has a list approaching 100 pesticides which must be monitored with “action levels” that reflect low part-per-billion lower limits of quantitation (LLOQ).¹¹⁸ This large number of pesticides, coupled with the need to quantify them at part-per-billion levels, may pose challenges to some cannabis testing laboratories. Different states may require testing for different pesticides, perhaps at different action levels.

In general, most state laboratories suggest use of LC/MS/MS techniques for the quantitative determination of trace levels of pesticides in cannabis and cannabis-derived products.¹¹⁹ This technology, coupled with recommended sample preparation techniques, may provide broad coverage with high sensitivity and selectivity for the quantitative determination of more than 100 pesticides.

MICROBIOLOGY

Cannabis is often grown in greenhouses under carefully controlled conditions, including warm temperatures with relatively high humidity. These are excellent conditions for the growth of a wide variety of bacteria, such as *Salmonella* and Shiga toxin-producing *E. coli*, and fungi, such as *Aspergillus flavus* and *Aspergillus parasiticus*. Accordingly, most states now require analysis for both microbial growth and byproducts of such growth. Microbiological contamination of cannabis plants and products is typically detected using either culture growth or quantitative polymerase chain reaction (qPCR) techniques.¹²⁰

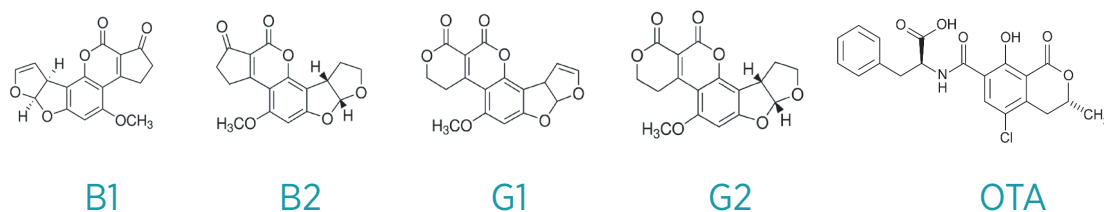


Figure 3A

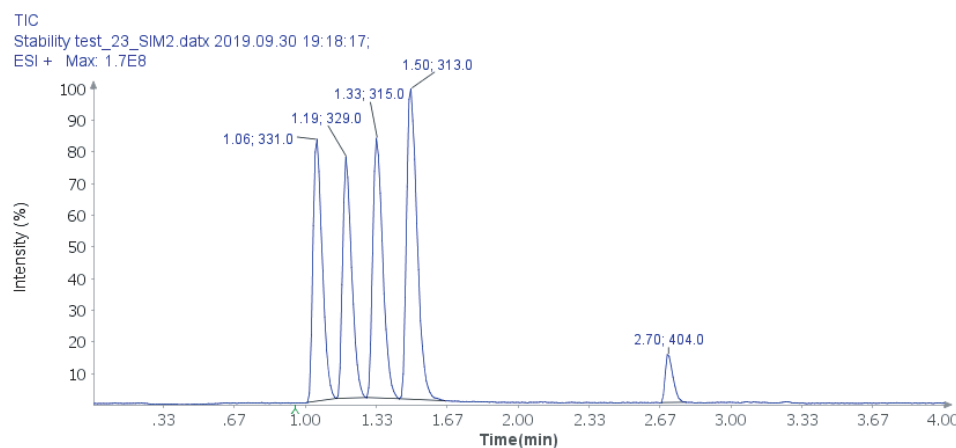


Figure 3B

Figure 3AB. Chemical structures for five targeted aflatoxins (A) and the SIM LC/MS total ion chromatogram obtained from the LC/MS analysis of a synthetic mixture of these five aflatoxins (B)

MYCOTOXINS

Mycotoxins, which are toxic secondary metabolites of mold, are a concern in cannabis plants because carcinogenic mycotoxins may also cause acute, chronic, or both types of toxicosis.¹⁰⁴ Aflatoxins are a subset of mycotoxins produced by *Aspergillus flavus* and *Aspergillus parasiticus*. Aflatoxin B₁ is considered the most toxic, but the presence of B₂, G₁, and G₂ must also be considered. **Figure 3** shows the structures for aflatoxins B₁, B₂, G₁, G₂, and OTA (ochratoxin A), which are often targeted in the chemical analysis of cannabis and its associated products. Although capillary GC/MS may be used, it is generally preferred that LC separations coupled with mass spectrometry be used for the quantitative determination of mycotoxins.

RESIDUAL SOLVENTS

When cannabinoids are extracted from the cannabis plant, particular solvents are used for the extraction process, and residual solvents often remain in the cannabis product. Some of these solvents include hexane, ethanol, butane, propane, and, in some cases, chlorinated solvents.¹⁰⁴ Many states require testing for solvent residuals via analysis of headspace (solvent that is evaporated from the sample and into the air) samples, using GC/FID. Although an alternative analytical technique for analysis of such headspace samples could be electron ionization gas chromatography/mass spectrometry (EI GC/MS), the lower equipment costs of GC/

FID may cause that approach to prevail for the foreseeable future. The difference in cost may be justified given the positive selectivity of MS detection in the event of any potential GC retention time deviations.

HEAVY METALS AND ICP-MS

Cannabis plants, both marijuana and hemp, are hyperaccumulators of inorganic heavy metals from the soil in which they grow. Among those heavy metals most commonly evaluated are lead, cadmium, mercury, and arsenic, although, depending which U.S. states are involved, this list may also include magnesium, copper, chromium, and cobalt. These latter metals are often found if the plant is grown near mining, smelting, sewage sludge, or automobile emission sites.¹²¹

Cannabis testing laboratories are adding a growing list of heavy metals to the analysis of cannabis and cannabis-derived products. Cannabis plant materials can be tested for heavy metals in many ways, including various forms of atomic spectrometry, among them: [atomic absorption](#) (AA), [inductively coupled plasma optical emission spectroscopy](#) (ICP-OES) and [inductively coupled plasma mass spectrometry](#) (ICP-MS). Experienced analytical chemists generally report that ICP-MS offers the best sensitivity and is the method of choice in many modern laboratories. For some important organometallic compounds, it can be useful to employ liquid chromatography inductively coupled plasma mass spectrometry (LC/ICP-MS) techniques that can allow detection and quantitation of individual organometallic compounds.¹²² The FDA and United States Pharmacopeia (USP) have standardized methods for heavy-metal analysis, which are very useful resources for the fledgling cannabis testing industry.¹²³

QUALITY CONTROL SAMPLING AND SAMPLE PREPARATION PROTOCOL FOR CANNABIS IN THE FIELD

A detailed analysis of sampling and sample preparation is beyond the scope of this resource. However, veterinarians should note that variation in sampling and sample preparation can contribute to inconsistent chemical profiles from samples from the same harvest. Regulatory employees, as well as laboratory employees, should follow local guidance or consider recent USDA guidance for sampling and sample preparation until further updates are published.¹²⁴ In the end, sampling protocols are not yet well defined or consistent, and each state tends to use their own interpretation of best practices. All this can reflect forward to the CoA of a cannabis-derived product that is intended for safe and efficacious use in a veterinary patient.

SUMMARY THOUGHTS

There is an urgent need for accurate and precise chemical analysis of both cannabis plant materials and final consumer products. The financial incentives in the cannabis industry are sufficiently great that both existing laboratories and startup laboratories are seeking new business opportunities. Some of these efforts do not include the rigor and professionalism practiced in the recent past by Good Laboratory Practices (GLP) laboratories meeting pharmaceutical industry and FDA requirements. In most cases the turnaround times for sample results are quite long because testing requires considerable manual intervention. Limited automation currently exists because of a lack of widespread focus on improving the workflow of cannabis analyses in laboratories. As a result, some growers and producers have submitted the same sample to two different laboratories and received different results. Rigorous, high-quality chemical analyses can reduce the risk of such inter-laboratory inconsistencies. Good examples to follow are those recommended by GLP procedures as well as approved methods and guidance provided by well-established organizations such as the International Organization for Standardization/International Electrotechnical Commission (ISO/IEC)

17025,¹²⁵ [AOAC](#) (Association of Official Agricultural Chemists), A2LA (American Association of Laboratory Accreditation),¹²⁶ and individual state departments of health, agriculture, or both.¹¹⁹ In other rigorous laboratory testing arenas, such as the regulation of the use of performance-enhancing substances in athletes, an independent organization will submit blind samples to the laboratory for chemical analysis. This is called proficiency testing and assures the industry that the laboratory is competent. This also would be one way for a veterinarian evaluating a cannabis product to be comfortable that the potency of the product is as indicated on the label and contaminants are unlikely.

Although mass spectrometry techniques are currently used to some extent in the cannabis industry, some suggest they should be more widely adopted to achieve the superior selectivity and sensitivity demanded by the chemical complexity and diversity of the plant, its many products, and many potential contaminants. Quality testing is necessary for the production and sale of consistently safe products needed to earn consumer confidence. When well-qualified analytical service laboratories are in place and used for monitoring the chemical safety and integrity of cannabis and cannabis-derived products, wider acceptance, use of approved products, and more success in their use to treat medical ailments in humans and animals is likely.

SECTION 5

CANNABIS TOXICOSIS IN COMPANION ANIMALS

Reported cases of cannabis toxicosis in companion animals are primarily associated with exposure to Δ^9 -tetrahydrocannabinol (THC). Such cases have become more common as recreational and medical marijuana products have become legal to some degree for human use in most states.¹²⁷ Most cases of cannabis exposure to date have affected companion animals and horses. This review, however, focuses on exposures in companion animals because there is limited data regarding cannabis exposure and subsequent potential toxicoses in horses.

Historically, cannabis toxicoses have been associated with exposure to marijuana plant material. However, a wide variety of edible products are also now readily available. Edible products often are made by extracting lipid-soluble THC from cannabis plant material and adding it to butter or oil. These edible products are now the most common source of companion-animal exposures to THC, due to both high palatability and very high concentrations of THC.¹ Recently, veterinarians are seeing an increase in companion animal toxicoses resulting from exposures to vaping devices containing THC or cannabidiol (CBD).¹ In addition, the concentration of THC in marijuana plants raised for recreational products has increased significantly over time.¹

Dogs account for most exposures reported to animal poison control centers, but cats and other companion animal species also have been affected.¹²⁸ Toxicoses have been documented for dogs of all ages, although younger dogs are most likely to be affected.¹²⁹ The clinical presentation, exposure types, diagnosis, therapy, and prognosis of cannabis toxicosis in companion animals follows.

CLINICAL PRESENTATION

Dogs may be more sensitive to the psychoactive properties of THC than humans due to a larger number of cannabinoid receptors in the canine brain.¹³⁰ However, the minimum lethal dose of THC is high (greater than 3 to 9 grams of plant material per kilogram), and an LD₅₀ has not yet been established.¹²⁸ Although such dosages are calculated based on measurements of plant materials, veterinarians should note the THC content of plant material can vary considerably ([see Section 4: Analytical testing and quality control in the cannabis industry](#)). Depending on the route of exposure, clinical signs may become evident within minutes (if inhaled) to hours (if ingested).¹ Clinical signs are most commonly seen within one to three hours after ingestion, although delays of up to 12 hours are reported.¹²⁹ THC is primarily eliminated in the feces via the biliary system and therefore undergoes enterohepatic recirculation, which can prolong elimination. Recovery from toxicosis normally occurs within 24 hours in most cases, but clinical signs may persist up to 96 hours depending on the exact THC exposure (longer periods of clinical effect tend to be associated with edibles).^{1,129}

THC toxicosis in companion animals has high morbidity, but low mortality. The most common clinical signs in dogs are ataxia/incoordination and lethargy/depression. Other common clinical signs are vomiting, urinary incontinence/dribbling, increased sensitivity to motion or sound (often manifested as flinching), head bobbing, mydriasis, hyperesthesia, ptialism, and bradycardia. Other, less common clinical signs include agitation, aggression, bradypnea, hypotension, tachycardia, and nystagmus. Hypothermia is more common, but hyperthermia can occur.

Cats are less often affected. A single case report in the literature describes disorientation, alternate periods of agitation/aggression and apathy, polyuria, polydipsia, and periods of polyphagia mixed with periods of inappetence.¹³¹

SYNTHETIC CANNABINOID EXPOSURE

“Synthetic cannabinoids” typically are designer recreational drugs that became popular in the 2000s and have a higher affinity for cannabinoid receptors in the brain than THC. These compounds either are sprayed on dried plant material to be smoked, or are sold as liquids to be vaporized and inhaled in e-cigarettes and other inhalant devices. Synthetic cannabinoids are more likely than marijuana-derived THC products to cause serious toxicosis in both people and animals.^{132,133} In dogs, signs may include hyperesthesia, aggression, inappropriate mentation, tremors, and seizures.^{132,133} In one case, signs progressed to a comatose condition with apnea, tremors, and opisthotonos.¹³² Also of concern is that these products may be laced with other chemicals or drugs, including caffeine or other stimulants. Recently, synthetic cannabinoids contaminated with rodenticides led to a multistate outbreak of severe coagulopathy in humans. Fortunately, no animal patients were affected during the outbreak, but pesticide contamination should be considered in cases of synthetic cannabinoid exposure.¹³⁴

CBD PRODUCT EXPOSURE AND CONSIDERATION OF DRUG INTERACTIONS

CBD is currently the cannabinoid of greatest therapeutic interest in veterinary medicine. CBD products recently have become widely available, and a multitude of products are marketed for companion animals. These products have become more accessible with the recent removal of hemp (defined as *Cannabis sativa* and derivatives of cannabis with less than 0.3% Δ^9 -tetrahydrocannabinol [THC] on a dry weight basis) from the [Controlled Substances Act](#) (see [Section 6: Regulatory overview of use of cannabis-derived products in animals](#)).² However, quality control and evaluation of such products has been limited (see [Section 4: Analytical testing and quality control in the cannabis industry](#)). The Pet Poison Helpline reports that up to 45% of CBD exposures reported to that organization required veterinary intervention.¹³⁵ Current thinking is that this may reflect contamination of the products with THC or other substances rather than the effects of CBD itself. However, further investigation is needed.¹³⁵ Elevations in liver enzymes have consistently been reported, although preliminary pharmacokinetic studies of relatively small numbers of dogs have indicated a general tolerance to CBD over a 6-week period with oral, transdermal, and transmucosal administration.^{82,84}

Research into the short- and long-term effects of CBD on veterinary patients is needed. One issue of concern to veterinary practitioners is any potential interaction between CBD and FDA-approved drugs used in practice. The human literature reports both inhibition and potentiation of metabolizing enzymes by CBD and THC, which can impact blood concentrations of FDA-approved drugs. Potential interactions with FDA-approved drugs used in people that are also used in an extralabel manner by veterinarians include warfarin, tacrolimus, theophylline, ketoconazole, and zonisamide.^{136,137} Investigations of similar or additional drug interactions with THC, CBD, or both are needed for companion animal species.

DIAGNOSIS

Diagnosis of THC toxicosis is most often made based on clinical signs and a history of possible exposure. With regard to the latter, thorough and tactful history-taking is important to get accurate information from animal owners. In states where recreational marijuana use is legal, clients may be more willing to admit to

the possibility of such exposure. However, there have been cases where the clients were unaware of potential exposure (e.g., dogs that had ingested cannabis while playing in a park or while on a walk through an apartment complex), and it also is important to rule out other possible toxins that may mimic the signs of THC toxicity. Urine dribbling is uncommon after exposure to most other toxins, so the presence of this sign should increase suspicion of THC toxicosis.

Over-the-counter human urine drug tests are generally unreliable for the diagnosis of THC exposure in companion animals.¹ For dogs, while a positive urine drug test is typically supportive of THC exposure, false positives are possible (e.g., in humans, the presence of NSAIDs such as ibuprofen and naproxen may cause false positives on the THC test). In addition, false negatives are very common. Dogs excrete different urine metabolites than humans, which may account for the latter finding. False negatives can also occur if the test is run too soon following exposure, as a result of errors in sample collection and storage (THC binds to glass and rubber stoppers), or due to dilute urine secondary to increased water consumption by the patient. Additionally, it is important to keep in mind that synthetic cannabinoids are not detected by urine THC tests.¹

Other toxins that may cause signs similar to THC include alcohols, ethylene glycol, benzodiazepines, muscle relaxants, opiates, tranquilizers, ivermectin or other macrocyclic lactones, bromethalin, and other hallucinogenic substances. In some patients, other diseases can cause similar CNS signs and a thorough diagnostic workup is indicated in cases where clinical signs are progressively worsening or do not resolve after 24 to 48 hours of symptomatic/supportive care.¹

TREATMENT

Treatment is largely symptomatic and supportive, and depends on the severity of clinical signs. Emesis can be considered in companion animals with a history of recent cannabis ingestion that are not showing clinical signs. Emesis should not be induced in companion animals exhibiting clinical signs due to the risk of aspiration.^{1,128} For companion animals with significant clinical signs where there is concern about a large amount of cannabis-containing material remaining in the stomach (e.g., wads of buds, large quantity of brownies containing marijuana butter), gastric lavage is a safer, and thus preferred, option. Gastric lavage should be performed under sedation with an inflated endotracheal tube to prevent liquid from entering the airway. Activated charcoal can be given through the orogastric tube following lavage.

Activated charcoal can be given to companion animals that are still alert and that have an intact gag reflex. An anti-emetic (e.g., maropitant, ondansetron) should be administered to prevent vomiting of the charcoal provided there is not concern for a foreign body obstruction. Due to enterohepatic recirculation, multiple doses of activated charcoal (two to three) given every eight hours may be beneficial if clinical signs persist.¹²⁸ If multiple doses of activated charcoal are given, companion animals should be hospitalized with administration of intravenous fluids and evaluation of electrolyte concentrations prior to administering each dose of charcoal to prevent development of hyponatremia. Use of activated charcoal may not be necessary in all cases, and the benefits of its use should be weighed against potential risks (e.g., vomiting and aspiration, hyponatremia, dehydration).¹

In mild cases of toxicosis, where patients remain alert, ambulatory, normotensive, normothermic, and with no cardiovascular effects, outpatient monitoring and supportive care may be appropriate. Patients that are more severely affected should be hospitalized. Anti-emetics should be considered to prevent vomiting and aspiration, especially in patients that are recumbent or non-responsive. Balanced crystalloid therapy

is used to maintain hydration and perfusion, although intravenous fluid therapy has not been shown to hasten recovery. Anxiolytics (e.g., diazepam, butorphanol, acepromazine) can be used for patients who are agitated, tachycardic, and/or hypertensive.^{1,128} Acepromazine should not be used in hypotensive patients.¹ Good supportive care, including thermoregulation, is necessary. Monitoring should include assessing temperature, heart rate, blood pressure, and rate and quality of respiration. Patients that are comatose and/or hypoventilating may need to be intubated and mechanically ventilated. Atropine may be used in bradycardic patients (HR 40 to 50 bpm).¹

Although intralipids have been used in more severe cases of toxicosis, especially if edibles or oils are involved, clinical results have been mixed, especially without prior emptying of the gastrointestinal tract.^{127,132} At this time, the clinical efficacy of intralipids has not been demonstrated via controlled studies. Intralipids may also bind other drugs that may be indicated to treat clinical signs (e.g., diazepam).¹ Dosing for the use of intralipids in veterinary medicine has been extrapolated from human use. Protocols include administration of a 20% solution, 1.5 to 4 ml/kg intravenously over one minute, followed by 0.25 mg/kg/min, over 30 to 60 minutes, or re-dosing of aliquots of 1.5 ml/kg every four to six hours for up to 24 hours.¹³⁸

PROGNOSIS

Prognosis for recovery from THC toxicosis is generally good. However, life-threatening toxicosis is possible, and fatalities have occurred.¹ Causes of fatality have included secondary complications, such as combined toxicities (e.g., THC and chocolate toxicity from ingestion of edibles, multiple medications or illicit drugs) or aspiration, and insufficient financial resources to support necessary therapy (e.g., comatose patients that require mechanical ventilation).

SECTION 6

REGULATORY OVERVIEW OF THE USE OF CANNABIS-DERIVED PRODUCTS IN ANIMALS

Regulation of cannabis and cannabis-derived products at the state, federal, and international levels continues to evolve. At the federal level, this document focuses on the roles of the U.S. Department of Agriculture (USDA), Food and Drug Administration (FDA), and Drug Enforcement Agency (DEA), although other agencies may have authority to regulate the promotion, manufacturing, distribution, and use of cannabis products. The regulatory approach at the state level is highly variable.

We first present a reminder of the regulatory definitions of cannabis, hemp, and marijuana, and follow with an overview of the federal regulatory landscape, as well as information about state and international regulatory activities.

DEFINITIONS

“Cannabis” is the name of a group of plants that, depending on their Δ^9 -tetrahydrocannabinol (THC) concentration, are further defined as either “hemp” or “marijuana.” Cannabis is a genus of flowering plants in the family Cannabaceae, of which *Cannabis sativa* is a species, and *Cannabis indica* and *Cannabis ruderalis* are subspecies. Cannabis refers to any form of the plant where the THC on a dry weight basis has not yet been determined to allow categorization of cannabis as hemp or marijuana. “Cannabis” is important in describing regulations that apply to plant production, sampling or handling prior to determining its THC content.⁴

“Marijuana” is cannabis that has a THC level exceeding 0.3 percent. Marijuana remains classified as a schedule I controlled substance regulated by the DEA under the Controlled Substances Act (CSA).³

“Hemp” is defined in the Agricultural Improvement Act of 2018 (Farm Bill 2018) as the plant species *Cannabis sativa* and any part of that plant, including the seeds and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a Δ^9 -tetrahydrocannabinol (THC) concentration of not more than 0.3 percent on a dry weight basis.²

CANNABIS REGULATION AT THE FEDERAL LEVEL

On October 31, 2019, the USDA Agricultural Marketing Service published an [interim final rule](#), as mandated by the [Agriculture Improvement Act of 2018](#), that established rules and regulations to produce hemp.⁴ The rule describes the process for USDA approval of plans submitted by states and indigenous tribes for the domestic production of hemp, including provisions for maintaining information on the land where hemp is produced, testing the concentrations of THC, disposing of plants not meeting necessary requirements, licensing requirements, and ensuring compliance with new requirements.

Hemp cultivated under state and tribal plans will serve as the starting material for hemp-derived consumer products that are regulated by the FDA. The [Federal Food Drug and Cosmetic Act](#) (FDCA) authorizes FDA to obtain evidence of safety for new drugs, issue standards for food, and conduct factory inspections.¹³⁹ On July 22, 2020 FDA released draft guidance, [“Cannabis and Cannabis-Derived Compounds: Quality Considerations](#)

[for Clinical Research; Draft Guidance for Industry](#)". This guidance addresses quality considerations such as sourcing compounds for clinical research and calculation of percent (THC) in botanical raw materials, extracts, and finished products. However, this draft pertains to the development of cannabis derived products intended for human use only and does not pertain to products intended for animals.¹⁴⁰

Questions often arise as to whether cannabis-derived products are regulated as drugs, food, food additives, or dietary supplements. Here we discuss these terms in the context of their application to veterinary patients, as well as the current approach to enforcement for products available in the marketplace.

Cannabis-derived products regulated as drugs

"Drugs" are defined in the FDCA as articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals, and articles (other than food) intended to affect the structure or any function of the body of man or animals.¹⁴¹ "New animal drug" means any drug intended for use for animals other than people, including any drug intended for use in animal feed that is not generally recognized as safe and effective.¹⁴²

"Intended use" is an important concept. FDA defines [intended use](#) as "... the objective intent of the persons legally responsible for the labeling of drugs"—most often the pharmaceutical sponsor. FDA indicates "the intent is determined by such persons' expressions or may be shown by the circumstances surrounding the distribution of the article."¹⁴³

When a pharmaceutical sponsor begins drug development and investigates a substance for therapeutic potential and safety in animals, the [new animal drugs for investigational use regulations](#) apply.¹⁴⁴ Following successful demonstration that the [technical requirements](#) have been met (e.g., chemistry, manufacturing and controls, target animal safety, human food safety [if applicable], environmental impact, effectiveness, labeling, freedom of information summary), the drug sponsor normally submits a [new animal drug application](#).^{145,146} After the application has been approved by the Center for Veterinary Medicine (CVM) at FDA, the pharmaceutical sponsor may then legally market the drug. It is illegal to market a drug for use in non-human animals prior to FDA approval, conditional approval, or indexing.ⁱ

With respect to cannabidiol (CBD), the FDA [states](#) "...any product intended to treat a disease or otherwise have a therapeutic or medical use, and any product (other than a food) that is intended to affect the structure or function of the body of humans or animals" is a drug. The FDA has not approved any CBD products other than [one prescription human drug product](#) to treat rare, severe forms of epilepsy.^{147,64} There is very limited information for other marketed CBD products, which likely differ in composition from the FDA-approved product and have not been evaluated for potential adverse effects on the body.⁶⁴

As of the date of this report, Epidiolex®, containing cannabidiol, is the only cannabis-derived product approved by the FDA.ⁱⁱ Epidiolex® is approved for use in people under Section 505 of the FDCA; however, under the Animal Medicinal Drug Use Clarification Act (AMDUCA) it may be prescribed by veterinarians for use in animals (extralabel use) as long as the Extralabel Drug Use regulations in [21 CFR Part 530](#) are met.¹⁴⁸

ⁱ Articles meeting the definition of a new animal drug that also meet the definition of an animal biologic or pesticide, after inter-agency jurisdiction discussions, may be legally marketed after appropriate regulatory review by the USDA Center for Veterinary Biologics (CVB), or U.S. Environmental Protection Agency (EPA), respectively.

Therefore, under AMDUCA, Epidiolex® remains the only cannabis-derived drug available for extralabel use by veterinarians. For completeness, there are also some FDA-approved THC-related drugs that may be used for veterinary patients under AMDUCA, including Marinol® and Syndros®, which contain dronabinol, a synthetic THC. CBD unapproved drug products have recently been recalled.¹⁴⁹

CANNABIS-DERIVED INGREDIENTS IN ANIMAL FOOD OR FEED

“Food” under the FDCA means “articles used for food or drink for man or other animals, chewing gum, and articles used for components of any such article.”¹⁵⁰ “Animal feed” means “an article which is intended for use for food for animals other than man and which is intended for use as a substantial source of nutrients in the diet of the animal, and is not limited to a mixture intended to be the sole ration of the animal.”¹⁵¹ The [FDA has indicated that CBD or THC cannot be an ingredient of a food product](#) because:

“...it is prohibited to introduce or deliver for introduction into interstate commerce any food (including any animal food or feed) to which has been added a substance which is an active ingredient in a drug product that has been approved under section 505 of the FD&C Act [21 U.S.C. § 355], or a drug for which substantial clinical investigations have been instituted and for which the existence of such investigations has been made public.”^{152,153}

“There are exceptions, including when the drug was marketed in food before the drug was approved or before the substantial clinical investigations involving the drug had been instituted or, specifically in the case of animal feed, that the drug is a new animal drug approved for use in feed and used according to the approved labeling. However, based on available evidence, FDA has concluded that none of these is the case for THC or CBD. FDA has therefore concluded that it is a prohibited act to introduce or deliver for introduction into interstate commerce any food (including any animal food or feed) to which THC or CBD has been added.”

[It is possible for FDA to make an exemption to this rule](#), but thus far, FDA has not done so.¹⁵³

The Association of American Feed Control Officialsⁱⁱⁱ (AAFCO) maintains an official publication (OP) that includes the most comprehensive list of ingredients approved by AAFCO for use in pet food or animal feed. The AAFCO does not maintain a forbidden list of ingredients because if an ingredient is not approved for use it is forbidden. The AAFCO has indicated that it has received no applications for cannabis-derived substances to be included in its OP as feed ingredients.¹⁵⁴ Therefore, as of the date of this report, there are no cannabis-derived substances approved at the federal level for use in pet food or animal feed.¹⁵⁴

FDA has [responded with “no questions”](#) to petitions for three hemp seed-derived products: hemp seed oil, hemp seed protein, and dehulled hemp seed. However, the response for these food additives was specific for human food only, not animal feed or food.¹⁵⁵

ⁱⁱ Dronabinol is a synthetic cannabinoid reported as not derived from cannabis so was not included here.

ⁱⁱⁱ The Association of American Feed Control Officials (AAFCO) is a voluntary membership association of local, state and federal agencies. Members are charged by local, state or federal laws to regulate the sale and distribution of animal feeds and animal drug remedies. FDA and local and state agencies all play a role in regulating pet food and participate in the AAFCO.

Cannabis-derived substances as food additives

“Food additive” means “any substance the intended use of which results or may reasonably be expected to result, directly or indirectly, in its becoming a component or otherwise affecting the characteristics of any food ... if such substance is not generally recognized ... to be safe under the conditions of its intended use”¹⁵⁶ Analogous to a new animal drug application, an approved [food additive petition](#) is needed for the food additive to legally enter the marketplace. A food additive petition describes target animal safety, environmental impact, utility, and labeling.¹⁵⁷

Included in its list of permissible food ingredients in pet food or animal feed, the AAFCO maintains a list of FDA-approved food additives for use in animal feed within the AAFCO official publication. As is the case for food ingredients, AAFCO has indicated that no applications for cannabis-derived substances to be approved in pet food or animal feed as food additives have been submitted. Although the scope of this resource is limited to the use of cannabis products in companion animals, it is worth noting that to achieve approval for use in feed for food-producing animals, scientific evidence of appropriate withdrawal periods to limit consumer exposure to drug residues is also required.¹⁵⁴

Cannabis marketed as dietary supplements for animals

The [Dietary Supplement and Health Education Act of 1994](#) (DSHEA) provided a pathway to legally market vitamins, minerals, herbs or other botanicals, amino acids, a dietary substance for use by man to supplement the diet by increasing the total dietary intake, or a concentrate, metabolite, constituent, extract, or combination of these substances that do not meet the definition of a drug.¹⁵⁸ Manufacturers of such products must ensure that the product is safe, that the label claim is accurate, and that the products comply with all regulations including good-manufacturing-practice regulations of the FDCA. FDA indicates that DSHEA only applies to products for use in humans.¹⁵⁹ Therefore, if a product is marketed as a dietary supplement intended for animals, it is regulated by the FDA as either a drug or a food; there is no statutory language that defines “dietary supplements” for animals. The regulatory pathway for a particular product is determined by FDA CVM on a case-by-case basis.

“Dietary supplement” means a product other than tobacco that is intended to supplement the diet and bears or contains one or more of the following dietary ingredients: a vitamin mineral, an herb or other botanical, an amino acid, or a dietary substance for use by man to supplement the diet by increasing the total dietary intake. Regarding the use of CBD products marketed as dietary supplements, FDA has stated in association with cannabis warning letters: “Some of the products are marketed as dietary supplements. However, CBD products cannot be dietary supplements because they do not meet the definition of a dietary supplement under the FD&C Act.”¹⁴⁷

Similar to FDA’s analysis of CBD or THC in animal food or feed, the FDA has concluded that THC and CBD products are excluded from the dietary supplement definition under section 201(ff)(3)(B) of the FDCA.¹⁶⁰ Under that provision, if a substance (such as THC or CBD) is an active ingredient in a drug product that has been approved under section 505 of the FDCA [21 U.S.C. § 355], then products containing that substance are excluded from the definition of a dietary supplement. There is an exception to section 201(ff)(3)(B) if the substance was marketed as a dietary supplement or as a conventional food before the drug was approved or before the new drug investigations were authorized, as applicable. However, based on available evidence, FDA has concluded that this is not the case for THC or CBD.¹⁵³

Cannabis products and the Controlled Substances Act

Some FDA-approved drugs are also categorized or scheduled as controlled substances under the [Controlled Substances Act](#) (CSA).³ The scheduling of a controlled substance is based on its medical use, potential for abuse, and safety or dependence liability.³ Scheduled products are subject to enforcement by the DEA, along with the FDA's enforcement based on the intended use of the product as a drug. Controlled substances are scheduled into one of five schedules. Under the CSA, Schedule 1 drugs have no currently accepted medical use and are at the highest level of abuse potential, and Schedule 5 drugs carry the least abuse potential. The CSA prohibits the prescription, administration, or dispensing of any Schedule 1 substance, and at present marijuana is a Schedule 1 substance. As previously indicated, marijuana is defined within the CSA as all parts of the plant *Cannabis sativa*, the seeds, resin extracted from any part of the plant, and every compound, manufacture, salt, derivative or preparation of its seeds with several exemptions that has a THC concentration exceeding 0.3 percent.³

Hemp-derived products marketed for use in animals no longer fall under the oversight of the DEA unless the THC concentration exceeds 0.3% because the 2018 Farm Bill removed hemp from the definition of marijuana. Hemp-derived products, however, remain subject to oversight by FDA under the FDCA with respect to the FDA's evaluation of their intended use as either food or a drug.

Federal approach to enforcement of statute and regulations concerning cannabis products

As of the end of November 2019 the FDA had sent at least 22 [warning letters](#) to companies illegally selling CBD products because the companies claimed they could prevent, diagnose, treat, or cure disease.¹⁴⁷ Fifteen of these warning letters included mention of products targeted toward animals. In some cases, there were additional violations of the FDCA because these products were marketed as dietary supplements or because they involved the addition of CBD to food.¹⁶² In some cases, letters were co-signed by the Federal Trade Commission because of concerns about unsubstantiated advertising, which is a violation of the Federal Trade Commission Act.¹⁶¹

FDA indicates that, when deciding to take action, it considers [multiple factors](#), including agency resources and threats to public and animal health. The egregiousness of the label claim and any safety concerns associated with the product are key in determining those products for which it allocates enforcement resources.¹⁶² Examples of what FDA considers to be therapeutic claims associated with the marketing of CBD products for animals include language such as:

"...CBD and other chemicals found in cannabis have antitumor effects and could be used to improve standard treatments..."

"...Due to its anti-inflammatory effect, cannabinoids may provide relief of joint pain and swelling, and decrease joint destruction and disease progression..."

FDA also [communicates](#) with federal and state agencies when making decisions about whether to initiate federal [enforcement actions](#).^{162,163} The long-term availability of unapproved cannabis products (including CBD and other hemp-derived compounds) in the marketplace will ultimately be determined by FDA enforcement actions targeting such products.

CANNABIS REGULATION AT THE STATE LEVEL

Various states have legalized medical marijuana, recreational marijuana, or both for human use only. Currently, these laws do not authorize veterinarians to prescribe or recommend medical marijuana for dogs or cats in any state. However, there are bills that have been signed into law that may impact the use of cannabis-derived products in companion animals. Some states have adopted laws defining “hemp” and “marijuana” similarly to the federal definitions and, in some instances, including language indicating products derived from hemp may be intended for human or animal consumption.¹⁶⁴ Some states also have passed legislation regarding manufacturing and labelling requirements for such products.¹⁶⁵

In certain states veterinary medicine has received greater legislative attention, such as in California’s adoption of [AB 2215](#), which states that the board of veterinary medicine is prohibited from disciplining or revoking a veterinarian’s license solely for discussing the use of cannabis in an animal for medicinal purposes but also prohibits a licensed veterinarian from dispensing or administering cannabis or cannabis products to an animal patient.¹⁶⁶ This legislation also required the board to adopt [guidelines](#) for these discussions including conveying the risks associated with such products and, in many cases, their lack of regulatory evaluation for safety and efficacy.¹⁶⁷ For information on a specific state’s approach to regulating cannabis-derived products for veterinary patients, veterinarians should consult their state’s veterinary practice act and pharmacy act, and also should inquire with their state board of veterinary medicine.

CANNABIS REGULATION AT THE INTERNATIONAL LEVEL

The World Health Organization (WHO), which sits within the United Nations (UN), is responsible for, among other human-health-related activities, promoting global access to safe and effective medicines for people while preventing or mitigating substance abuse risks and illicit drug trafficking. The WHO [Expert Committee on Drug Dependence](#) (ECDD) is tasked with reviewing psychoactive substances, including cannabis and cannabis-related substances, and making recommendations to the UN [Commission on Narcotic Drugs](#) (CND) regarding appropriate controls needed to address potential risks.^{168,169} The CND is then charged with making final decisions on whether to place narcotic drugs and psychotropic substances under international control in compliance with three ratified drug control conventions.

Cannabis and cannabis-related products are regulated internationally by the CND in compliance with two of the three ratified drug control conventions: the [1961 Single Convention on Narcotic Drugs](#) and the [1971 Convention on Psychotropic Substances](#).^{170,171} In accordance with these conventions, however, UN member states, including the United States, must pass their own laws giving federal agencies enforcement authority. The U.S. Controlled Substances Act does so and largely complies with the obligations set forth in these international drug control conventions. Over the past several years, international scheduling of cannabis and cannabis-related products has undergone an extensive review by both the WHO ECDD and UN CND. Currently, cannabis resin and extracts and tinctures of cannabis are all listed under the least restrictive Schedule I of the [1961 Single Convention on Narcotic Drugs](#), with cannabis and cannabis resin also listed under the most restrictive Schedule IV.¹⁷⁰ This approach differs from that of the U.S. Controlled Substances Act, which places the most restricted substances that carry the greatest concerns for illicit use into Schedule 1 and places the least restricted substances into Schedule 5. Drugs placed in Schedule IV of the 1961 Convention include those with significant abuse and dependency potential—for example, opioids such as heroin and fentanyl. Man-made THC, or dronabinol, and its stereoisomers are currently listed under Schedule II of the [1971 Convention](#).¹⁷¹ Because the 1971 Convention uses a different system than that used in the 1961 Convention

to assign public health risk—and hence restrictions on use—to each schedule, drugs included under Schedule II of the later document are considered a greater public health risk than are drugs included under Schedule II of the 1961 document.

During its 40th [meeting](#) in June 2018, the ECDD concluded that cannabidiol (CBD) does not have psychoactive properties and, therefore, has no potential for abuse or development of dependency.¹⁷² As such, the ECDD recommended that pure CBD not be placed under international control. In November 2018 during its 41st [meeting](#), the ECDD recommended deleting cannabis and cannabis resin from Schedule IV of the Single Convention on Narcotic Drugs (1961), which would not impact their continued inclusion in the less restrictive Schedule I list.¹⁷³ Additional ECDD recommendations from that meeting effectively lessened restrictions on cannabis extracts and tinctures, as well as THC (either naturally derived or man-made) and its isomers. The [WHO recommendations](#) derived from the 40th and 41st ECDD meetings in 2018 were forwarded to the CND for consideration at its [62nd session in March 2019](#).¹⁷⁴ However, the CND did not take definitive action on these recommendations at that time, citing the need for further review and to provide UN member states the opportunity to comment. Additional stakeholder meetings were held later in 2019, and the recommendations were put before the CND again when it convened its 63rd session in January 2020. Again, no action was taken by the CND at that meeting. The WHO recommendations to amend the scheduling of cannabis and cannabis-related substances are on the agenda again for potential action at the next meeting of the CND, which is scheduled for December 2020.

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ADDITIONAL RESOURCES

FDA

Cannabis-related webpages

[FDA Regulation of Cannabis and Cannabis-Derived Products, Including Cannabidiol \(CBD\)](#)

[FDA Regulation of Dietary Supplements & Conventional Food Products Containing Cannabis and Cannabis Derived Compounds](#)

[FDA warns 15 companies for illegally selling various products containing cannabidiol as agency details safety concerns](#)

[FDA Warns Companies Illegally Selling CBD Products to Treat Medical Conditions, Opioid Addiction Warning Letters and Test Results for Cannabidiol-Related Products](#)

Links to regulations

Human food

[Substances Generally Recognized as Safe](#)

[Direct Food Substances Affirmed as Generally Recognized as Safe](#)

[Indirect Food Substances Affirmed as Generally Recognized as Safe](#)

Animal food

[Food Additives Permitted in Feed and Drinking Water of Animals](#)

[Substances Generally Recognized as Safe](#)

[Food Substances Affirmed as Generally Recognized as Safe in Feed and Drinking Water of Animals](#)

Animal drug

[Extralabel Drug use in Animals](#)

DEA

[DEA announces steps necessary to improve access to marijuana research](#)

[Clarification of the New Drug Code \(7350\) for Marijuana Extract](#)

[List of Controlled Substances](#)

[Marijuana](#)

USDA

[USDA Agriculture Marketing Service – Interim Final Rule](#)

[USDA National Institute of Food and Agriculture – Industrial Hemp](#)

AAFCO

[Questions and Answers Concerning Pet Food Regulations](#)

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