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Comment

Limiting the Escalation of Medical Cannabis Use. Comment on Hammad et al. Association Between Medical Cannabis Use and Substance Use Disorder in Patients with Dysuria: A Propensity-Score Matched Cohort Study Using Federated Network of Global Real-World Data. *Soc. Int. Urol. J.* 2026, *7*, 13

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The article by Hammad et al. [1] is an important piece of scholarship that presents concerning findings regarding the risk of developing a substance use disorder (SUD) among adults diagnosed with dysuria who have been prescribed medical cannabis (MC) for symptom management. In their large, representative and well-controlled study, the authors document that exposure to MC significantly increases short- and long-term risks related to the development of SUDs among patients with no history of SUDs. Specifically, the authors are able to demonstrate that exposure to MC results in close to a fivefold increase in the risk of a diagnosis of SUD over a one-year period, a disparity that appears to persist over time. While alarming, this finding is not surprising given substantial evidence that the initiation of opioid prescriptions and prescription continuation are significantly associated with an increased incidence of SUD diagnoses among both adolescents and adults [2,3].

The authors provide prescient guidance regarding the critical need for strategies to manage risk for the development of SUDs among patients prescribed MC, including the consideration of non-addictive pain medications, alternative pain management strategies and MC dosing guidance. In addition, the authors recommend limiting the prescriptions of MC in patients at high risk for the development of SUDs using provider-initiated risk assessments, the maintenance of ongoing screening and monitoring, and preventive patient education. The implementation of these concrete strategies may be effective in terms of interrupting the escalation of inappropriate MC use to the development of SUDs. Evidence from developmental science can supplement the risk management guidance provided by Hammad et al. [1].

The enhancement of health care providers' familiarity with the significant risk factors for the development of SUDs and, in particular, cannabis use disorder (CUD) is critical. In addition to assessments relating to male sex, and a past history of SUDs and other psychiatric disorders, patients should be assessed for additional developmental risk factors, including adverse childhood experiences (ACEs), the early onset of substance use, emotional dysregulation, a history of internalizing or externalizing problems, and personality traits such as impulsivity and sensation seeking [4–6]. Accumulating evidence underscores the value of a developmental systems perspective, in which risk and protective factors interact in a probabilistic manner, raising or lowering the cumulative likelihood of specific individuals manifesting a CUD diagnosis [7]. This perspective also emphasizes the possibility of multiple intervention points during different developmental periods [8,9].

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High-quality, brief, valid, and reliable screening tools exist in order to monitor patients prescribed MC for signs of the escalation of MC use and negative consequences, screeners that can easily be integrated into clinical service delivery. For example, the eight-item Cannabis Use Disorder Identification Test—Revised (CUDIT-R), the six-item Cannabis Abuse Screening Test (CAST), the two-item Screen of Drug Use (SoDU), and the Single-Item Screen—Cannabis (SIS-C) all demonstrate excellent psychometric properties and are brief enough to be used in clinical encounters with patients prescribed MC without an excessive time burden for either party [10–13]. These instruments can be integrated into broader SBIRT (Screening, Brief Intervention, and Referral to Treatment) initiatives to identify patients who manifest early signs of escalating MC use and connect them to appropriate intervention options. These or similar measures may be used in the context of SBIRT to increase patient participation and engagement in motivational interventions [e.g., motivational interviewing (MI) and motivational enhancement therapy (MET)] to reduce MC use by targeting important psychological barriers to CUD treatment utilization [14–16].

Published guidance for MC dosing, and patient safety considerations and patient education materials are currently available for translation into clinical practice, and customizations for specific groups of patients [17–19]. The translation of these materials into guidance for clinical interactions with patients and their implementation, as with screening and monitoring MC use, may be time consuming for primary care physicians. In integrated health care settings, however, these multiple forms of follow-up with MC-prescribed patients may be effectively accomplished by other health care professionals including nurses, health educators, social workers or mental health counselors [20]. The scope of the public health threat outlined by Hammad et al. [1] requires innovation, forward thinking and planning to reduce specific risk factors that increase the probability that patients prescribed MC will develop CUD in subsequent years.

Conflicts of Interest: The author declares no conflict of interest.

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