Smokers are at increased risk for panic attacks

The association between depression and smoking is well-established. Smokers are more likely to have a history of depression than nonsmokers, and persons with depression are more likely to start and continue smoking than those without a history of depression. Now there is evidence of a relationship between smoking and panic attacks. Breslau and Klein analyzed data from two epidemiologic studies, the Epidemiologic Study of Young Adults in Southeast Michigan (n=1007) and the National Comorbidity Survey-Tobacco Supplement (n=4411). They found that daily smoking increased the risk of new onset panic attacks and panic disorder, more so in active than past smokers. No increased risk of beginning smoking was detected in persons with prior panic attacks or disorder. Exploratory analyses suggested that lung disease might be a mechanism linking smoking to panic attacks.

Given these data and the accumulating evidence that there is an increased risk for developing major depression after smoking cessation (Tsah JY, Humfleet GL, Munoz RF, et al. Development of major depression after treatment for smoking cessation. Am J Psychiatry 2000; 157:368-74), physicians must be vigilant for the development of affective and anxiety symptoms in their smoking patients.
The Office of National Drug Control Policy commissioned a study by the Institute of Medicine to evaluate scientifically the claims that marijuana is medically useful. This paper summarizes the findings. There is evidence from both human and animal studies that cannabinoids can produce a significant analgesic effect. Compared with current antiemetics, marijuana and THC are only modestly effective and seldom used. Since cannabinoids’ are likely to act through different mechanisms than other antiemetics, there might be a role for a nonsmoking cannabinoid inhaler in patients whose nausea is not controlled by other agents. Cannabinoids may be promising for treating wasting syndrome in cancer and AIDS, by mitigating nausea, anorexia, pain, and anxiety. There are too few data to draw any conclusions about whether cannabinoids improve spasticity and other movement disorders. While marijuana does reduce intraocular pressure, it is not an appropriate therapy for glaucoma. Its benefit is short-lived and requires high doses with side effects; the risk benefit ratios of existing alternatives are much better.

The report also summarizes what is known about marijuana’s adverse effects. Long-term marijuana smoking, like tobacco, is associated with lung damage, increased risk of respiratory cancer, and poorer pregnancy outcomes. However it has not been proven (or disproven) that marijuana causes cancer. Few marijuana users develop true dependence, but some do. A withdrawal syndrome has been characterized, but it is mild and short-lived. While most users of other illicit drugs (e.g., heroin or cocaine) have used marijuana first (and begin earlier with alcohol and nicotine), there is no conclusive evidence that smoking marijuana causes subsequent abuse of other drugs.

The study also makes specific recommendations regarding clinical trials. There are no convincing data to support the fear that medical use of marijuana might increase its use among the general population. The IOM report recommends against the use of smoked marijuana as medicine and for the development of a cannabinoid inhaler, preferably containing a purified compound.