Cannabis/marijuana is the most frequent illicit drug used today for recreational purposes. Yet it is not widely known that the cannabis plant (Cannabis sativa; Latin for “planted hemp”) (fig 1) is one of the oldest drugs used for medical purposes. Its therapeutic use was first recorded in a classical medicine book by the Chinese emperor Shen Nung in 2737 BC. The medical use of cannabis was also known in other ancient cultures throughout India, Assyria, Greece, Africa, South America, Egypt, and the Roman Empire.1

Cannabis was introduced on a larger scale into Western medicine during the 19th century, primarily by British doctors. They accumulated experience in the use of “Indian hemp” while working in the colonies, recommending it as an appetite stimulant, analgesic, muscle relaxant, anticonvulsant, and hypnotic. In 1839, Dr William Brooke O’Shaughnessy, an Irish physician at the Medical College of Calcutta, published a detailed report “On the preparations of the Indian Hemp or Gunjah.” After performing animal studies, he determined that cannabis preparations were safe and effective in treating rables, rheumatism, epilepsy, and tetanus. The Ohio Medical Society of Physicians reported in 1860 successful treatment of “stomach pain and gastric distress,” psychosis, chronic cough, gonorrhoea, and neuralgia with cannabis. The plant was difficult to store, its extracts were variable in potency, and the effects of oral ingestion were not constant. Other new drugs were becoming available in the early 1900s with more reliable effects, and cannabis began to be misused for recreational purposes. The American Marijuana Tax Act of 1937 intended to prevent non-medical use, but made cannabis difficult to obtain for medical purposes too, and it was subsequently removed from the US pharmacopoeia in 1942.

In the United States cannabis is now classified as a schedule I drug, regarded as having high potential for abuse, and to be unsafe to take without medical supervision. Recently, several states have legalised the medical use of cannabinoids. In the United Kingdom, cannabis is registered as a schedule I—class C drug.4 The medical use of cannabinoids is currently restricted to dronabinol (Marinol, synthetic Δ9-tetrahydrocannabinol) and nabilone; these drugs are administered orally as anti-emetics and appetite stimulants for patients with AIDS or on chemotherapy. Other potential clinical applications for cannabinoids, including glaucoma therapy, are currently under intense investigation (see below).

PHARMACOLOGY
The cannabis plant has more than 480 chemical constituents.9 Of these, there is a group of at least 66 compounds that contain only carbon, hydrogen, and oxygen and are known collectively as cannabinoids. The remaining constituents of cannabis include nitrogenous compounds such as amino acids, proteins and glycoproteins, sugars, hydrocarbons, alcohols, aldehydes, ketones, simple acids, fatty acids, esters and lactones, steroids, terpenes, non-cannabinoid phenols, flavonoids, pigments (carotene and xanthophylls), and vitamin K. Terpenes are thought to be responsible for the characteristic odour of cannabis plants (fig 1). The main psychoactive constituent of cannabis is the cannabinoid, Δ9-tetrahydrocannabinol (Δ9-THC), the structure of which was determined by Gaoni and Mechoulam in the 1960s (fig 2).5

Most research into the pharmacological properties of plant cannabinoids has focused on this cannabinoid and, indeed, with the exception of cannabinol and cannabidiol (figs 2 and 3), other plant cannabinoids have been subjected to little or no pharmacological research.6–7

It is now generally accepted that Δ9-THC produces many of its effects by acting through cannabinoid receptors of which there are at least two subtypes, CB1 and CB2.6 Both subtypes are coupled through Gαo proteins, negatively to mitogen activated protein kinase. In addition, CB1 receptors are positively or negatively coupled through Gqα0 proteins to certain calcium and potassium channels. CB1 receptors, which were cloned in 1990, are present in brain, spinal cord, and certain peripheral tissues that include lung, heart, urogenital and gastrointestinal tracts, and the eye.8–11 Many CB1 receptors are present on central and peripheral neurons, one of their functions being the modulation of neurotransmitter release. CB2 receptors, cloned in 1993, seem to be located especially in cells and tissues associated with the immune system, such as the tonsils, spleen, and different types of
leucocytes. One role of these receptors is modulation of cytokine release.

Endogenous agonists for cannabinoid receptors have also been discovered; this system of “endocannabinoids” and receptors constituting what is now generally known as the endocannabinoid system. The endocannabinoids that have been indentified to date are all analogues of arachidonic acid. They include arachidonoyl ethanolamide (anandamide; AEA), 2-arachidonoyl glycerol (2-AG) which bind more or less equally well to CB1 and CB2 receptors, and 2-arachidonyl glyceryl ether (noladin) which is CB1 selective (fig 4). AEA behaves as a partial cannabinoid receptor agonist with less CB2 than CB1 efficacy. Within the nervous system, endocannabinoids are synthesised and released by neurons on demand, functioning as neurotransmitters or neuromodulators. There is also evidence that endocannabinoids serve as retrograde synaptic messengers. Following their release, the effects of at least some endocannabinoids are thought to be rapidly terminated by cellular uptake and intracellular enzymatic hydrolysis.

As detailed elsewhere some established cannabinoid receptor agonists bind more or less equally well to CB1 and CB2 receptors, important examples being WIN55212-2, which has marginally greater CB2 than CB1 affinity, and Δ⁹-THC, HU-210, CP55940, and nabilone (fig 3). As to CB1 selective agonists other than noladin, these include the anandamide analogues, methanandamide, O-1812, arachidonyl-2'-chloroethylamide (ACEA), and arachidonyleclopophylamide (ACPA). Examples of CB2 selective agonists are the THC analogues, L-759633, L-759656, JWH-133 and HU-308. Selective CB1 and CB2 receptor antagonists have also been developed, the most important of these being the CB2 selective SR141716A, AM251, AM281 and LY320135, and the CB2 selective SR144528 and AM630. There is evidence, however, that these compounds are not “silent” antagonists. Thus, as well as attenuating the effects of CB1 or CB2 receptor agonists, they can by themselves elicit responses in some cannabinoid receptor-containing tissues that are opposite in direction from those elicited by CB1 or CB2 receptor agonists. While some of these “inverse cannabimimetic effects” may be attributable to a direct antagonism of responses elicited at cannabinoid receptors by released endocannabinoids, there is evidence that this is not the only possible mechanism and that these compounds are in fact all inverse agonists that can reduce CB1 or CB2 receptor constitutive activity.

![Figure 1](Cannabis_sativa_plant.png)  
Photograph of the Cannabis sativa plant (provided by GW Pharmaceuticals, Wiltshire, UK)

![Figure 2](Cannabinoid_structures.png)  
Chemical structure of typical classic cannabinoids Δ⁹-tetrahydrocannabinol, cannabinol, and HU-211.

![Figure 3](THC_analogues.png)  
Chemical structure of nabilone, cannabidiol, and cannabigerol.

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dysphoria, disruption of short term memory, cognitive impairments, sense of time distortion, reduced coordination, and sleepiness.4 An earlier report on the effect of smoked marijuana indicated the possibility of tolerance. Thus, the IOP reduction appeared to be inversely related to the duration of marijuana use.10 In contrast, Dawson et al11 reported on their ophthalmological findings comparing non-users with long term users of marijuana (10 years or more). After applying the water loading test to both groups, the reduction of IOP associated with marijuana treatment was similar between users and non-users.

Since these early observations numerous studies have been conducted confirming that different cannabinoids, including cannabidiol, cannabigerol, endogenous cannabinoids, and some synthetic cannabinoids, can reduce the IOP when administered systemically and topically (see below). Obviously, smoking of marijuana is not advisable as a long term treatment. In addition to the acute side effects, long term marijuana smoking is associated with emphysema-like lung changes, and possible increase in the frequency of lung cancer.21 Oral administration has been evaluated. However, there is a poor and variable absorption with this route,22 at least for the cannabinoid formulations that have been investigated so far.

Mechanism of IOP reduction

The mechanism of action of cannabinoids in the human eye is not fully understood. Until recently, the effect of cannabinoids on IOP was assumed to be mediated through the CNS. Studies involving unilateral topical application of cannabinoids34 35 showed a large difference between the treated and untreated eye, suggesting a localised action. The experiments of Liu et al36 revealed evidence pointing in the same direction: bolus administration of Δ9-THC into the cerebral ventricles, as well as ventriculocisternal perfusion with Δ9-THC in rabbits, in contrast with intravenous administration, did not change the IOP. Thus, the main site of action of cannabinoids on IOP is not in the central nervous system.

Pharmacological and histological studies support the direct role of ocular CB1 receptors in the IOP reduction induced by cannabinoids. Straiker et al37 detected CB1 receptors in ocular tissues of the human eye, including the ciliary epithelium, the trabecular meshwork, Schlemm’s canal, ciliary muscle, ciliary body vessels, and retina. Porcella et al38 found high levels of CB1 mRNA in the ciliary body. The anatomical distribution of cannabinoid receptors suggests a possible influence of endogenous cannabinoids on trabecular and uveoscleral aqueous humour outflow and on aqueous humour production. In addition to the proved IOP lowering effect of CB1 receptor agonists, Pate et al39 could antagonise the IOP lowering effect of CP-55,940 (a synthetic CB1 agonist) by pretreating the animals with SR 141716A (a CB1 receptor antagonist). Similarly, Song et al40 found that the IOP lowering effect of topical WIN-55,212-2 was significantly reduced by topically administered SR141716A.

Using the synthetic cannabinoid WIN-55,212-2, Chien et al41 could demonstrate an 18% reduction in the aqueous humour production in monkeys but without significant change in the trabecular outflow facility. As this percentage appeared not sufficient to account for the total IOP lowering effect, other additional mechanisms were thought to be involved.

The IOP reducing effect does not seem to be related to a systemic reduction of arterial blood pressure.42 However, a direct effect on the ciliary processes, and specifically a reduction in capillary pressure, leading to changes in aqueous humour dynamics, has been proposed.43 Green et al44 showed
that Δ⁶-THC decreased the secretion of ciliary processes and led to a dilatation of the ocular blood vessels through a possible β adrenergic action. In addition, Sugiura⁴⁴ indicated that cannabinoids may inhibit calcium influx through presynaptic channels and in this way reduce the noradrenergic release in the ciliary body, leading to a decrease in the production of aqueous humour. Porcella et al.⁴⁵ proposed that cannabinoids might be acting as vasodilators on blood vessels of the anterior uvea, thus improving the aqueous humour vasoconstriction.

Green et al.⁴⁶ postulated that some cannabinoids may influence the IOP through a prostaglandin mediated mechanism. For example, topically applied AEA is hydrolysed to arachidonic acid, which is a COX pathway precursor of prostaglandins. This effect on IOP has been considered by Porcella et al.⁴⁶,⁴⁷ The topical application of the CB₁ receptor agonist JWH-133 used in vivo experiments by Laine et al.⁴⁸ did not have any effect on IOP compared to vehicle treatments, indicating that CB₂ receptor agonists may not be involved in the regulation of IOP.

**Topical application of cannabinoids**

To minimise possible systemic adverse side effects and maximise the dose at the site of action, topical application would be the ideal form of administration. However, natural cannabinoid extracts as well as synthetic forms are highly lipophilic and have low aqueous solubility, creating practical difficulties for this mode of administration.

After instillation of an eye drop of any medication, loss of the instilled solution via the lacrimal drainage system and poor drug penetration results in only <5% of an applied dose reaching the intraocular tissues. The cornea is usually the major pathway for intraocular penetration of topical medications. The corneal epithelium is highly lipophilic and its penetration is a rate limiting step for lipophilic drugs. Aqueous solubility is another drug property important for efficacy of delivery, as the surface of the eye is constantly moistened by tear fluid. Additional factors affecting corneal absorption include the molecular size, charge, and degree of ionisation.⁴⁹

Previous experiments with topical cannabinoid solutions involved the use of light mineral oil as a vehicle, but proved to be irritant to the human eye.⁵⁰–⁵¹ Recently, different microemulsions and cyclodextrins (macrocyclic oligosaccharides) have been shown to improve the corneal penetration of cannabinoids. These formulations successfully induced an ionisation.⁴⁹

The anti-inflammatory properties of CB₂ receptor agonists may not be involved in the pathogenesis of ischaemic stroke, Raynaud’s phenomenon, ischaemic heart disease and pulmonary arterial hypertension, among others.⁵³ The possible role of endothelin-1 in the pathogenesis of glaucoma has been suggested. For example, patients with open angle glaucoma may have an abnormal increase in plasma endothelin-1 in response to vasoconstriction. Thus, cannabinoids may have beneficial properties in ischaemia induced optic nerve damage.

**FUTURE DIRECTIONS**

Cannabinoids have the potential of becoming a useful treatment for glaucoma, as they seem to have neuroprotective properties and effectively reduce intraocular pressure. However, several challenges need to be overcome, including the problems associated with unwanted systemic side effects (psychotropic, reduction in systemic blood pressure), possible tolerance, and the difficulty in formulating a stable and effective topical preparation. Some cannabinoids such as HU-211 and cannabidiol do not have psychotropic effects, while maintaining their IOP lowering action, so that further research on these compounds would be desirable. Tolerance may develop after repeated use of cannabinoids. However, tolerance might be beneficial if it develops only to preferentially unwanted side effects. There has been recent progress in the use of microemulsions and cyclodextrins to overcome the barriers in ocular penetration of topically applied cannabinoids.

Other possible applications of cannabinoids in ophthalmology could be explored. Age related macular degeneration (AMD) is the leading cause of blindness in the United Kingdom. Perhaps the potent antioxidant properties of the cannabinoids may be beneficial in AMD, offering a possible alternative to established antioxidant supplements.⁵⁶ Cannabinoids have been shown to inhibit angiogenesis, leading to a decrease in the expression of proangiogenic factors such as VEGF.⁵⁷ Evidence suggests that VEGF plays a significant role in the development of choroidal neovascularisation in AMD, and clinical trials using anti-VEGF therapies are being conducted. The CB₂ receptors are also under intense investigation for their possible immunomodulatory effects.⁵⁸ The anti-inflammatory properties of CB₂ receptor agonists might also prove to be of therapeutic relevance in different forms of inflammatory eye disease.

**Authors’ affiliations**

I. Tomida, A. Azausa-Blanco, Department of Ophthalmology, Aberdeen Royal Infirmary, University of Aberdeen, UK

R G Pertwee, Department of Biomedical Sciences, Institute of Medical Sciences, University of Aberdeen, UK

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