Marijuana and Cardiac Arrhythmias: A Scoping Study

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Abstract

With increasing legalization, marijuana has become the most commonly abused substance in the United States. Together with the introduction of more potent marijuana products over the years, more adverse events are being reported and clinically characterized. Delta-9-tetrahydrocannabinol (THC) is the active psychotropic component of marijuana, which acts mainly on G-protein cannabinoid receptors CB1 and CB2. Multiple isolated cases of arrhythmias associated with marijuana use have been published. In this manuscript we conduct a scoping study of a total of 27 cases of arrhythmia associated with marijuana. Most cases were reported in young males (81%) with a mean age of 28 ± 10.6 years. Atrial fibrillation (26%) and ventricular fibrillation (22%) were the most common arrhythmias reported. Brugada pattern was reported in 19% of the patients. Marijuana associated arrhythmia resulted in a high mortality rate of 11 %. While the exact mechanisms of arrhythmias associated with marijuana are not clear, several hypothesis have been introduced including the effect of marijuana on cardiac ion channels as well as its effects on the central nervous system. In this paper we discuss the possible mechanisms of marijuana induced arrhythmia citing the evidence available to-date.

Introduction

Marijuana is the most common drug of abuse in the United States [1]. In 2016, a national drug survey indicated that lifetime marijuana use in ages 12 years or older was approximately 118 million in the United States [2]. The potency of marijuana has seen a tenfold rise in the past decade [3]. Implementation of medical marijuana laws in the period from 2004-2012 lead to an overall 15 percent increase in the probability of almost daily or daily marijuana use among adults aged 21 years or above [4]. Certain states in the United States of America which have legalized marijuana for recreational use have reported a higher rates of marijuana use when compared to states where all forms of marijuana is illegal [5,6,7]. Multiple isolated cases of arrhythmias associated with marijuana use have been reported. We present a scoping of the same.

Methods

On August 27th, 2018, a systematic search was conducted using Pubmed, Google Scholar, CINAHL, Cochrane CENTRAL and Web of Science databases. Studies listing the keywords “Marijuana, cannabis, arrhythmias, atrial arrhythmia, ventricular arrhythmia” were used to identify cases of myocardial arrhythmias associated with marijuana use (Figure 1). The reference list of each report was reviewed for potential additional cases. All cases were reviewed in detail. Data review included demographic data, cardiovascular (CV) risk factors, electrocardiography (EKG) findings, troponin levels, transthoracic echocardiography, electrophysiology study, urine drug screen findings, and management when available.

Results

A total of 27 cases of arrhythmias associated with marijuana use were identified from 24 papers (Table 1) (8-31). The mean age was 28 ± 10.6 years (median age 24 years) and 81% were males. The other reported risk factors were: smoking in 22%, hypertension in 11%, alcohol abuse in 11%, use of other drugs of abuse in 11%, hyperlipidemia in 7.4%, coronary artery disease in 3.7%, and family history of sudden cardiac death in 3.7%. Atrial fibrillation was the most common arrhythmia (26%) followed by ventricular fibrillation (22%). Brugada pattern was reported in 19%. All reported arrhythmias have been summarized in table 2. Urine toxicology screen was positive for...
<table>
<thead>
<tr>
<th>Case</th>
<th>Year and author</th>
<th>Reported arrhythmia in EKG</th>
<th>Transthoracic echocardiogram</th>
<th>Coronary angiography</th>
<th>Chemical/electrical Cardioversion/ Defibrillation</th>
<th>Medical management</th>
<th>Device implantation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1981, Akins (8)</td>
<td>Sinus bradycardia, first degree atrioventricular block, second degree atrioventricular block</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>2</td>
<td>2000, Kosior (9)</td>
<td>Atrial fibrillation</td>
<td>-</td>
<td>-</td>
<td>Propafenone</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>2000, Singh (10)</td>
<td>Atrial fibrillation</td>
<td>Normal</td>
<td>-</td>
<td>Digitalization</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>2001, Kosior (11)</td>
<td>Supraventricular tachycardia, atrial fibrillation</td>
<td>Normal</td>
<td>-</td>
<td>-</td>
<td>Beta-blockers</td>
<td>-</td>
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<tr>
<td>5</td>
<td>2001, Kosior (11)</td>
<td>Atrial fibrillation</td>
<td>Normal</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>6</td>
<td>2003, Rezkella (12)</td>
<td>Ventricular tachycardia</td>
<td>-</td>
<td>Normal coronaries, slow flow (TIMI I-II)</td>
<td>Propafenone</td>
<td>-</td>
<td>-</td>
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<tr>
<td>7</td>
<td>2005, Fischer (13)</td>
<td>Atrial fibrillation to Atrial fibrillation after adenosine was given</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>8</td>
<td>2005, Charbonaery (14)</td>
<td>Atrial fibrillation</td>
<td>-</td>
<td>-</td>
<td>Flecaainde</td>
<td>-</td>
<td>-</td>
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<tr>
<td>9</td>
<td>2007, Dacarett (15)</td>
<td>Brugada pattern</td>
<td>Normal</td>
<td>-</td>
<td>Procainamide</td>
<td>-</td>
<td>-</td>
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<tr>
<td>10</td>
<td>2008, Baranchuk (16)</td>
<td>Ventricular fibrillation</td>
<td>-</td>
<td>-</td>
<td>Defibrillation</td>
<td>Amsodarone</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>2009, Sanchez- Lazaro (17)</td>
<td>Ventricular tachycardia</td>
<td>Normal ejection fraction Moderate pericardial effusion</td>
<td>40% lesion in the mid-LAD and 100% lesion in the distal LAD</td>
<td>-</td>
<td>-</td>
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<tr>
<td>12</td>
<td>2009, Sattout (18)</td>
<td>Asystole, Ventricular tachycardia</td>
<td>-</td>
<td>-</td>
<td>Defibrillation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>2011, Fernandez- Fernandez (19)</td>
<td>Asystole, ventricular fibrillation</td>
<td>-</td>
<td>-</td>
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<td>14</td>
<td>2012, Ramero- Punche (20)</td>
<td>Brugada pattern, frequent ventricular premature complexes</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>15</td>
<td>2012, Diffley (21)</td>
<td>Ventricular tachycardia</td>
<td>Normal</td>
<td>Normal coronaries</td>
<td>Cardioversion</td>
<td>-</td>
<td>Implantable cardioverter defibrillator</td>
</tr>
<tr>
<td>16</td>
<td>2013, Menahem (22)</td>
<td>Incomplete right bundle branch block pattern, asystole, ectopic atrial tachycardia</td>
<td>Normal</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>17</td>
<td>2013, Kouzam (23)</td>
<td>Nonsustained ventricular tachycardia</td>
<td>Normal ejection fraction Abnormal left ventricular filling pattern Trace mitral regurgitation</td>
<td>Slow coronary flow in LAD (TIMI II) and RCA (TIMI II-III)</td>
<td>-</td>
<td>Metoprolol</td>
<td>-</td>
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<tr>
<td>18</td>
<td>2014, Hartung (24)</td>
<td>Ventricular fibrillation</td>
<td>-</td>
<td>-</td>
<td>Defibrillation</td>
<td>-</td>
<td>-</td>
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<tr>
<td>19</td>
<td>2014, Hartung (24)</td>
<td>Sudden cardiac death</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>20</td>
<td>2014, Singh (25)</td>
<td>Atrial fibrillation</td>
<td>Normal except for The size of the right ventricle was reported to be 1.5 cm, and the estimated right ventricle systolic pressure was 32 mm Hg</td>
<td>-</td>
<td>Cardioversion</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>21</td>
<td>2016, Branchecas (26)</td>
<td>Asystole /sinus arrest</td>
<td>Normal</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Permanent pacemaker implantation</td>
</tr>
<tr>
<td>22</td>
<td>2016, Valle- Alonso (27)</td>
<td>Brugada pattern</td>
<td>Normal</td>
<td>-</td>
<td>Flecaainde</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>23</td>
<td>2016, Orsini (28)</td>
<td>Ventricular fibrillation</td>
<td>Left ventricular ejection fraction 20%, global hypokinesia, septal akinesia</td>
<td>-</td>
<td>Defibrillation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>24</td>
<td>2017, Yalsin (29)</td>
<td>J waves (type III pattern)</td>
<td>-</td>
<td>-</td>
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<tr>
<td>25</td>
<td>2017, Yalsin (29)</td>
<td>J waves (type II pattern)</td>
<td>-</td>
<td>-</td>
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<tr>
<td>26</td>
<td>2017, Doctorian (30)</td>
<td>Ventricular fibrillation, Brugada pattern</td>
<td>Normal</td>
<td>Normal coronaries</td>
<td>Quinidine</td>
<td>Implantable cardioverter defibrillator</td>
<td></td>
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<tr>
<td>27</td>
<td>2018, Theetha Kariyanna (31)</td>
<td>Brugada pattern</td>
<td>Normal</td>
<td>-</td>
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</tbody>
</table>

Table 1: Table summarizing cases or arrhythmias associated with marijuana use, EKG and Echo findings and management employed.
Influences predominate in SA node while sympathetic neurons in ventricle [39]. Lower doses are known to cause sympathetic stimulation while higher doses drive parasympathetic stimulation [40].

Myocardial ischemia is a known substrate of arrhythmogenesis [41]. Marijuana induces myocardial ischemia and infarction by various mechanisms [42]. CB1 agonists and CB2 antagonists are proatherogenic, while CB2 agonists are antiatherogenic. The underlying mechanism has been discussed elsewhere [42]. Marijuana smoking leads to elevated carboxyhemoglobin in blood [43], slow coronary flow [44], and no coronary flow [45] in the absence of coronary artery stenosis. Tachycardia induced myocardial oxygen demand [34,35], coronary vasospasm [46], and increase platelet activation [47] all create ischemic milieu and thus may cause ischemia induced arrhythmias. Scar that results from myocardial infarction can further act as a substrate for reentry and thus is arrhythmogenic [41]. Myocardial ischemia and infarction can modulate cardiac neurons and thus may lead to arrhythmogenesis [48]. Ischemia induced alteration in cardiac ion channel expression and function may create a milieu for arrhythmia [49].

A change in P wave morphology has been noted following marijuana use suggesting effects on the atrium [50]. Decrease sinoatrial (SA) conduction, delay in A-H (atrium to bundle of His) interval and decrease in atrioventricular (AV) node refractory period are known effects of THC [51]. However, another study reported autonomic nervous system mediated increase in SA node automaticity, and influences predominate in SA node while sympathetic neurons in ventricle [39]. Lower doses are known to cause sympathetic stimulation while higher doses drive parasympathetic stimulation [40].

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facilitation of SA and AV nodal conduction [52]. Little is known about the effect of cannabinoids on ion channels. Anandamide is known to inhibit α-subunit of neuronal sodium channels Nav 1.2, Nav 1.6, Nav 1.7 and Nav 1.8 [53]. Cannabinol is known to inhibit bacterial homomeric Nav channel (NaChBac) and voltage-gated potassium channel subunit Kv2.1 (54). A patch clamp study showed that the human cardiac Ito 1 channels and Kv4.3 channels are inhibited by endocannabinoids [55]. Inhibitory effect on sodium and potassium channels may explain Brugada pattern induced by marijuana, however it may also be secondary to high vagal tone [56]. Image 2 summarizes the mechanisms of arrhythmias discussed. The scoping study is based on published case reports and hence suffers from selection bias which may affect the reported age, sex and type of arrhythmias reported.

Conclusion
In conclusion, these mechanisms alone or synergistically may contribute to initiation and maintenance of arrhythmia following marijuana use. A detailed history obtained from patients helps to identify marijuana as precipitant of arrhythmia and urine screening for THC may further confirm the same. Due to trends towards marijuana use. A detailed history obtained from patients helps to identify marijuana as precipitant of arrhythmia and urine screening for THC may further confirm the same. Due to trends towards marijuana use and screening for marijuana/THC in patients who present with new onset arrhythmia. Further patch clamp and animal studies are required to understand the effects of marijuana on cardiac ion channels and the conduction system of the heart

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Competing Interests
The authors declare that they have no competing interests.

References
1. Abuse, Substance, and Mental Health Services Administration (2014) "National survey on drug use and health."


