



LETTER TO THE EDITOR

Association Between Recreational Cannabis Use and Cardiac Structure and Function

Cannabis is one of the most widely produced and consumed recreational drugs in the world, with over 192 million global users (1). The World Health Organization has warned against the potential harmful health effects of nonmedicinal cannabis use and highlighted the need for more research assessing the link between cannabis smoking and cardiovascular disease (CVD) in adults (2). Legalization of cannabis is increasing. In the United States, recreational cannabis use is legal in 12 states and has been decriminalized in many others. Discussions on the potential public health impact are hampered by gaps in evidence and variable quality of available data. Little or no mention of cannabis exists in CVD risk assessments or lifestyle advice guideline (3,4).

We studied the association of cannabis use with cardiac structure and function using cardiovascular magnetic resonance (CMR) parameters in the UK Biobank population study (covered by the general ethical approval for UK Biobank studies from the NHS National Research Ethics Service [16/NW/0274]).

Participants without CVD but with CMR imaging data were included (5). Self-reported cannabis use was categorized as rare/never: (no use or less than monthly use of cannabis), previous regular (weekly or daily use of cannabis up to 5 years before the interview), or current regular (weekly or daily cannabis use within 5 years of the interview). Investigators were blinded to cannabis use. CMR scanning was performed at 1.5-T (MAGNETOM Aera, Siemens, Munich, Germany) with CVI42, version 5.1.1, post-processing software (Circle Cardiovascular Imaging Inc., Calgary, Canada) and semiautomated analysis of left ventricular myocardial tagged cine images was performed with CIMTag2D, version 8.1.5 (CIM Software, Medina, Minnesota). Myocardial global circumferential strain at the mid-left ventricular level was reported in absolute values.





Analysis included 3,407 individuals (age: 62 ± 7 years; 55% female), with 47 current regular, 105 previously regular, and 3,255 rare/never users.

Current regular users were more likely to be younger, male, and current tobacco smokers and have greater levels of social deprivation compared with rare/never users and previous regular users. They were also less likely to be taking anti-hypertension medication. Regular cannabis use was associated with larger indexed left ventricular end diastolic volume ($+5.31 \text{ ml/m}^2$; 95% confidence interval [CI]: 1.4 to 9.3 ml/m^2 ; $p = 0.008$), end systolic volume ($+3.3 \text{ ml/m}^2$; 95% CI: 0.78 to 5.83 ml/m^2 ; $p = 0.010$), and impaired global circumferential strain (-0.78 ; 95% CI: -1.47 to -0.09 ; $p = 0.026$) compared with rare/no cannabis use, even after adjustment for potential confounders including age, sex, body mass index, systolic blood pressure, use of cholesterol medication, diabetes, smoking, and alcohol consumption (Figure 1). After multivariable adjustment, there were no differences between left ventricular myocardial mass, ejection fraction, and stroke volume or right ventricular, left atrial, and right atrial parameters. Previous cannabis users had similar parameters to rare/never users.

To the best of our knowledge, this is the first study to systematically report alterations in cardiac structure and function associated with recreational cannabis use using CMR, the current gold standard for cardiac chamber assessment. The exact mechanisms for the observed changes are not currently known. Potential study limitations include the mainly white study population (96%); use of self-reported cannabis consumption with possible recall bias; and observational study design, whereby residual confounding cannot be fully excluded, and it is unclear whether the associations observed are due to cannabis use alone or other unmeasured confounders. Cannabis also remains illegal in the United Kingdom, creating additional barriers to reporting use.

Regular cannabis use was independently associated with adverse changes in left ventricle size and subclinical dysfunction compared with rare/never cannabis use, whereas previous regular cannabis use was not. Findings should be interpreted with caution, and further research is required to understand the potential pathophysiology, dose-response effects of cannabis use, and long-term implications of regular use on the cardiovascular system. Health care professionals and policy makers may need to advise caution on regular recreational cannabis use until such systematic research is available.

FIGURE 1 Cardiac Chamber and Function Changes With Regular Versus Rare/Never Recreational Cannabis Use (N = 3,407)

	Ventricular measures	Right ventricle	Left ventricle	Atrial measures	Right atrium	Left atrium
						
Morphology	End diastolic volume	↑	↑* #	Maximum volume	↔	↔
	End systolic volume	↑	↑* #	Minimum volume	↔	↔
	Stroke volume	↑	↑			
	Mass		↑ #			
Function	Ejection fraction	↔	↔	Emptying fraction	↔	↔
	Global circumferential strain		↓* #			

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*Changes remain significant after multivariable adjustment. #Changes remain significant after adjustment for age and sex.

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