Complementary and Integrative Gastroenterology

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KEYWORDS

• Gastroenterology • Complementary and alternative medicine
• Inflammatory bowel disease • Crohn disease • Ulcerative colitis • Yoga

KEY POINTS

- Polyphenols, including curcumin, resveratrol, and epigallocatechin-3-gallate (EGCG), have supportive data for the treatment of ulcerative colitis (UC) flares.
- Quality of life for patients with inflammatory bowel disease (IBD) and irritable bowel syndrome (IBS) benefit from lifestyle interventions and stress management techniques, although without a clear benefit for reduction of disease flares.
- Yoga has beneficial effects on symptoms, anxiety, physical functioning, and quality of life for patients with IBS.
- A large randomized trial demonstrated superiority of melatonin and nutritional supplements compared with omeprazole for reduction of gastroesophageal reflux disease (GERD) symptoms.

INTRODUCTION

The use of complementary and alternative medicine (CAM) has grown tremendously within gastroenterology. Use is particularly high for chronic conditions, such as IBD, IBS, and reflux esophagitis, where a considerable unmet need to treat the underlying

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process or control symptoms persists.[1–5] People with IBD are more motivated by ongoing symptoms and concerns over adverse events from medications that suppress the immune system. The remarkable diversity of CAM compounds and approaches used in gastrointestinal (GI) disorders makes a comprehensive review not feasible in this article. In addition, the line between CAM approaches and mainstream therapies sometimes moves as growing evidence moves an alternative therapy to the mainstream. Herbal therapies, such as curcumin for UC, is one such example where larger trials have been performed. Another example is the ascendency of mainstream interest in the intestinal microbiome. The popular appeal of probiotics, the expanding interest in the microbiome in medical research, and the dramatic results in fecal transplant have fueled a renewed focus on probiotics and prebiotics as potential medical therapies. This thrust has been embraced by mainstream medicine with research and by pharma with investments. This likely will lead to multiple microbial-based therapies in the near future not only for GI disorders but also for areas seemingly further outside the GI tract, such as hypertension and depression.[6–8] Thus, a review of probiotics or the more extreme version with fecal microbial transplant is beyond the scope of this review and is not discussed in this article. This review surveys CAM treatment modalities for IBD and IBS following the proposed categorization system by Wieland and colleagues[9] for the Cochrane Collaboration: mind-body medicine, whole medical systems, natural product–based therapies, manipulative and body-based practices, and energy medicine. Many of these trials of CAM in GI, however, tend to be single-center studies and small without the thoroughness of costly, multicentered, sponsored conventional studies. With those acknowledged limitations, the range of options studied with some supportive data opens up a new set of approaches for many patients.

INFLAMMATORY BOWEL DISEASES

Mind-body Medicine

Although the contribution of stress in provoking IBD flares has been difficult to quantify, studies have suggested stress, anxiety, and depression influence the likelihood of flares in UC and Crohn disease (CD).[10] These data are reinforced by patients' impressions that stressful events are implicated in initiating disease activity. Because GI diseases may be modified by stress, treatments like mind-body interventions, which aim to strengthen patients' resources and resiliency, have been studied and used. Mind-body treatments include, for example, lifestyle modification, mindfulness interventions, relaxation techniques, and hypnotherapy. In addition, anxiety and depression are increased in patients with IBD, particularly in those with more active disease. Nonpharmacologic approaches to counter this issues have been also examined in IBD.

Clinical trials of mind-body interventions show promising results: a lifestyle-modification program with 60 patients with UC led to improvements in psychological quality of life and reduction of anxiety.[11] The program consisted of a structured 60-hour training program over a period of 10 weeks, which included stress management training, psychoeducational elements, and self-care strategies. Regarding inactive UC, mindfulness-based stress reduction was found to positively influence facets of quality of life compared with attention control.[12] Those findings, however, could not be confirmed within a study that included both UC and CD patients.[13] Both studies did not find significant group differences regarding disease activity, relapse, or psychological variables in the main analysis. Subset analyses revealed that significant effects on quality of life were found in patients with IBS-type symptoms. Furthermore, mindfulness-based stress reduction decreased perceived stress and C-reactive protein during flare.