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Predictive factors of complementary and alternative medicine use for patients with inflammatory bowel disease in Korea



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Inflammatory bowel disease;
Crohn's disease;
Ulcerative colitis;
Risk factors

Summary

Objectives: The aim of this study was to assess characteristics and predictive factors of complementary and alternative medicine (CAM) use for patients with inflammatory bowel disease (IBD) in Korea.

Design: Prospective, questionnaire based study for patients with IBD in Korea.

Setting: Six university hospitals and one primary IBD clinic.

Main outcome measure: Overall characteristics and predictors of CAM use were compared between CAM users and non-users.

Results: During the study period, 366 patients with IBD (ulcerative colitis=228, Crohn's disease=138) completed the full questionnaire; 29.5% ($n=108$) reported CAM use and 70.5% ($n=258$) reported no CAM use after diagnosis of IBD. In total, 64.0% were male, the mean patient age was 42.3 ± 15.5 years, and the mean duration of IBD was 5.5 ± 5.8 years. Using logistic regression analysis, university education ($p=0.040$), higher income levels ($p=0.009$), and longer duration of IBD ($p=0.003$) were found to be independent predictors of CAM use. Among CAM users, 65% of CAM was attained within 2 years of IBD diagnosis and only 28.7% discussed CAM use with their physician. Furthermore, 13.9% of CAM users discontinued conventional IBD therapy while using CAM.

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Conclusions: The overall use of CAM in Korea was comparable with those in the West. Physicians should be aware of the high prevalence of CAM use by patients with IBD, especially among those with higher education levels, higher income levels, and longer IBD duration. Furthermore, physicians should ask about CAM use, and help their IBD patients make a more informed choice about CAM use.

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Introduction

The terms complementary and alternative medicine (CAM) involve a wide group of systems, theories, and practices of medicine not included in the conventional scientific approach. The use of CAM among patients with inflammatory bowel disease (IBD) is increasing.^{1,2} Currently, nearly half of IBD patients report having used CAM at some point during their illness.^{3–5} This observation has been fairly consistent throughout various populations across North America, Norway, Europe, New Zealand, and China.^{3–11} However, most studies were reported from the West,^{3–5,8–11} and two studies from China were limited because the one was focused only on traditional Chinese medicine⁶ and the other small study was not designed to investigate CAM use.⁷ Moreover, the characteristics of CAM use in Korea may be different from those of the West, as the prevalence of CAM use in a general population was very high (up to 75%) in Korea.¹²

Physicians need to make an effort to understand why patients with IBD use CAM and understand the benefits patients gain from such treatment. Reasons for the high prevalence of CAM use in IBD include lack of response to conventional therapy, perceived favorable safety profile, and a sense of greater control over their disease.^{1,2,4,13} Many patients who used CAM reported minimal discussion with their physicians regarding CAM use,¹⁴ which may erode trust and affect the therapeutic patient–physician relationship and lead to potentially dangerous drug interactions and toxicities.

Culture, acceptance, and faith in the ability of Western medicine and perpetuation of misconceptions may influence the use of CAM in patients with IBD. Therefore, the prevalence and predictive factors of CAM use may be different in Korea, however, little is known about the use of CAM in IBD patients of Korea. In this multicenter study based in Korea, we evaluated the characteristics and predictive factors of CAM use in patients with IBD.

Methods

Participants

All adult IBD patients with a confirmed diagnosis of ulcerative colitis (UC) or Crohn's disease (CD) who received care at one of six university hospitals and one primary IBD clinic between December 1, 2012 and February 28, 2013 were invited to participate in the study. Patients with IBD were approached by the study coordinators and administered a questionnaire. The questionnaire gathered information on the following variables: age, gender, smoking/alcohol habit, marital status, religion, employment status, educational attainment, income levels, IBD phenotype, prior medication history, adverse events with conventional therapy,

hospitalizations, prior surgery, disease duration, quality of life (QOL) score, and history of non-adherence to medication. Respondents were classified as CAM users or non-users and characteristics and predictive factors of CAM use were compared between groups. This study was approved by the Institutional Review Board of each hospital (KHNMIC IRB-2-12-124), however, an informed consent for IBD patients was waived for this survey-based study.

Definition and assessment of CAM use

CAM was defined as a therapy that falls beyond the domain of conventional medicine and is not based on rigorous scientific evidence for a particular indication.^{15–17} CAMs used by patients with IBD were diverse, often overlapping, so CAMs were classified simply as CAM techniques or CAM products, like in Manitoba IBD study.¹⁵ CAM techniques include naturopathic medicines (holistic approaches that focus on natural remedies), homeopathy (treatments with diluted remedies prescribed by a homeopath), massage, relaxation, reflexology, aromatherapy, hypnosis, acupuncture, Chinese traditional service (including moxibustion and cupping), and any services delivered by a spiritual healer, religious healer, or others. CAM products include Chinese medicine, herbal remedies, ginseng, deer antlers, chamomile, lavender, ginkgo biloba, probiotics, vitamins, and others. Respondents completed questions about their specific use of CAM techniques or products, and if the use was specifically for IBD or other reasons. CAM users were defined as those who reported use of any CAM techniques or products after diagnosis of IBD. The CAM non-users were those who did not use CAM techniques or products after diagnosis of IBD.

Income levels were classified as one of 3 groups: less than 1818 US dollars/month (2,000,000 Korea won), 1818–4545 US dollars/month, and more than 4545 US dollars/month (5,000,000 Korea won). For evaluation of the QOL, patients were assessed for 4 parameters—bowel symptoms, systemic symptoms, social function, and emotional function^{18,19}—using an unscaled visual analog self-assessment (0=excellent, 100=very poor) that has been validated across a wide range of medical conditions and populations.²⁰ Self-reported adherence was measured using the Morisky scale,²¹ a validated adherence tool used in several chronic diseases. According to prior studies using the Morisky scale in IBD patients,^{22,23} subjects were categorized into the non-adherence group if they reported “yes” to any of the four items (Morisky scale score ≥ 1).

Statistical analysis

The primary endpoints were predictive factors of CAM use and secondary endpoints included the characteristics of

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