The Practical Pros and Cons of Complementary and Alternative Medicine in Practice

Integrating Complementary and Alternative Medicine into Clinical Care

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KEYWORDS

• Complementary and alternative medicine • Inflammatory bowel disease
• Psychosocial care • Health care delivery • CAM safety and efficacy

KEY POINTS

- Complementary and alternative medicine (CAM) has its limitations with regard to the need for better and more robust data, particularly because most studies in CAM for inflammatory bowel disease (IBD) are small, short-term, and do not address drug interactions with IBD medications.
- IBD care is gradually expanding to address other concerns that can affect health outcomes, including diet, psychosocial care, exercise, stress management, and sleep, among other areas.
- A movement toward increased patient autonomy is driving many of the choices of medications and other approaches to include CAM as an option for disease management.
- Physicians should expand their knowledge in CAM to be able to fully address their patients' needs and expectations.

The widespread use of complementary and alternative medicine (CAM) relies on an expectation or belief that the conventional calculus of risk and benefit used to select most standard medications, whether an anti-tumor necrosis factor (anti-TNF) agent or mesalamine, can be tilted toward the same or greater benefit with less risk through nonconventional approaches. CAM therapies may also rely on different theories of health and possibly a different conception of care that incorporates a more inclusive

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or holistic set of concerns. This article discusses a broad overview of the promise and limitations of CAM with regard to the philosophic issues and their practical use, as well as more far reaching implications that CAM embodies in terms of delivery of care for people with inflammatory bowel disease (IBD). Although the promise is great, and CAM has been embraced by many patients and providers, the barriers to successful use are considerable and need to be well understood.

Patients with IBD and their providers are often frustrated with available medications due to concerns about adverse events or because of inadequate efficacy. The alternatives offered by CAM may answer these needs. However, a difficulty with many CAM studies and approaches is that the data are often promising but weak. The large methodologically rigorous multicenter randomized controlled trials (RCTs), which are the gold standard for trials registered with the US Food and Drug Administration (FDA), do not have a counterpart in CAM trials. Some of the therapies, such as an herbal preparation, should be able to be studied with similar clinical trials methods as a new potential biologic for IBD, whereas other interventions, such as Reiki, dietary interventions, or energy healing, would require less conventional clinical trial designs. In addition, most of the published trials relied on to support the use of CAM are small, single-center studies. When the applicability of large multicenter studies to a particular subject cohort is assessed, the relevance of even these large trials is often tenuous.[1] Few CAM trials are followed up with larger multicenter studies with rigorous endpoints and most do not meet accepted research standards. Longer term use of these CAM therapies in IBD is also not frequently studied and extrapolation from short-term trials is relied on. The safety of many of these approaches is not entirely known.

Even with development and growth of funding through governmental support, such as the National Center for Complementary and Integrative Health, the grants available for CAM are dwarfed by the costs shouldered by large pharmaceutical companies for a phase 3 program in IBD. Government funding for complementary and integrative health in IBD in particular has been limited and has focused more on small but promising pilot studies.[2,3] Furthermore, the funding for the development of alternative approaches has not been a priority in the larger pharmaceutical industry approaches, though some areas, such as microbial-based therapeutic and potential probiotics, are receiving considerable industry support.

A further issue is that negative larger trial results might be ignored in clinical practice if smaller studies are positive. A medication example is the use of omega-3 or fish oil fatty acids in Crohn disease. A small high-profile study was positive for maintenance of remission with only 39 subjects in the fish oil group and a similarly sized placebo group.[4] Two larger trials with 188 and 189 subjects in active treatment and parallel placebo groups were negative but this therapy is still widely used.[5] Although a case can still be made for the use of fish oil, the data are certainly contradictory. Other interventions, such as the specific carbohydrate diet, are tried widely in IBD despite the lack of RCTs among the IBD patient population. Although some patients report a benefit and open-labeled series have been published, robust data are lacking.[6,7] A more difficult question is what level of data should be required to determine efficacy of these therapies and to influence real-world decisions. Limited data and inadequate trials make it difficult for patients to select, or for practitioners to recommend, a specific diet for IBD, and often decisions are made based on guidance from anecdotes or open-labeled series. Furthermore, the increasing awareness of limitations of RCTs and the growth of patient-shared data through networks such as http://www.patientslikeme.com and www.crohnology.com offer alternative sources of data to guide choices.

If an approach is deemed very safe, the level of supportive data required to prove its efficacy might arguably be less, particularly if the therapy is being added to other