Editorial

Use of complementary and alternative medicine by oncology patients: challenges and opportunities

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The article by Jones and colleagues (1) recently published in *Integrative Cancer Therapies* reported on complementary and alternative medicine (CAM) use by minority and medically underserved oncology patients at one hospital setting in Houston, Texas, USA. They find that cancer patients had very high awareness and interest in various CAM modalities as well as high prevalence of use of CAM. The authors conclude that while CAM use is common among the oncology patients they surveyed it, is not guided by providers and they highlight the importance of patient-provider discussions about CAM.

Over the past two decades, Americans are increasingly using CAM. In 2012, over one-third of adults used some form of CAM in the past year (2) and spent $28.3 billion in out-of-pocket expenses for it (3). The most common types used are natural products and botanicals, followed by mind-body therapies (e.g., meditation, yoga), and manipulative and body-based therapies (e.g., massage). There is continuing interest in better understanding the ways in which individuals with health conditions utilize CAM, including those with cancer. Cancer patients are an especially important clinical group to consider because of the possible interactions of CAM modalities and conventional cancer treatment and care.

In 2009, the US Society for Integrative Oncology published evidence-based clinical practice guidelines for integrative oncology (4). In this document, rubrics for levels of scientific evidence for various CAM modalities for use in integrative oncology treatment were presented with recommendations for clinical practice. Strength of evidence was assessed according to grading recommendations (1A, 1B, 1C, 2A, 2B, 2C) where 1A is the strongest recommendation, with high-quality evidence and benefits, and the recommendations can be applied to most patients. 2C represents the weakest recommendation with the lowest level of scientific evidence. *Table 1* summarizes the CAM modalities that meet the highest grading recommendations (1A–1C). Highest levels of evidence are demonstrated for acupuncture, several mind-body techniques, energy therapies, and massage. In addition, the society recommends against use of dietary supplements, including botanicals for cancer prevention, or during standard cancer treatment.

Subsequent to 2009, the Society for Integrative Oncology has endorsed and published Complementary Therapies and Integrative Medicine in Lung Cancer [2013] (5), Clinical Practice Guidelines on the Use of Integrative Therapies as Supportive Care in Patients Treated for Breast Cancer [2014] (6), and Clinical Practice Guidelines on the Evidence-Based Use of Integrative Therapies During and After Breast Cancer Treatment [2017] (7). These recommendations and guidelines highlight the potential utility of incorporating evidence-based CAM modalities during and/or after conventional treatment to reduce symptoms and improve overall quality of life among cancer patients and survivors.

Jones *et al.* (1) sought to investigate knowledge, use, barriers, and interest in using CAM among cancer patients

Table 1 Summary of recommendations on CAM from Society of Integrative Oncology

Level of evidence	Modality	Recommendation
1A	Acupuncture	Poorly controlled pain, nausea & vomiting associated with chemotherapy, when side effects clinically significant
1A	Specific dietary supplements	Not recommended for cancer prevention
1B	Specific dietary supplements including botanicals	Should be evaluated for possible side effects & possible interactions with drugs. Supplements that may interact with treatment drugs should not be used concurrently
1B	Acupuncture	Radiation-relation xerostomia
1B	Energy therapies (e.g., reiki)	Considered safe; some benefit for enhancing QoL & reducing stress
1B	Mind-body techniques (meditation, yoga, tai chi, hypnosis, relaxation techniques, music therapy	Reduce anxiety, mood disturbance, & chronic pain & improve QoL
1C	Massage therapy	Anxiety or pain. Massage administered by oncology-trained massage therapist. Deep pressure not recommended

Summarized from: Deng *et al.*, 2009 (4). CAM, complementary and alternative medicine.

in a urban community hospital in Houston, TX, in the US. They interviewed 164 cancer patients who were largely minority and medically underserved. Several types of specific CAM modalities were investigated: acupuncture, aromatherapy, herbs, massage, meditation, prayer, relaxation, special diets, and yoga. Knowledge of these modalities was very high and interest in using them was also high varying from 93.8% (prayer) to 49.7% (acupuncture). Current use varied widely by modality (84.7% for prayer to 5.6% for acupuncture) and overall, patients were interested in using these modalities if they were available. However, about 1 in 5 patients felt they did not know enough about acupuncture or herbs. Despite this being a low-income clinical sample, the percentages reporting cost as a hindrance to use was low. These findings underscore cancer patients' interest in and use of CAM modalities and point to medically underserved patients' need and attempt to have more integrative care. The authors also note the importance of oncologists and other health care providers have frank communication about CAM with their patients.

A limitation of the Jones *et al.* study is the small and non-representative sample, but their substantive findings appear to be in-line with larger and more representative studies. A recent study using data from several panels of the National Health Interview Survey (NHIS), a nationally representative survey, found 35.3% of cancer survivors used some type of CAM in the past year (8). Biologically based approaches (including vitamins, natural supplements, and herbs) were the most commonly used (22.8%), followed by mind-body therapies (14.9%), manipulative and body based therapies (14.2%), and whole systems medicine (e.g., acupuncture, homeopathy) (3.7%). A particularly interesting finding in light of this editorial is that less than 5% of cancer patients used CAM for treatment of the disease. An earlier study analyzing an older wave of NHIS found 43.3% of cancer survivors used CAM in the past year (9). The authors also report that cancer survivors are more likely than general population to use CAM for general disease prevention, immune enhancement, and pain management. As in the Clarke study, biologically based CAM modalities were the most common reported (36.8%). Use of biologically based CAM modalities including natural supplements and herbs is a serious concern for cancer patients because of the possibilities of drug-herb interactions as well as possible side effects and adverse effects of the supplements and herbs themselves. Given the recommendations of the Society of Integrative Oncology and the growing evidence-base of specific CAM modalities, these findings suggest opportunities for both patient education and patient-physician discussions regarding CAM.

In addition to patient-provider discussions about CAM, patient disclosure of CAM use to their oncologist and other health care providers is also an important aspect of care. Only 22.7% of cancer survivors disclosed CAM use to their health care provider and the percentage was even lower for

survivors who used herbs (14.6%) (9). A systematic review of patient-provider discussion and disclosure of CAM use found anywhere from 20% to 77% of cancer patients did not disclose their CAM use to their provider (10). The main reasons for non-disclosure were physician's failure to inquire and concerns about disapproval. Patient-provider discussions about and disclosure of CAM use not only have direct implications for patients' health and wellbeing, but also benefits the patient-provider relationship and overall quality of care. Jones and colleagues highlight the need for medically supervised CAM use in oncology patients and recommend integration of evidence-based modalities into conventional care to improve symptoms and quality of life. They state this may be especially useful for minority and medically underserved cancer patients.

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Footnote

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