Complementary therapies in cancer: a global perspective

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It is now more than 10 years since the highly cited report on the use of complementary and alternative medicine (CAM) in cancer, with the contribution of many EONS national societies, was published.1 It showed that one-third of all cancer patients in Europe used CAM, primarily to manage symptoms and improve the impact of the cancer/cancer treatment on their quality of life. Since then, we have seen a huge growth in the use of CAM, improvements in access to CAM-related therapies and delivery of some of these therapies through national health services in several countries.

It is estimated that in the UK alone the expenditure in CAM is well above €260 million per year, and in the USA it is more than €30.5 billion according to the 2007 National Health Interview Survey carried out by the Centers for Disease Control in the USA. In Asia, this use is even higher, as patients are well accustomed to traditional healing practices that are not only embedded in their cultures, such as traditional Chinese medicine and acupuncture in China, but are also more affordable. In China, for example, there are state-funded hospitals specifically for traditional Chinese medicine. Australia, with many of its population being of Asian origin, shows consistently high numbers of users in the literature. Many health insurance companies, both in the East and the West, now cover a number of complementary therapies, recognising there are health gains from such therapies.

Large well-conducted trials

Until recently, however, the research evidence around such therapies has been of poor quality that in most cases does not allow for strong recommendations to be made and conclusions drawn. This is slowly changing with the appearance of large and well-conducted trials, funded from mainstream competitive funding bodies. We have recently published the largest acupuncture trial in managing fatigue in breast cancer patients (n=302) showing significant and clinically important improvements in fatigue, psychosocial aspects and quality of life in the acupuncture group. A new trial, consolidating research of several years, showed that a ‘package’ of symptom education, breathing training, cough suppression exercises and acupressure was effective in managing the respiratory distress symptom cluster (breathlessness-fatigue-cough) in lung cancer patients,3 giving more options to patients in terms of their symptom management in a very limited field of knowledge. This work has now been funded by the UK’s National Institute for Health Research to run a large national trial starting this year. Several other ‘good’ trials, providing a high level of evidence, are appearing in the literature, such as on mindfulness training; herbal medicines; mind-body interventions, etc., and there is more evidence to come.

Establishing priorities

Do all CAM therapies work? Definitely not. Do we need to have research evidence for all of the CAM therapies used? I do not think so, as funding for research is limited and competitive, with CAM research only receiving a tiny percentage of the available funding. Also, some therapies, such as massage, may not necessarily need to be tested, as they are of ‘low’ risk and enjoyable to patients, and we must prioritise therapies that really need to be further investigated and funded, particularly if there
are safety or public health risks with their use. We need to understand more about the mechanisms behind the effects of some of the prominent therapies, and whether there is a strong placebo effect (therapeutic or not). A number of ‘placebo’ (sham) approaches used in current trials are questionable and perhaps not appropriate, and this is an area we need to develop further in order to obtain more reliable results from trials. We should also not forget that many CAM therapies offer some of the basic tenets of care – touch, talk and time – which the specialised but fragmented care we offer in our current health care systems does not offer well.

Using CAM can also lead to patients feeling more in control of their health, and this element of empowerment can also be therapeutic.

Not only should we do more around establishing better evidence for CAM, we also need to focus on improving communication with patients and be more ‘accepting’, as health professionals, of the patient’s choice. Training plays a key role in this and can allow health professionals to guide patients and have appropriate discussions with them about CAM use. A good example of such training is in Hong Kong, my adopted home, where all nursing degree curricula include a minimum of 60 hours of traditional Chinese medicine practice and a minimum of two taught subjects before registration, in order to allow nurses to understand the basics of this traditional Chinese medicine and enhance the related communication with patients.

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