

Use of Complementary and Alternative Medicine by Rheumatology Patients

Leora Schachter MD

Department of Complementary Medicine, Maccabi Healthcare Services, Tel Aviv, Israel

Key words: complementary and alternative medicine, rheumatology, osteoarthritis, rheumatoid arthritis

IMAJ 2006;8:203–204

The Practice of medicine... Is an art based to an increasing extent on the medical science, but comprising much that still remains outside the realm of any science

W.F. Peabody, 1926 address to the Harvard Medical School [1].

Rheumatologic conditions are composed of the entire spectrum of reasons that lead patients to turn to complementary and alternative medicine. They are chronic, usually progressive conditions causing pain and physical disability and a dependence on medications that are not always fully able to provide symptom relief. Quality of life is affected at every stage of the disease. Added to this is the fear and uncertainty of how much worse the condition may become.

In recent years it has become acceptable to widen the range of medical solutions and seek symptom relief “outside of the prevailing scientific mainstream” [2] even if the doctor did not recommend them. In this issue of *IMAJ* [3], Breuer and his colleagues asked and found that 42% of their patients had done just that and were willing to admit to turning to such solutions. Other studies show a range of 18–94% of CAM use among rheumatic patients [4,5]

Will doctors consider the use of treatment methods that are “outside of the prevailing scientific mainstream”? For a start, we cannot overlook the fact that most rheumatologic conditions are progressive and degenerative, leading to eventual disability despite progress in treatment protocols. It is also generally accepted that a multidisciplinary team approach is preferable for treating rheumatic patients [6]. Should CAM practitioners be a part of that team?

In the case of treatment options for rheumatologic conditions, the line between “mainstream” and CAM methods has become fuzzy; methods that previously were unquestionably seen as CAM methods, such as paraffin wax oil baths [7], balneotherapy [8], and even the oral ingestion of glucosamine-chondroitin [9,10], have been scientifically challenged, yet the attitude towards them is inconsistent and varies from one treatment group to another. Breuer and team [3] included balneotherapy as “mainstream” and chose to leave chondroitin outside the realm of mainstream treatments.

Acupuncture is another example of the fuzzy border and undetermined attitude. More than any other CAM method this

treatment modality has been put to scientific scrutiny. It was also the first CAM method to have received at least partial official recognition by the medical community [11]. Acupuncture has been evaluated for the treatment of various rheumatologic conditions and was found helpful for osteoarthritis [12,13], although there is insufficient evidence as to its efficacy in rheumatoid arthritis. Yet it is not considered an integral part of “mainstream” medical treatment.

There is a Cochrane Review summarizing the positive effect of Tai-Chi on a range of motion in patients with rheumatoid arthritis [14]. Like Tai-Chi, Shiatsu combines passive joint work on the same treatment philosophy. Can we extrapolate that Shiatsu will have a positive effect on rheumatic patients as well?

Breuer and co-workers asked patients attending their hospital’s outpatient rheumatic clinic about CAM use. Aside from the conclusion that a substantial percentage turned to CAM, it is obvious that there was a lack of professional guidance in the use of CAM methods. Had there been professional guidance available, the choice of treatments would have been disease-related. There would have been greater use of glucosamine and chondroitin (especially for osteoarthritis patients) and more use of manual treatment methods for pain relief. We would also expect to have found a correlation between intensity and duration of disease and CAM use. With professional guidance, patients would be advised regarding the potential benefit of adding gamma linoleic acid (omega-6 fatty acid) especially for those with rheumatoid arthritis [15].

But who is responsible for providing professional guidance on CAM use? According to the results of Breuer’s study it was friends and other patients who recommended the choice of treatments. Why have doctors decided not to consider CAM methods as part of their responsibility? With all the diversity of treatments and the quest for “other” caregivers, the doctor is still viewed as the primary leader of the healthcare team and is still the first to be consulted [16]. Why, then, do doctors disregard treatment methods that are used by 42% of their patients? It may be because of the uneasy feeling that scientifically trained doctors have in prescribing treatment modalities that are sometimes only “promising” or “probably useful.” Or perhaps they do not want to take responsibility for “questionable” treatment methods.

But that is exactly the point: The doctors’ responsibility is not to the treatment methods but to their patients. By learning to recognize the various CAM methods and knowing the potential

CAM = complementary and alternative medicine

benefit and hazards of each, doctors will be able to provide learned advice and, more important, they will be able to guide and protect their patients from unsuitable treatment modalities, herbs, or other means.

There is by now sufficient evidence to justify patients' expectation that their doctor consider other treatment options especially in conditions where "mainstream conventional" medicine cannot provide all the answers. Scientific medicine has enabled prolonged duration of life, which increases the importance in which supportive care and symptomatic treatment should be seen. Because, ultimately, "The secret of the care of the patient is in caring for the patient" [1]

References

1. Peabody Fw. The care of the patient. *JAMA* 1927;88:877-82.
2. Panush RS. American College of Rheumatology position statement. Complementary and Alternative Therapies for Rheumatic Diseases. *Rheum Dis Clin North Am* 2000;26:189-92.
3. Breuer GS, Orbach H, Elkayam O, et al. Use of complementary medicine among patients attending rheumatology clinics in Israel. *IMAJ* 2006;8:184-7.
4. Ramus-Remos C, Gutierrez-Urena S, David P. Epidemiology of complementary and alternative medicine practices in rheumatology. *Rheum Dis Clin North Am* 1999;25:789-804.
5. Ernst E. Complementary and alternative medicine in rheumatology. *Balliere's Clin Rheum* 2000;14:731-49.
6. Li LC. What else can I do but take drugs? The future of research in nonpharmacological treatment in early inflammatory arthritis. *J Rheumatol Suppl* 2005;72:21-4.
7. Robinson VA, Brosseau L, Casimiro L, et al. Thermotherapy for treating rheumatoid arthritis. *Cochrane Database of Syst Rev* 2002;2:CD002826.
8. Sukenik S, Flusser D, Codish S, Abu-Shakra M. Balneotherapy at the Dead Sea area for knee osteoarthritis. *IMAJ* 1999;1(2):83-5.
9. Richy F, Brugere O, Ethgren O, Cucherat M, Henrotin Y, Reginster JY. Structural and symptomatic efficacy of glucosamine and chondroitin in knee osteoarthritis: a comprehensive meta-analysis. *Arch Intern Med* 2003;163(13):1514-22.
10. Towheed TE, Maxwell L, Anastassiades TP, et al. glucosamine therapy for treating osteoarthritis. *Cochrane Database Syst Rev* 2005;18(2):CD002946.
11. National Institutes of Health Consensus Conference. Acupuncture [Review]. *JAMA* 1998;280(17):1518-24.
12. Berman BM, Lao L, Langenberg P, Lee WL, Gilpin AM, Hochberg MC. Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. *Ann Intern Med* 2004;141(12):901-10.
13. Vas J, Mendez C, Perea-Milla E, et al. Acupuncture as a complementary therapy to the pharmacological treatment of osteoarthritis of the knee: randomised controlled trial. *Br Med J* 2004;329:1216.
14. Han A, Robinson V, Judd M, Taixiang W, Wells G, Tugwell P. Tai chi for treating rheumatoid arthritis. *Cochrane Database Syst Rev* 2004;3:CD004849.
15. Agency for healthcare research and quality. effects of omega-3 fatty acids on lipids and glycemic control in type ii diabetes and the metabolic syndrome and on inflammatory bowel disease, rheumatoid arthritis, renal disease, systemic lupus erythematosus, and osteoporosis. Evidence Report/Technology Assessment no. 89. Rockville, MD: Agency for Healthcare Research and Quality; 2004. 04-E012-1.
16. Eisenberg DM, Kessler RC, Van Rompay MI, et al. Perceptions about complementary therapies relative to conventional therapies among adults who use both: results from a national survey. *Ann Intern Med* 2001;135(5):344-51.

Correspondence: Dr. L. Schachter, Director, Dept. of Complementary Medicine, Maccabi Healthcare Services, 2 Kaufman Street, Tel Aviv 68012, Israel.
Phone: (972-3) 514-3726
Fax: (972-3) 514-1536
email: schachter_l@mac.org.il