

# Use of Complementary and Alternative Medicine by Patients with Inflammatory Bowel Disease

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**Abstract:** In this review article we provide a broad overview of complementary and alternative medicine (CAM) use in inflammatory bowel diseases (IBDs), including prevalence of use, common therapies used, and reasons for and factors associated with CAM use. CAM is commonly used by those suffering from IBD. Multiple forms of CAM are used to treat IBD, and often patients use multiple CAM therapies and continue to use conventional medical therapies. Patients using CAM report benefits that extend beyond simply improved disease control. Using CAM allows patients to exert a greater degree of control over their disease and its management than they are afforded by conventional medicine. There is limited evidence on the efficacy of CAM therapies in IBD. It is important for physicians caring for those with IBD to be familiar with common forms of CAM and to be able to provide general counseling to their patients about CAM use.

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**Key Words:** complementary and alternative medicine, inflammatory bowel disease, evidence-based medicine, communication

Complementary and alternative medicine (CAM) is commonly used by the general public and by those suffering from chronic diseases,<sup>1–4</sup> including individuals with Crohn's disease (CD) and ulcerative colitis (UC).<sup>5–12</sup> Increased recognition of the limits of conventional medicine has helped drive the growing interest in alternatives. The increase in patients' use of CAM has prompted substantial interest in CAM among gastroenterologists and other physicians who care for those with inflammatory bowel disease (IBD). However, for many CAM remains an area of uncertainty and confusion. The general lack of CAM teaching in medical school and the limited availabil-

ity of high-quality research or continuing medical education on CAM make most physicians unprepared to counsel and advise their patients about CAM or to anticipate potential benefits or harms of CAM when used alone or in combination with conventional IBD therapies.

Defining CAM remains elusive. The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine.<sup>13</sup> NCCAM groups CAM practices into five, often overlapping, categories: 1) whole medical systems; 2) mind-body medicine; 3) biologically based practices; 4) manipulative and body-based practices; and 5) energy medicine. Table 1 shows common therapies representative of each of these groups.

While medicine applies biological and physiological principles to clinical practice, CAM practitioners often have quite different views about the origin and treatment of diseases. Given the diversity of CAM approaches, such views are wide ranging. Several authors have pointed out that restoring the balance of opposing factors that are relevant to health is a critical feature of CAM.<sup>14,15</sup> Within individual CAM practices, the concept of balance may be translated into a focus on providing whole-person care, balancing energy forces, and/or an emphasis on naturalism. A holistic approach is characterized by an emphasis on diagnosing and treating illness through an understanding of the whole person (body, mind, and spirit) and how an individual fits in and interacts with the world around them. Treatments can also be directed at restoring a healthy balance and flow in vital energy that stimulates the self-healing potential of the body. Naturalism emphasizes people's intimate relationship with the natural world and relies on detoxification (often through fasting or purges) and natural remedies (herbs, vitamins) to restore balance and improve and maintain health. These philosophies often lead to highly individualized treatments, which can make the design of rigorous efficacy studies difficult.<sup>16</sup>

In many alternative medical systems the patient plays a more active role in their treatment than in conventional medicine. The patient may be seen as the primary agent of healing helped by the guidance of the practitioner. The patient-centered focus of CAM along with the common

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**TABLE 1.** Major Types of Complementary and Alternative Medicine

Major Types of CAM	Examples
Whole Medical Systems	Homeopathic medicine Naturopathic medicine Traditional Chinese medicine/Acupuncture Ayurveda
Mind-Body Medicine	Meditation Prayer Mental healing
Biologically Based Practices	Herbal products Dietary supplements
Manipulative and Body-Based Practices	Chiropractic Osteopathy Massage
Energy Medicine	Meditation Prayer Mental healing

emphasis of health and well-being, rather than on disease, may be particularly appealing to patients. This appeal is further enhanced by the common belief that CAM therapies are less toxic and safer than conventional medicines.<sup>17</sup>

In this article we provide a broad overview of CAM use in IBD. The first sections focus on the prevalence of use, common therapies used, and reasons for and factors associated with CAM use. We then describe CAM use by pediatric patients with IBD. Next, we address the evidence base for CAM therapies for IBD, focusing on the ratings of effectiveness of CAM therapies given in four reputable evidence-based CAM resources. We do not discuss in any detail individual CAM therapies used in IBD, but direct readers to other reviews on this topic.<sup>18,19</sup> We conclude

with advice on how healthcare providers can approach IBD patients wishing to use CAM.

### CAM USE BY IBD PATIENTS

CAM use is common among adult patients with IBD. To determine the prevalence of and reasons for CAM use, we focused on studies reporting on samples of over 100 IBD patients published in English after 1997 from the United States, Canada, and/or Europe. Table 2 shows that current use of CAM for IBD by North American and European patients ranges from 11%–34%, while current or past use of CAM ranges from 21%–60%.<sup>5–12</sup> However, it should be noted that not all these studies specified whether or not CAM use was specifically for IBD or also included CAM use for other health problems and/or for disease prevention and general well-being.

Table 3 lists the type of therapies most commonly used by IBD patients. In many surveys, herbal therapies are the most commonly used form of CAM.<sup>6,20,21</sup> Rates of use for individual therapies vary markedly, which likely reflects local patterns of CAM use. For example, homeopathy use is more commonly reported by European IBD patients than those in North America.<sup>7,9,12,17,22,23</sup> Patients commonly report the concurrent use of multiple therapies.<sup>9,10</sup>

Published studies also do not use a consistent definition of CAM. The number and types of therapies that are included as CAM vary dramatically from study to study. For example, some studies include vitamins, diet, exercise, and/or prayer as CAM. Generally speaking, studies reporting higher prevalence of CAM use included two or more of these therapies in their definition of CAM. For example, Burgmann et al<sup>10</sup> found that 60% of IBD patients used CAM in the past; however, when they excluded exercise, diet, and prayer, the prevalence decreased to 29%.

**TABLE 2.** Prevalence of Use of CAM to Treat IBD in North American and European Studies

Author	Year	N	Country	Sample	Current CAM use	Current or Past CAM Use
Hilsden et al. (5)	1998	134	Canada	Clinic	17%	51%
Hilsden et al. (8)	1999	263	International	Internet	34%	46%
Rawsthorne et al. (9)	1999	289	US/Canada	Clinic	n/a	51%
Langmeadet al. (21)	2002	239	UK	Clinic	28%	n/a
Hilsden et al. (6)	2003	2828	Canada	National Association	24%	47%
Burgmann et al. (10)	2004	150	Canada	Clinic	n/a	60%
Kong et al. (11)	2005	311	UK	Clinic	n/a	50%
Langhorst et al. (7)	2005	671	Germany	National Association	27%	51%
Bensoussan et al. (12)	2006	325	France	Clinic	11%	21%

**TABLE 3. Most Commonly Used CAM in North American and European Studies**

Therapy	Proportion of CAM Users
Vitamins (nonspecific) (5;8;11;12)	24–65%
Homeopathy (5-8;12;23;29;50)	6–52%
Herbal products (5-8;29)	5–58%
Diet (non-specific) (5;10;50)	16–45%
Carbohydrate specific diet (5;6;8)	5–10%
TCM/Acupuncture (6-8;12;23;29)	13–38%
Physical (massage, chiropractic, reflexology) (5)	9–30%
Boswellia Serrata (7;23)	40%
Naturopathy (6;23)	10–34%
Probiotics (6;23)	19–54%

**REASONS AND PERCEIVED BENEFITS**

When studies explore why IBD patients first sought CAM therapies, two broad categories are addressed: 1) direct disease-related benefits and 2) indirect, nondisease-related benefits. Common reasons patients have reported using CAM therapies are shown in Table 4. Research also shows that patients’ health beliefs play an important role in deciding to use CAM; for example, belief in a whole-person approach or in natural healing as opposed to beliefs that conventional medicine is not natural and does not focus on the person but on the disease.

Some reasons have been defined as pull factors (pulling a patient toward CAM) and others as push factors (pushing a patient away from conventional medicine).<sup>24</sup> For example, if a patient’s health beliefs match well with the tenets of CAM, such as a holistic approach and focus on naturalism, the patient is likely to be pulled toward using CAM. Alternatively, if patients have used conventional therapies but did not find that these controlled their disease adequately or resulted in adverse effects, they may be pushed toward using CAM.

The largest survey of CAM use in IBD found that the three most common reasons patients stated for using CAM were 1) “I wanted greater control over my life and my IBD,” 2) “I heard or read that complementary treatments might be helpful,” and 3) “I value the emphasis complementary treatments place on the treating the whole person.”<sup>25</sup> Therefore, most patients were drawn toward the use of CAM due to an indirect benefit (control), a direct benefit on their disease, and/or a characteristic of CAM (holism). Some patients also reported reasons that indicated that they had been pushed away from conventional therapy to CAM: For example, CAM was used by 42% of patients because conventional IBD treatments were unhelpful and

by 36% because of side effects of conventional treatments. Analogous results have been found by others.<sup>7,20,26</sup>

There is little information on the frequency with which IBD patients abandon conventional medicine in favor of CAM. However, evidence from other populations suggests that this is uncommon.<sup>27</sup> It is likely that IBD patients tend to use both to obtain a synergistic effect or in the hope that CAM will ameliorate or prevent side effects from a conventional medicine.

Often people use CAM because they anticipate certain outcomes or benefits or they indicate they have experienced benefits related to their CAM use. Clearly, anticipated benefits may serve as reasons for CAM use and therefore there is substantial overlap between reasons for use and perceived benefits. In general, most IBD patients who have used CAM are satisfied with the results.<sup>5,10</sup> Burgmann et al<sup>10</sup> found 95% of users felt that exercise, diet, and prayer helped them and 67% indicated that other forms of CAM were helpful. Langmead et al reported that 53% of IBD patients indicated that they perceived that CAM had worked “very well” or “quite well,” but these investigators reported that those with UC found greater benefit than those with CD.<sup>21</sup> Kong et al<sup>11</sup> found that 41% of IBD patients reported a benefit from CAM use: this was lower than the rate reported by general gastrointestinal (GI) patients (54%) and a general population control group (69%). Joos et al<sup>23</sup> found that in German IBD patients satisfaction was greatest with probiotics (57% satisfied) and lowest with naturopathy (34%) and homeopathy (39%).

In our Canadian survey we asked about several potential benefits.<sup>6</sup> The most commonly reported benefits were an improved sense of well-being and relief of IBD

**TABLE 4. Common Reasons for CAM Use by IBD Patients**

	Study	Proportion
Direct disease-related benefit		
Search for “optimum” therapy	(7)	79%
Better control of the disease	(12)	64%
Terminate or avoid steroid medication	(7)	63%
Deal with side effects of conventional therapy	(7;12;17)	38–45%
Ineffectiveness of conventional medical therapy	(6;12;20)	39–42%
Indirect nondisease-related benefit		
Wish to take personal responsibility for treatment	(7)	42%
Greater control of my life and my IBD	(6)	73%
Being more in control of own health care	(20)	29%
Natural therapy is safe		
Emphasis on treating the whole person	(17)	51%

symptoms. However, two-thirds of current CAM users also reported an improved sense of control over their disease. The emphasis placed on “sense of control” by IBD patients, an indirect benefit of CAM use which has been reported in several studies,<sup>12,25,28</sup> is important. IBD patients experience flares that are usually unpredictable and difficult to prevent. Conventional therapies are complex and, therefore, decisions about conventional therapies, as well as access to such therapies, are largely controlled by physicians. Therefore, IBD patients likely often feel that they have little control over their disease or its treatment. The use of CAM provides one mechanism for IBD patients to exert control, which they greatly value. A patient may not appreciate any improvement in their disease but still be satisfied with their use of CAM because of their increased sense of control. It is important for physicians to understand this because it helps explain why rational patients demonstrate what, from the physician’s perspective, is an irrational health behavior—the use of an unproven therapy. Understanding a patient’s use of CAM requires looking beyond symptoms to the impact the disease and its treatment has on every aspect of a patient’s life.<sup>26</sup>

In our survey, 8.3% of past CAM users reported suffering side effects.<sup>6</sup> The most common negative effect of CAM use reported by past users was that their use of CAM had been a waste of money, likely reflecting the lack of any perceived therapeutic benefit. Mostly patients respond to questions about benefits of CAM in general and not as related to specific CAM therapies.

### FACTORS ASSOCIATED WITH CAM USE

Several studies have attempted to link patient or disease-related factors to the use of CAM. In general, studies link CAM use to severity of the disease and/or patient characteristics. Disease characteristics that have been studied include disease activity and duration, medication use, quality of life, and history of hospitalization and surgery, and common patient characteristics include age, gender, education level, socioeconomic status, comorbidities, and healthcare behaviors.

In our Canadian survey we found that current disease activity, patients’ desired role in treatment decision, use of CAM for other purposes, and use of exercise and prayer were predictive of CAM use for IBD in both those with CD and UC.<sup>25</sup> Lower confidence in their treating physician was predictive of CAM use in those with UC, and younger age was associated with CAM use in those with CD.

However, factors predictive of CAM use are not consistent among published studies. For example, Rawsthorne et al<sup>29</sup> found marital status and number of physician visits in the prior year to be associated with CAM use, but Langhorst et al<sup>7</sup> found CAM use to be associated with younger

age and higher education, but not with gender or marital status.

Factors associated with CAM use are likely highly dependent on the sample being studied and the means used to elicit the factors. For example, our group completed studies using the same questionnaire in two very different populations (GI clinic and Internet discussion group).<sup>5,8</sup> Each of the samples reported different reasons for seeking CAM and different predictors of CAM use were identified. Disease duration and history of steroid use were predictors of use in the clinic-based population, but not in the Internet population.

Given that CAM use is so widespread amongst IBD patients, it should not be surprising that CAM use cuts across all demographic and disease-related groups. It is likely that the patient-centered focus of CAM along with the common emphasis on health and well-being, rather than on disease, is particularly appealing to patients with chronic diseases such as IBD.<sup>26</sup>

### CAM USE IN PEDIATRIC IBD

CAM use in children with IBD has several unique considerations. First, children often play no or a limited role in treatment decisions. Parents exert much greater control and therefore it is the parents’ attitudes and behaviors that most influence the use of CAM by their children. Second, there are often greater concerns about the use of conventional IBD therapies in children, such as concern about growth retardation with corticosteroids. Third, there is often only limited scientific evidence from high-quality studies, such as randomized controlled trials, on conventional medical therapies in pediatric populations.

The reported prevalence of CAM use in children varies widely, with estimates ranging from very low (6.7%) in Canadian children with IBD<sup>30</sup> to very high in Australian children (72%),<sup>31</sup> with other studies in between.<sup>32–34</sup> The CAM therapies most commonly reported in pediatric populations include probiotics, fish oils, herbs (aloe vera, evening primrose oil), dietary modifications, and megavitamin therapy.<sup>31–34</sup> As with adults, the use of more than one CAM therapy is common, with studies reporting a median of 2–3 CAM therapies per child.<sup>31,34</sup>

Parents report several reasons for using CAM in their children. The most common reasons include avoiding side effects of conventional IBD medicines, dissatisfaction with conventional medicines, and the positive experiences of others with CAM.<sup>31,32,34</sup> The two most common reasons for *not* using CAM reported in a Canadian study were that the conventional medical treatment appeared to be successful and worry that the CAM therapy might interfere with the conventional treatment.<sup>30</sup>

Several factors have been positively associated with CAM use in children with IBD. Children with a higher

number of adverse effects from conventional therapies were more likely to use CAM; the odds of CAM use increased by 30% with each additional adverse effect.<sup>32</sup> Younger age of child was also positively associated with current CAM use.<sup>30</sup> In addition to patient factors, several parental factors including parental CAM use, higher parental educational level, and younger parental age were reported to be positively associated with CAM use in children with IBD.<sup>32,34</sup> In several studies, disease severity (as determined by number of sick days, days off from school, nights in hospital, or number of prescribed medications) was not associated with CAM use.<sup>31,32</sup> However, other studies showed that CAM use was positively associated with various disease severity-related factors including: poor quality of life related to IBD, increased number of school absences, increased spending on prescription and nonprescription medications, use of certain treatments (corticosteroids, antibiotics, immunomodulators, biologics), number of steroid courses, calorie supplementation, and use of nonnarcotic analgesic agents.<sup>32,35</sup> In addition, CD (versus UC) and use of the Internet to research IBD are also predictors of CAM use.<sup>32</sup> Only previous bowel surgery for IBD has been shown to be negatively associated with CAM use.<sup>32</sup>

Despite the widespread use of CAM among children with IBD, one study found that only 12% of parents perceived that the CAM agents were effective or very effective.<sup>31</sup>

#### EVIDENCE OF CAM BENEFITS IN IBD

In general there is limited, high-quality evidence on the effects of specific types of CAM on IBD to reliably guide patients and clinicians.<sup>18,19</sup> Table 5 includes four books and Internet databases that are available to patients and clinicians. The Internet databases are revised regularly, and therefore have the advantage over the books of being more up-to-date in a rapidly evolving field. The four resources summarize the available research data on various CAM therapies using a structured, evidence-based approach. Mostly, the summaries are written by a team of experts using explicit rules of evidence. The authors have also rated the degree of effectiveness (see Table 5). The examples in Table 5 include only those for which there is evidence of benefit.

The summaries are constrained by the limited amount of high-quality research on CAM performed in IBD populations. This is because for most of these therapies no studies in an IBD population have been performed, and also because the authors of the resources have avoided extrapolating results from other patient populations, such as those with autoimmune diseases or other GI conditions (irritable bowel syndrome). They also do not attempt to rate whole medical systems, such as homeopathy and traditional Chi-

nese medicine, due the large number of specific therapies used within each system. Therefore, the resources rate individual therapies but not general approaches to management of IBD. Further, the four resources avoid using expert opinion or folklore in their formal rating of a therapy's effectiveness, and thus are more strict than other available resources which often do not discriminate between these different types of evidence and, therefore, may provide an overly optimistic rating of a therapy's potential benefit in IBD.

While the rating scales that were used differ, each of the resources has reached similar conclusions about the effectiveness of individual therapies. The large number of high-quality studies found for therapies such as fish oil and probiotics suggests that these have either transitioned or are in the process of transitioning from CAM to conventional medical therapies. Several relevant systematic reviews and meta-analyses of CAM therapies are available.<sup>36-41</sup>

The limited number of high-quality studies assessing evidence of CAM is not unique to IBD research. The quality of available studies on the effectiveness of CAM in general is impaired by small samples sizes, lack of adequate controls, inadequate study designs, and poor reporting of results.<sup>16,18</sup> Publication bias is also likely a significant problem, with positive studies being preferentially published.<sup>42</sup>

While IBD patients use CAM to control their disease or to deal with its symptoms, it is important to keep in mind that many of them use CAM for other reasons as well (Table 4). Such treatments include whole systems such as homeopathy and naturopathy as well as practices such as acupuncture and physical therapies (Table 3). Many patients report positive experiences with these treatments. It will be important to assess the safety of such therapies as well as the potential of interaction effects and to carefully monitor patients.

#### EVIDENCE-BASED MEDICINE

Evidence based-medicine has become the cornerstone of medical practice. The Oxford Handbook of Complementary Medicine concludes for UC that "best evidence suggests that there is no CAM intervention with convincing evidence of effectiveness," and reaches a similar conclusion for CD.<sup>43</sup> However, the understanding of what evidence means may differ greatly between patients and physicians. Types of information that patients label as evidence include anecdotes, expert opinion, gut feeling, popular literature, scientific evidence, testimonials/advertising, and trial and error.<sup>44</sup> This will not constitute evidence for practitioners; however, it is important to consider that evidence is more than scientific evidence alone, it is "the integration of the best research evidence with clinical expertise

**TABLE 5. General References on CAM**

Title	Description	Examples <sup>a</sup>
Oxford Handbook of Complementary Medicine (36)	The editor, Edzard Ernst, is a recognized authority on evidence-based CAM research. The Oxford Handbooks are well-respected with a thorough process of evidence evaluation. Therapies are rated as follows: LB: Likely to be beneficial; UE: Unknown effectiveness; UB: Unlikely to be beneficial; LI: Likely to be ineffective or harmful.	Probiotics are noted as having good scientific evidence (LB) for Bifidobacteria and E. Coli Nissle 1917 (Ulcerative Colitis) and S. boulardi (Crohn's disease)  Fish oil - Omega-3 fatty acids Psyllium (Ulcerative Colitis)
The Natural Standard (43)	Natural Standard ( <a href="http://www.naturalstandard.com">http://www.naturalstandard.com</a> ). Print and online versions are available. Natural Standard is an international research collaboration that provides detailed information on levels of evidence on the use of a therapy, safety and interaction issues, conditions for use, dosing, possible mechanisms of action, and the references used. Evidence is summarized as: Grade A: strong scientific evidence; Grade B: Good scientific evidence; Grade C: unclear or conflicting scientific evidence; Grade D: Fair negative scientific evidence; Grade E: Strong negative scientific evidence).	Probiotics are noted as having good scientific evidence (grade B) with emphasis on Bifidobacteria E. Coli Nissle 1917 (for Ulcerative Colitis) VSL #3
Natural Medicines Comprehensive Database (44)	Natural Medicines ( <a href="http://www.naturaldatabase.com">http://www.naturaldatabase.com</a> ) is another international research collaboration. Print and on-line (free of charge) versions are available. Provides detailed information on levels of evidence on the use of a therapy, safety and interaction issues, conditions sited for use, dosing, possible mechanisms of action, and the references used. Evidence is rated as: E: Effective; LE: Likely effective; PE: Possibly effective; PI: Possibly ineffective; LI: Likely ineffective; I: Ineffective.	Probiotics are noted as being possibly effective, including Bifidobacteria Lactobacillus (ulcerative colitis)
Integrative Medicine (45)	Comprehensive textbook, also available online ( <a href="http://www.mdconsult.com/das/search">http://www.mdconsult.com/das/search</a> ) Uses patient-centered approach to grading evidence as: Grade A: consistent, good quality evidence; Grade B: inconsistent or limited quality evidence; Grade C: consensus, usual practice or opinion.	Probiotics  VSL #3 - Grade B (ulcerative colitis) S. boulardi - Grade B

<sup>a</sup>Examples are not exhaustive and focus on beneficial effects.

and patient values."<sup>45</sup> Both clinical expertise and patient values will need to play an important role in treatment decision-making. Along the same lines, the Canadian Health Services Research Foundation has identified that evidence is context-sensitive,<sup>46</sup> suggesting evidence has limited meaning or importance for decision-making if it is not adapted to the circumstances of an individual patient. This again implies that it is important to discuss the reasons for CAM use with patients (see below).

Langhorst et al<sup>7</sup> found that only 48% of all IBD patients regarded a scientific foundation for CAM treatments as being important. We found that 65% of IBD

CAM users would continue to use CAM if a scientific report came out reporting that the therapy was ineffective.<sup>47</sup> This was particularly true in those who had found a disease-related benefit through their use of CAM.

Very little data have been collected on the information sources used by patients regarding CAM therapies. A 2005 study from Germany indicates that sources of CAM information are family/friends, self-support groups, physicians, media (including Internet), and nonmedical practitioners.<sup>7</sup> Further research is needed to determine the sources and quality of CAM information written for and used by those with IBD.

### APPROACH TO THE PATIENT USING OR WISHING TO USE CAM

Given the widespread use of CAM, it is important for physicians to consider CAM use by their patients at each encounter. In general, CAM should be treated as any conventional medication. All CAM therapies that a patient is using should be incorporated into their “medication” list in their medical records. As with conventional medications, physicians must consider the potential for both benefit and harm from CAM use and to be alert for the potential for interactions between CAM therapies and conventional medicines.

Counseling patients about CAM use is important and can help the patient make a more informed choice. To be effective, it must be done in a sensitive and nonjudgmental fashion. Dr. David Eisenberg has written a valuable article on advising patients who seek alternative medical therapies.<sup>48</sup> We have previously adapted these recommendations to assist those caring for patients with IBD.<sup>49</sup>

As a first step, it is important to determine current and past use of CAM for several reasons. First, the use of a CAM may be an indication that the patient is dissatisfied with their current conventional treatment either because they are not achieving the benefits they desire or because they are suffering side effects. Second, potentially harmful therapies or potential drug-CAM interactions can be identified. Finally, the effects of the CAM, either good or bad, will not be misconstrued as resulting from a conventional IBD treatment.

A patient who is using or considering using a CAM should be asked about their reasons for doing so. This questioning should take into consideration the three broad categories of reasons that lead patients to use CAM: 1) a desire to achieve direct, disease-related benefits; 2) a desire to obtain indirect, nondisease-related benefits, such as sense of control; and 3) congruence of CAM with the patients' health beliefs. Identifying specific reasons for CAM use could determine specific areas of dissatisfaction with conventional treatment that could allow modifications to be made. However, if the patient is a firm believer in the principles of CAM, then it is unlikely that they will be convinced not to use it. If on the other hand the patient is more comfortable with conventional medicine but is seeking alternatives because they are experiencing problems, then they may be willing to first try a modification in their conventional medical treatment. This patient-centered approach allows the physician and patient to work together, and on its own may provide the patient with a sense of greater control of their healthcare and greater satisfaction with their medical care.

Patients should be encouraged to define realistic treatment goals and to reevaluate their use of a therapy after a set period of time. Many patients believe that CAM therapies are without risk, often because they are “natural”

therapies. Physicians should ask patients whether they know the possible side effects of a therapy and should warn patients about the possibility of interactions with alcohol or other drugs. Interaction effects are mostly relevant for ingestible CAMs, such as herbs and other natural health products.<sup>44–46</sup> There are several sources to inform physicians and patients about potential interactions, including those shown in Table 5.

Apart from the CAM guides shown in Table 5, we recommend two other resources to assist physicians in obtaining information about CAM and specific therapies. The Turning Research into Practice (TRIP) database ([www.tripdatabase.com](http://www.tripdatabase.com)) is a meta-search engine for identifying high-quality evidence to guide clinical practice. The Website of the National Center for Complementary and Alternative Medicine ([nccam.nih.gov](http://nccam.nih.gov)) provides research-based information on CAM therapies.

### CONCLUSION

CAM is commonly used by those suffering from IBD. Multiple forms of CAM are used to treat IBD, and often patients use multiple CAM therapies at the same time and usually continue to use conventional medical therapies. Patients using CAM report benefits that extend beyond simply improved disease control. Using CAM allows patients to exert a greater degree of control over their disease and its management than they are afforded by conventional medicine. It is important for physicians caring for those with IBD to be familiar with common forms of CAM and to be able to provide general counseling to their patients about CAM use.

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