

CAM use in cancer patients. Classification criteria determine level of use.

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To be able to compare studies on self reported CAM use among cancer patients the researchers have to agree upon common criteria for classifying a patient as a CAM user. What are the criteria a researcher should use to classify a patient as a CAM user?

*Exercising
more?*

*Changing
diet?*

*Taking
supplements*

*Visiting a CAM
provider once?*

*Visiting a CAM
provider at least 4 times*

BACKGROUND

Several studies have presented data on self-reported use of Complementary and Alternative Medicine (CAM) among cancer patients. The use varies from 7 to 83 %. This wide range of self-reported CAM use is mainly due to different criteria in defining a CAM user. To compare different studies there is a need to clarify what criteria a patient needs to fulfill to be classified as a CAM user.

Harris 2003 reports that 16.4 % of the cancer patients in his study had consulted a CAM provider the last 12 months. The questionnaire involved seven types of therapies: Acupuncture, aromatherapy/massage therapy, chiropractic/osteopathy, homeopathy, hypnotherapy, herbal medicine, spiritual/faith healing.

Risberg 1998 estimates that 45 % of the cancer patients will use CAM for their cancer within the first five years after diagnosis. His results are based on a positive response to one of the following questions:

"If you are using or have used alternative medicine please mark which type: Healing, homeopathy, zone therapy, herbal- or vegetable cure, The nitter cure, iscador, sevenstar treatment, change in diet, healing by prayer or other types of alternative (other) treatment".

Richardson 2000 reports that 83.3 % of the cancer patients had used at least one CAM approach. Her results are based on a positive response to one of the following questions concerning CAM:

"Have you used it to treat Cancer?" Y/N, "Have you used it for issues related to Cancer?" Y/N, "Have you used it for other purposes?"

Her questionnaire is very detailed with the following headlines:

Special diet (5 subgroups), **psychotherapy** (4 subgroups), **movement/physical therapies** (5 subgroups), **mind/body** (8 subgroups), **spiritual practices** (2 subgroups), **vitamins/herbs** (11 subgroups), **others** (specify) (5 subgroups). Both exercise and prayer are considered as CAM in this study.

MATERIAL AND METHODS

885 cancer patients with distant metastases were chosen to participate in the study. All of them had survived at least five years despite an expected five-year survival below 60% at the time of diagnosis. 317 returned the postal questionnaire asking about CAM-use, dietary supplements, diet and physical activity. The CAM-use is reported in five categories:

CAM level 1: Visiting a CAM provider at least 4 times.

CAM level 2: Visiting a CAM provider at least once.

CAM level 3: Classified as a CAM level 2 user or have used dietary supplements (RDA not included) or actively done self-support.

CAM level 4: Classified as a CAM level 3 user or made major change in diet.

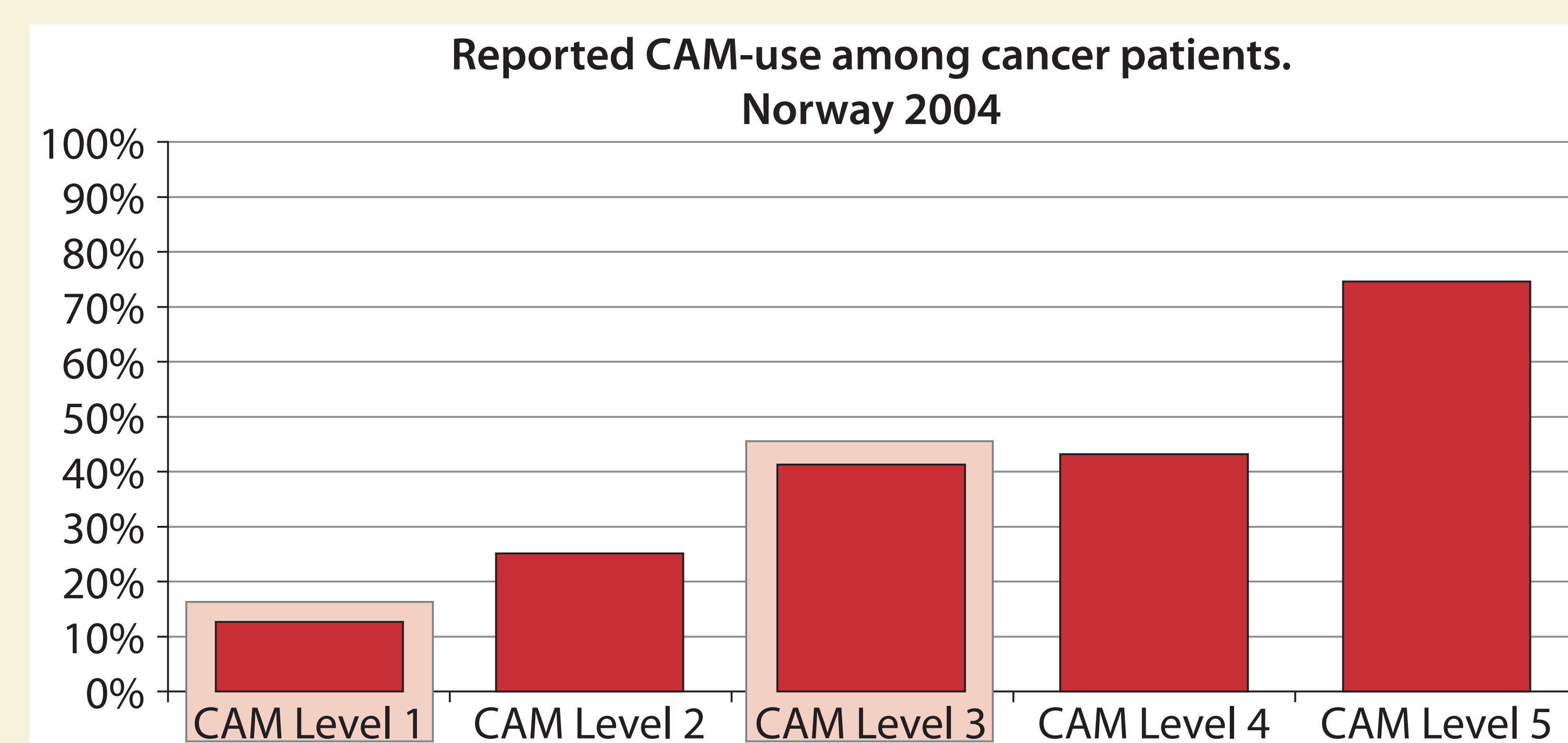
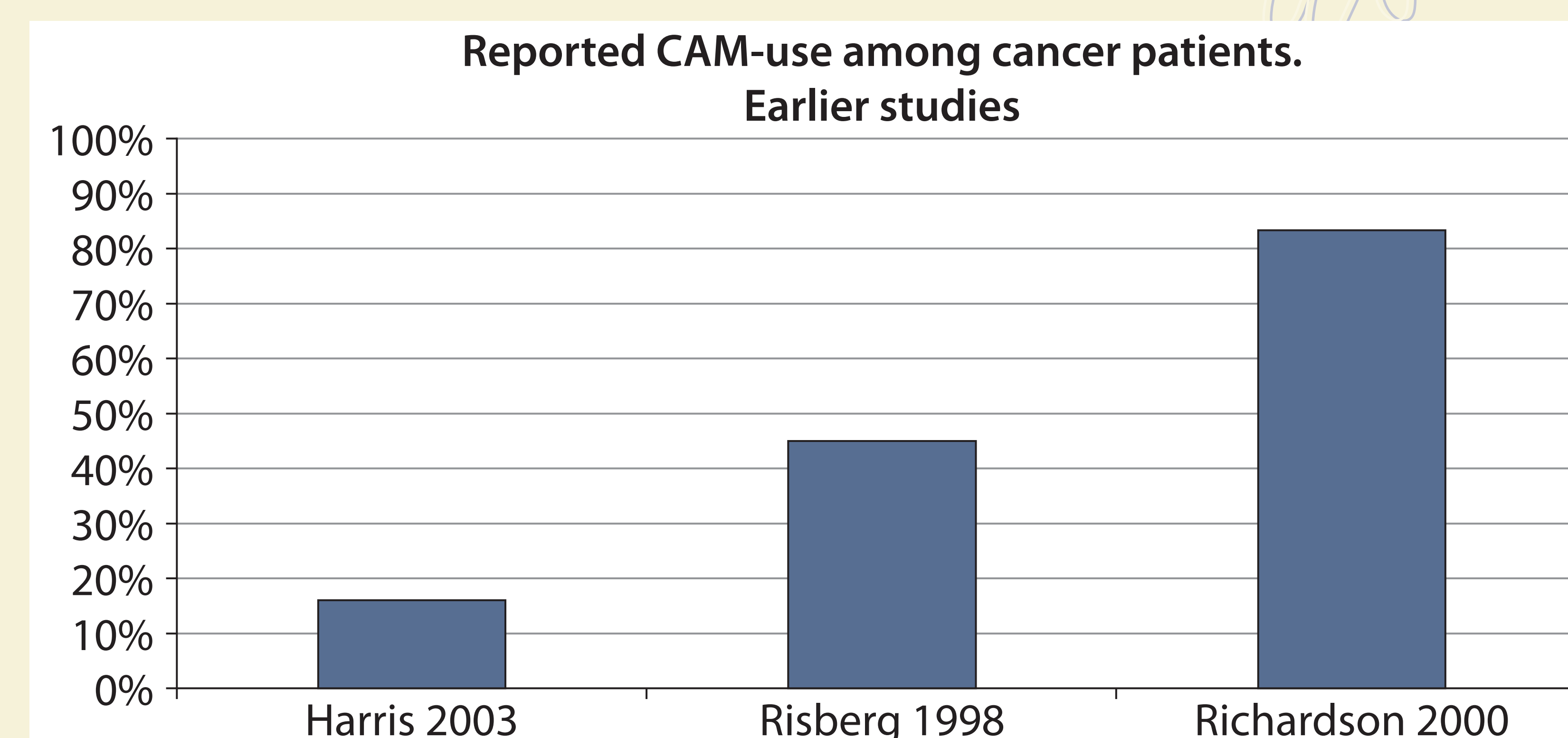
CAM level 5: Classified as CAM level 4 user or also indicated that physical activity is important.

RESULTS

Use of CAM in the studied population varied from 12.7 % (CAM level 1) to 74.6 % (CAM level 5). Among women the use of CAM varied between 18 and 75.8 % while CAM-use among men varies from 5.8 % to 71 %. The relative probability of being a CAM user given you are a woman varies from 3.1 (CAM level 1) to 1.1 (CAM level 5).

DISCUSSION

This study shows that the use of CAM in cancer patients varies considerably depending on what treatments are defined as CAM. The relative probability of being a CAM user if you are a woman increases substantially if the definition is stricter. To be able to compare studies we will propose CAM-use to be reported on level 1 (CAM level 1) and level 3 (CAM level 3). We are aware of the fact that CAM level 1 is a category that is somewhat stricter than what we normally see in reported studies, but if the focus is to report the number of patients choosing an alternative or complementary treatment regime for their cancer, the CAM level 1 definition might be a suitable definition. The patient sees a practitioner over a clinically important period of time. If the focus of the study is to register the number of people who are actually "trying" unconventional approaches, the CAM level 3 definition might be useful. We find it unreasonable to define dietary changes and ordinary exercise as CAM-treatments. These are elements that have been advocated in the conventional health care system for a very long time, and from our material we can see that the number of "CAM users" increases substantially when exercise (CAM level 5) is included as CAM. Also by including prayers, the number of CAM users increases substantially (Ricardson 2000). Most countries in the world have a strong tradition for praying, particularly in connection with illness. By including prayers, moderate changes in diet and ordinary exercise, we might be given a wrong impression of CAM-use among cancer-patients.



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