Alternative Therapies: Learning from Patients Who Choose Them

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INTRODUCTION

In their interesting article published in this issue [1], Citrin et al. describe the, fortunately, rare decision among breast cancer patients to forego evidence-based mainstream care, at least initially, in favor of “alternatives.” As is clear to readers of this journal, there are no viable “alternatives” to nationally developed standards for breast cancer treatment. What defines the women and their rationale for declining mainstream care? That is the topic studied by Citrin et al. [1].

The research included 30 breast cancer patients who initially declined recommended treatment in favor of literal alternatives and who eventually sought the combination of appropriate treatment plus therapies termed “alternatives” as offered at the Midwestern Regional Medical Center (MRMC) in Zion, Illinois, a cancer treatment facility operated by Cancer Treatment Centers of America. These women were compared with 30 others who accepted the combination at MRMC following diagnosis. The comparison group was selected to mirror the racial mix and educational level of the decliners.

No sociodemographic differences were found between the two groups, but they differed significantly in their perceptions of the risks and benefits of chemotherapy and radiation therapy versus “alternative” therapies. Women who initially declined mainstream treatment and sought alternative therapies exclusively perceived mainstream treatments as risky or harmful and alternatives as beneficial.

LEARNING FROM CITRIN ET AL. STUDY RESULTS

Apparently, no study participant was seen at a National Cancer Institute–designated cancer center. Those who initially declined recommended treatments for breast cancer had been seen at community hospitals or university medical centers before coming to MRMC. Others apparently sought care at MRMC, described as consistent with National Comprehensive Cancer Network guidelines, from diagnosis onward. The decliners explained their decision to forego recom-

mended treatment on the basis of their negative experiences with physicians following diagnosis and their “belief in holistic therapy as a viable alternative, perceptions that chemotherapy and radiotherapy were high risk and low benefit, and misinformation.”

Study patients felt that the statements and behavior of the oncologists they saw originally provided little reason for hope and that these physicians were dismissive of their wishes “to incorporate alternative medicine into their regimens.” One can picture oncologists’ surprise or dismay that these patients refused conventional treatment, in light of the fact that >80% of study patients who initially declined mainstream care (and 67% of all study participants) were stage 3 or 4 at diagnosis.

Per Surveillance, Epidemiology, and End Results data, breast cancer is diagnosed at stage 3 or 4 in a small minority of cases. Late-stage disease at diagnosis generally is associated with women who are less aware of the importance of early diagnosis, or less educated about medical treatment. Such status is consistent with study participants’ pursuit of the less-than-rational purported cures they sought in the U.S. and Mexico as their disease continued to progress.

Hopefully, ever fewer women with breast cancer will be drawn to bogus therapies as information about excellent mainstream treatment results spreads further. Patients must learn that there are no viable “alternatives” to mainstream cancer care. Integrative medicine, the synthesis of proper cancer care and adjunctive complementary therapies, is an optimal and readily available approach.

TERMINOLOGY

The Citrin et al. [1] paper highlights the terminology problem that still plagues the field of integrative oncology. Unproven or disproved methods promoted and used to treat cancer are appropriately termed “alternatives.” They are simply quackery. However, the term “alternative” does not accurately describe

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evidence-based “complementary therapies,” which are additions, rather than alternatives, to mainstream cancer care.

Terminology difficulties began when Congress created the National Institutes of Health Office of Alternative Medicine in 1993. Five years later, this minimally funded office was renamed the National Center for Complementary and Alternative Medicine (NCCAM), and its budget was greatly expanded. The original office and the current center have been swathed in controversy from the outset. Many continue to fault NCCAM for its support of projects perceived as irrational, unscientific, or bogus. However, NCCAM also has supported critical research that demonstrated the ability of complementary modalities to control many physical and emotional symptoms, including those that are not well managed with mainstream means.

The schizoid nature of the language remains a problem. Quackery abounds in the form of heavily promoted, useless, and sometimes dangerous “alternatives” to mainstream care, a \$40 billion per year megalith in the U.S. with similar levels of popularity and cost in developed countries around the world. Participants in this study who declined mainstream care are reported to have used a variety of alternative “therapies,” including raw fruits and vegetables, juicing, supplements and prayer, colon cleanses, proprietary herbs and salves said to dissolve tumors, “insulin potentiated chemotherapy,” Laetrile, and treat-

ments involving lasers, oxygen, and ozone. Patients believed these therapies would cure them, just as their promotional claims suggest.

Whereas such “alternative” therapies are falsely promoted as viable substitutes to mainstream cancer care, “complementary therapies,” by definition, are adjunctive; that is, they are used with, not instead of, evidence-based mainstream care. Complementary therapies are nonpharmacologic interventions that include massage therapy, acupuncture treatment, mind-body therapies, exercise and fitness programs, music and art therapy, and nutritional counseling, all of which are intended to reduce the physical and emotional symptoms associated with cancer and its treatments. Virtually all major U.S. cancer centers have integrative medicine or integrative oncology programs in which complementary therapies are offered and often subjected to study. An expanding evidence base for these therapies can be found in top oncology and general medicine journals.

Many of us have long railed against the unfortunate conflation of NCCAM’s two unrelated terms, which at best perpetuates confusion and besmears the careful studies of useful complementary modalities. But even more than that, we have railed against the use of quack alternative therapies, such as those sought by patients in the Citrin et al. [1] study.

REFERENCE

1. Citrin DL, Bloom DL, Grutsch JF et al. Beliefs and perceptions of women with newly diagnosed breast cancer who refused conventional treatment in favor of alternative therapies. *The Oncologist* 2012;17:607–612.

See the accompanying article on pages 607–612 of this issue.