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EDITORIAL

Complementary therapies for supportive cancer care

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"Randomised controlled trials of specific therapies…rarely demonstrate any benefit in terms of quality of life" [1]. This is a statement from a recent article in this journal dealing with complementary therapies for supportive cancer care. It made me ponder. Is this really true? I don't think so!

Anyone who cares to look up the trial data will find hundreds of studies—far too many to review here in detail. So let's just look up (some of) the systematic reviews which are available, many from this journal. At least some encouraging evidence has emerged from systematic reviews of the following treatments: (for a fuller discussion of the treatments involved, the reader is referred elsewhere [2]).

- Acupressure for chemotherapy-induced nausea [3, 4]
- Acupuncture for cancer pain [5]
- Acupuncture for hot flushes in men with prostate cancer [6]
- Acupuncture for hot flushes in women with breast cancer [7]
- Aromatherapy for improving well-being of patients with cancer [8]
- Chinese herbal medicine for improving quality of life [9]
- Co-enzyme Q10 for reducing the toxicity of cancer drugs [10]
- Exercise for fatigue and nausea [11, 12]
- Exercise for improving quality of life [13]
- Guided imagery for reducing anxiety [14]
- Hypnosis for reducing cancer pain [15]
- Massage for a wide range of symptoms and for improving quality of life [16]
- Music therapy for improving quality of life [17]
- Qigong for improving quality of life [18]
- Tai chi for improving psychological symptoms [19]

I am, of course, not claiming that the evidence for all the listed treatments is compelling, but I insist that there are at least some encouraging trial data. In fact, some of the approaches, e.g. acupuncture in the treatment of nausea or exercise in the treatment of asthenia, are today generally accepted in routine supportive care. Other treatments, e.g. Co-enzyme Q10 or Qigong, are clearly not well enough researched and necessitate confirmatory studies.

I believe, we need to build on this evidence. We need more clinical trials and we need better clinical trials. By "better", I mean trials that successfully minimise bias. Certain study designs that are popular for pragmatic trials have zero chance of generating a negative result, even if the tested intervention is devoid of any specific therapeutic effects [20]. Therefore such investigations have the potential to mislead us.

The challenges for future research are numerous and complex. On the one hand, we need evidence that applies to "real life" situations in supportive care. On the other hand, we should thrive to establish cause and effect with reasonable certainty. Sailing between the "Scylla and Charybdis:" will not be easy, and a discussion about how this might be best achieved is clearly beyond the scope of this short comment, particularly as this area is the subject of much controversy within CAM research [21].

A likely strategy could be to employ a mixed method approach of observational studies, pragmatic and fastidious trials and, at the same time, be cognisant of the limitation of each of these approaches.

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If we follow this path, we might eventually arrive at a point where we are able to tell with confidence that this treatment is useful while that one is not, and to determine that one therapy is better than another for achieving a specific therapeutic goal. Ignoring or downplaying the importance of clinical trials [1] in sorting out the wheat from the chaff will not help anyone—least of all the cancer patient.

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