May-Supplements and Complementary Therapies

Patients with IBD commonly use complementary and alternative medicines (CAMs) or non-allopathic therapies at some point during their disease course. CAMs include herbal supplements, prebiotics, probiotics, as well as mind-body therapies such as acupuncture and hypnosis.

Although 30-50% of patients use CAMs in order to supplement conventional therapies and help ease their symptoms, they are reluctant to mention it to their treating providers. Due to limited, small sample size, controlled and uncontrolled clinical trials of CAMs, these therapies have not been widely accepted by providers as part of mainstream medical IBD care. Providers should familiarize themselves with the variable CAMs used by IBD patients and be open to discuss and ensure that they are used safely. Patients need to understand that CAMs should not be used in place of accepted and well-studied medical therapies that are available. Further research is necessary for validation of use. (Cheifetz, et al., 2017)

Four major domains of CAM:

- Mind-Body Medicine (prayer, tai chi, hypnosis, meditation, biofeedback, and yoga)
- Manipulative and Body-Based Practices (chiropractic manipulation, massage, and reflexology)
- Energy Medicine (biofield therapies and bioelectromagnetic-based therapies)
- Biologically-Based Practices (dietary supplements and functional foods)

TIP #1: Be aware that CAM use by your patients is likely and encourage them to alert you to any CAM therapies they are using.

CAM use has been found to be especially prevalent among university-educated individuals and among individuals who have experienced ineffectiveness and/or unwanted side effects from conventional therapies; however, adherence rates to conventional treatments were not found to be correlated to CAM use (Weizman et al., 2012). The level of trust in the health care provider was not found to be different between CAM users and non-users (Weizman et al., 2012), suggesting that CAM use on the part of your patient is not a sign of distrust in you as a provider. Because even seemingly innocent vitamins might contain ingredients that could interact with medications, it is important to build a bridge of communication that keeps you fully informed of your patients’ use of CAM.

**Cannabis/Marijuana – Although marijuana may reduce symptoms associated with IBD, there is little evidence to support an anti-inflammatory role outside of animal models and there is no evidence that it positively alters the disease course. There is no way to control the dosing in routine clinical practice and with the unpredictable psychoactive effects, its use cannot be recommended to treat IBD. Dosing strategies also cannot be recommended for patients with IBD until more data are available from clinical trials. (Cheifetz, et al., 2017)

For more information on CAM modalities in the context of IBD, see the Crohn’s & Colitis Foundation Fact Sheet and Educational Webcast:

http://www.crohnscolitisfoundation.org/resources/complementary-alternative.html

http://www.crohnscolitisfoundation.org/resources/CAM-webcast.html
TIP #2: Familiarize yourself with the most common forms of CAMs.

**Herbs and Dietary Supplements:**

1. **Cannabis/Marijuana** – this is available in multiple formulations and 21 states currently allow for the medical use of marijuana. *Results from human trials:* possible therapeutic potential in CD, reduction in CDAI score symptom driven, no evidence for mucosal healing. *Adverse effects (AE):* cognitive and motor impairment, anxiety, dizziness, nausea, psychosis, loss of balance.

2. **Curcumin/Tumeric** – curcumin is known for its anti-inflammatory properties and it may have a role in maintenance of remission in patients with UC. *Results from human trials:* 50% increased response vs placebo. *AE:* rare nausea and diarrhea, yellow stools.

3. **Fish Oil** – found predominantly in oily fish and thought to have anti-inflammatory effects. *Human studies:* results have been unconvincing for consistent effects. (Cheifetz, et al., 2017)

**Probiotics** – Little is known about the mechanisms and beneficial effects of probiotics. The largest effects have been observed in patients given VSL#3. *Results from human trials:* possible increase in clinical remission in UC, and in pouchitis prevention and reduction in relapse. *AE:* rare bloating and diarrhea.

(Cheifetz, et al., 2017)

**Other Therapies:**

1. **Trichuris Suis** – animals with parasitic infections have evidence for reduced colitis. Small open-label studies as well as randomized controlled trials were done with IBD patients after administration of eggs of T. Suis. Results: T. Suis appears to be well tolerated and may have some efficacy in patients with IBD. Further studies are needed.

2. **Acupuncture and Moxibustion** – these Chinese therapies have been used for over 4,000 years. Results from human studies are positive but carry multiple limitations since patients on immune modulators or biologics are excluded in these studies. Evidence based clinical application should therefore be restricted to patients that receive no other therapy or are unwilling or unable to be treated with conventional treatment.

3. **Mind-Body Therapies** – psychologic stress and IBD are intricately related. Patients with IBD have higher rates of anxiety and depression and a lower quality of life. There are links between psychologic stress and IBD flares. Cognitive techniques are safe adjunct approaches to improve psychological status and quality of life in patients with IBD. These therapies may not affect inflammatory activity directly and require further studies.

4. **Exercise** – It is likely that mild to moderate exercise programs provide multiple benefits to patients with IBD. Exercise does not appear to have detrimental effects on disease activity although reductions in intestinal inflammation have not been shown.

(Cheifetz, et al, Gastro 2017)

**Always be respectful of patients’ decisions to supplement their disease management using reputable CAM practices/practitioners, and be ready to have a thoughtful discussion regarding the most common types of CAMs.

**Related article:** Mindfulness May Be Helpful for People with Ulcerative Colitis

https://nccih.nih.gov/research/results/spotlight/041114
For more information on CAM modalities see the National Institutes of Health’s, National Center for Complementary and Alternative Medicine website at:

http://nccam.nih.gov/

**For a comprehensive review of CAM refer to: Complementary and Alternative Medicines Used by Patients with Inflammatory Bowel Diseases, Gastroenterology 2017; 152, pages 415-429.

**TIP #3:** Be mindful of the potential need for you to be proactive regarding the recommendation of supplements.

Intestinal inflammation, pharmaceutical agents, and intestinal resections are some of the conditions that can predispose individuals with IBD to serious nutritional deficiencies. Careful assessment and supplementation can help avoid these deficiencies and maximize health. Therefore, assessment of nutritional status is always warranted and supplementation may be needed even in cases of clinical remission and in the absence of obvious pharmaceutical or surgical risk factors.

Additional considerations include patients on steroids, who especially need supplemental calcium and Vitamin D, and patients on methotrexate or sulfasalazine, who especially need folic acid supplementation. Patients with ileitis as well as patients who have had an ileocolic resection may need SQ or intranasal B12 supplementation since Vitamin B12 is absorbed in the terminal ileum. Iron deficiency anemia is commonly seen in the IBD population and should be monitored and treated appropriately.

Children and adolescents with IBD are particularly vulnerable to nutritional deficiencies as they are growing. IBD affects the bone health of these young patients. Approximately 10-40% of children with IBD have bone mass deficits at diagnosis, especially those with Crohn’s disease (Breglio & Rosh, 2013). Vitamin D levels should be monitored on a regular basis and supplemented.

To learn more about anemia and malnutrition in clinical IBD practice, see the Virtual Preceptorship program at:


For a review of the added requirements for calcium and vitamin D in IBD, see “Bone Loss in IBD”:
http://www.crohnscolitisfoundation.org/resources/bone-loss.html

For a review of other deficiencies common in IBD, see the CCFA Complementary and Alternative Medicine (CAM) fact sheet: http://www.crohnscolitisfoundation.org/resources/complementary-alternative.html

**TIP#4:** Discuss with patients how to decipher credible internet sites and to ask questions about complementary medicines since patients use internet resources to get information and buy products related to CAM.

**TIP #5:** Always remember to document discussions you have regarding supplementation and CAM use in the patient’s chart.
Foundation Resources:

- Bone Loss in IBD: [http://www.crohnscolitisfoundation.org/resources/bone-loss.html](http://www.crohnscolitisfoundation.org/resources/bone-loss.html)
- Complementary and Alternative Medicine Fact Sheet: [http://www.crohnscolitisfoundation.org/assets/pdfs/CAM.pdf](http://www.crohnscolitisfoundation.org/assets/pdfs/CAM.pdf)

Additional Websites:

- Mindfulness resource from NIH: [https://nccih.nih.gov/research/results/spotlight/041114](https://nccih.nih.gov/research/results/spotlight/041114)
- NIH National Center for Complementary and Integrative Health: [https://nccih.nih.gov/](https://nccih.nih.gov/)

References

