Emphasizing the Complementary in CAM

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Each day of sleep medicine practice brings patients who use a variety of Complementary and Alternative Medicine (CAM) therapies. In this issue Sood and colleagues report on a survey regarding the use of CAM that was administered to sequential patients undergoing polysomnography at their center. The survey indicated that the majority of respondents have used CAM therapies consisting of what Sood terms “biological” therapies (i.e., mostly herbal products, excluding vitamins) and/or “other” CAM therapies such as meditation, stress management, and acupuncture therapies. They note that this is not surprising and is consistent with prior studies in other patient populations. While the majority had used CAM in the past, only 13% had used it specifically for sleep.

What does this say about our practice and how should we relate professionally to the use of CAM for sleep problems? The Clinical Practices Review Committee of the American Academy of Sleep Medicine has published a review of the subject of oral nonprescription sleeping aids. It noted that there is not enough evidence to support the use of most of the CAM biological products noted in this study.

Medicine, however, has always been a negotiation process. One person’s “evidence” is another person’s speculation. The process of deciding what works for an individual is more an art than we scientists would like to think. This is especially true when there is a significant body/mind aspect to the subject such as insomnia. Our patients make choices on the basis of their own experience, knowledge and risk/benefit equation. We contribute knowledge and advice. We are the navigators rather than the captains of our patients’ ships of health.

If patients believe they can fix their sleeping problems by purchasing a simple treatment that doesn’t require professional intervention, they are likely to try it. Of interest in the study, 13% of the OSAHS patients had used CAM biologicals for sleep in the past, but only 4% still did so. This implies a rational process of trying out a perceived benign therapy to treat common symptoms of fatigue and sleep fragmentation. This 4% number is about the same cited for CAM use in insomnia in another similar study. In fact, most of these agents don’t work very well for initiating and maintaining sleep, especially in patients with OSAHS, and after trying them patients move on to other options.

The main problem from our perspective is the delay in diagnosis and treatment of a potentially lethal disorder that this creates. Unfortunately, the general public views CPAP as very invasive and believes that if there is “softer” approach, they should try it first. Thus, a significant number of patients in the Sood study, in addition to biologicals and other CAM therapies, tried nasal strips and decongestant sprays, although very few continued them, presumably because they also didn’t work well. Our role is to help inform our patients. Nevertheless, we must recognize that many will still try other options first. This is certainly their prerogative.

Where might CAM fit into the practice of sleep medicine? Given the essentially mechanical nature of OSAHS, it would seem the least likely candidate for use of CAM.

Even so, looking at the complexity of innervation to the genioglossus muscle, we can’t completely rule out the possibility that an herbal or acupuncture could have an effect. Scattered reports of herbal and pharmacological approaches have been published. Didgeridoo training has been reported to improve OSAHS. With this in mind, perhaps we should think twice before completely ruling out other physical training modalities as well.

Sleep, however, is complicated and CAM may have a complementary role. In real life people have OSAHS plus other sleep disorders like insomnia associated with anxiety and depression. Unless other causes of arousal are addressed, we will have a “failure” in CPAP treatment. Thus, we routinely use other standard behavioral and medical interventions as complementary to our treatment of OSAHS. CAM can certainly be considered in this light.

The most promising use of CAM is in the area of insomnia. In fact, some of the “other” therapies listed as CAM by these authors are fairly standard fare. Melatonin is standard for phase delay.
Meditation, stress management, relaxation therapies and, by extension, massage and other body work all can and easily do fit within our current paradigm of CBT/stimulus response/relaxation therapy. Other physical modes such as acupuncture and energy therapies have not been adequately studied, but given the mind/body nature of insomnia, positive outcomes wouldn’t be surprising. Top on the list of therapies the respondents in the Sood study said they would like to try in the future are mind/body therapies such as stress management and massage.

Whether we initiate CAM biological therapies is one thing, but should we support their use in our patients? There is some, albeit weak, evidence to support several traditional herbal preparations as hypnotic or anxiolytic agents.\(^{5-13}\) Phytoestrogens have been used with some effectiveness for hot flashes and therefore sleep.\(^ {14,15}\) Magnesium has helped restless legs syndrome.\(^ {16}\) All these agents have a very low incidence of reported negative side effects.

Some therapies that had been considered to be CAM in the past now are standard treatment for insomnia. Others could potentially be in the future, so we shouldn’t ignore them because of the “unproven” label as long as they remain relatively benign. If nothing else they may have a placebo effect. In the body/mind area of medicine placebos can be therapeutic. Belief that a therapy works may well make it therapeutic.

We can look upon the use of CAM as the positive desire for self-help rather than a rejection of standard therapies. As navigators we can build on that self-help desire by guiding our patients toward areas where CAM may potentially work, such as insomnia, and away from those where it may be harmful, as in delaying treatment for OSAHS.

It would be interesting and worthwhile to follow-up on this particular group of patients particularly to see if they are more or less likely to adhere to standard CPAP treatment. Is use of CAM a marker for a group that might have more problems with treatment programs or because of the self help nature of the group are they better at maintaining a treatment program. These are questions that could be addressed once we start to identify these patients as the authors have done in this study.

REFERENCES


