

Cancer diets, cannabinoids in MS and rose-hip for arthritic pain, in *FACT*

Research published in the June issue of *Focus on Alternative and Complementary Therapies* is highlighted by Natalie Lane

An article in the June issue of *Focus on Alternative and Complementary Therapies* looks at the factual information available on diets (as forms of complementary and alternative medicine) and cancer. Data show that cancer patients attempt to treat their condition with dietary approaches, while others use a dietary regimen in order to prevent cancer.

The authors first searched the internet using keyword combinations such as “‘diet’ and ‘cancer’ and ‘prevention’ or ‘cure’”, which alone generated some 20 million hits in Google. The majority of such websites did not provide much information and there was little objective information. Three websites were discussed for their wide range of information about diets and inclusion of a variety of attitudes.

Additionally, the authors hand-searched department files at the Peninsula Medical School, Plymouth, and identified several CAM diets. These provided terms for searches in Pubmed, Embase, Amed and Cinahl databases.

Searches conducted by the authors identified 26 different diets, some claiming to be curative, others as preventive or supportive regimens.

The regimens varied and occasionally it was found that they contradicted each other. The authors' findings confirmed earlier findings that a variety of CAM cancer diets exist “without any scientific evidence in support”. And it was concluded that the “risk-benefit balance” was not positive for any CAM cancer diet. Ernst and Boddy found that this area of CAM was more akin to religion than nutrition (or science).

Cancer patients require appropriate nutritional care during both cancer therapy and recovery. It was thought that most of the diets jeopardised the important nutritional goal of caloric balance and might lead to overt malnutrition.

Ernst and Boddy are aware that their review has limitations — not all diets were listed in the article and relevant primary studies may have been missed out.

However, in conclusion, none of the diets has been proved effective in clinical trials but the risks are substantial. Cancer patients should be informed of this and be provided with “responsible nutritional guidance by conventional health care professionals” with expertise in nutrition.



Cannabinoids for symptoms of MS

A summary and commentary in *FACT* looks at the long-term effects of cannabinoids on spasticity and other symptoms in patients with multiple sclerosis (MS) by looking at a follow-up study, where 502 patients were followed for a total of 52 weeks. Patients received capsules containing one of three ingredients: synthetic delta-9-tetrahydrocannabinol (synthetic delta-9-THC), a standardised cannabis extract or a placebo. Muscle spasticity was measured using the Ashworth scale as the primary outcome. Secondary outcome measures included mobility and general health. The study found a small, but significant, effect of synthetic delta-9-THC on muscle spasticity over 12 months but the effect of *Cannabis sativa* (cannabis) was similar to the placebo. The authors concluded that there was limited evidence for long-term treatment with delta-9-THC for muscle spasticity, although cannabinoids may have benefits for the management of MS symptoms.

The commentator notes that there was no benefit for muscle spasticity on the Ashworth scale in the original 15-week study but that there was a small statistical benefit for the synthetic delta-9-THC group in the follow-up study. Also, as noted by the study's authors, the biases of the study include the voluntary nature of the long-term participation and the evidence of unmasking in the original study. Yet the study is noted for providing additional evidence about oral cannabinoids helping to ameliorate common MS symptoms.

The authors of the study responded that their study was the first randomised controlled trial of cannabinoids in MS and that they view the results as interesting. They say that some of the issues raised are not problems but questions, requiring further work to answer. The authors responded that the small change in the Ashworth score as a clinically relevant treatment effect is a difficult to answer. However, they have recently published a new scale, the “MS spasticity scale 89”, to be used in further studies looking at the symptomatic effects of cannabinoids. Furthermore, the authors are involved in a new study which they hope will address the issues discussed in this summary and commentary.

Rose-hip and arthritic pain

A study examined the effect of a subspecies of *Rosa canina* (rose hip) on the symptoms of osteoarthritis. Patients were given either *Rosa canina* powder or a placebo for three months. After three months the alternative treatment was given. The Western Ontario and McMaster Universities osteoarthritis index (WOMAC) and the consumption of analgesics was the primary outcome measure, with WOMAC scores of stiffness and limitation of physical function among the secondary outcome measures. The authors report that during active treatment there was reduction in WOMAC pain scores and consumption of analgesics in 21 patients. The study concludes that a standardised rose-hip powder from a subtype of *Rosa canina* has beneficial symptomatic effect in patients with knee and hip osteoarthritis.

The commentator remarks on a well-designed study but thinks the results are confusing and inconsistent, such that the authors do not explain what the delta value is, despite the important part it appears to play in analysis.

The commentator also remarks that there should be more attention paid to the magnitude of the effects. Comparisons of scores from outcome measures only serve to give the impression of confusion. The commentator agrees with the authors that this remedy should be studied further.

The authors' respond to the commentary agreeing that the table legends in their study could have been more explanatory and that the impact of *Rosa canina* powder on different symptom scores could have been demonstrated more clearly. They note that allowing a reduction in the consumption of rescue medicine during the period of study meant it became more difficult to “calculate the magnitude of the impact of treatment on symptoms”. Yet they note that it is a “strong point” if patients reduce consumption of rescue medicines and herbal medicines show only a poor impact if the consumption of additional painkillers are changed. Thus, the authors found it relevant to include “symptom scores as well as a possible change in the consumption of rescue medicines in the present study.” They also go on to discuss the inconsistencies as raised by the commentator.

The authors' response concludes with their explanation that enhancement of a symptom score in placebo treatment may be a progression of the disease and this might explain why active treatment did not reduce symptom scores, but meant they remained unchanged.

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