CANCER & PALLIATIVE CARE · PRIMARY CARE

Complementary therapies in cancer care

A practical, plain-English guide for GP trainees and international medical graduates. What patients use, **what the evidence really shows**, where the danger lies, and how to have the conversation well.

◆ **The one idea to hold onto**

Complementary therapies travel *alongside* cancer treatment to help people feel better. **Alternative** therapies try to *replace* it — and there is no evidence they treat or cure cancer. Your job is to keep the first safe and stop the second from doing harm.

WHAT'S INSIDE

1 Three words that change everything

Get these three apart and the rest falls into place. The difference is simply **where the therapy sits** in relation to real cancer treatment.

COMPLEMENTARY

Used *alongside*

Runs with conventional treatment. Aims to ease symptoms, lift mood and improve quality of life.

Goal: feel better — never to cure.

ALTERNATIVE

Used *instead of*

Replaces conventional treatment. **No evidence** it treats or cures cancer, and can cause real harm.

Risk: false hope and lost time.

INTEGRATIVE

Used *together, on purpose*

The modern approach: conventional treatment plus **selected, evidence-based** complementary support, coordinated by the team.

Today's name: integrative oncology.

◎ **A picture that sticks**

Think of cancer treatment as the **driver** taking the patient where they need to go. A **complementary** therapy is a good passenger — it makes the journey more bearable but never grabs the wheel. An **alternative** therapy tries to push the driver out and take over, with no idea of the route. Keep the passenger; protect the driver.

How common is this? More than you think

≈1 in 3

UK cancer patients use a complementary therapy (median ~30% across surveys; around half at some point in their illness).

#1

Herbal products are the most popular type — and the ones most likely to interact with cancer drugs.

~40%

only tell their medical team. **Most use is hidden** — so unless you ask, you will not know.

▸ **Why this matters to you**

Because use is common and usually undisclosed, **asking every patient — routinely and without judgement — is a safety act, not small talk.**

2 Why patients reach for them

People are **pushed** by gaps in conventional care and **pulled** by what these therapies seem to offer. Spot the real need behind the request and you can usually meet it safely.

→ | PUSHED away from conventional care

- Fear of treatment side-effects
- Feeling rushed or not truly heard
- Care that feels fragmented across teams
- Treatment that can't cure, or options running out
- A wish to **do something** themselves

| → PULLED towards complementary therapy

- ✓ A sense of **control** and an active role
- ✓ The appeal of "natural" and gentle
- ✓ Real symptom and side-effect relief
- ✓ **Touch, talk and time** — being cared for
- ✓ Hope, plus emotional and spiritual support

◆ **The clinical move**

Most of these needs — control, reassurance, symptom relief, being heard — **can be met within safe, conventional care.** When you name the need rather than argue about the therapy, the conversation stops being a tug-of-war.

The need behind the request

WHEN A PATIENT SAYS...	THE REAL NEED IS OFTEN...	...WHICH YOU CAN MEET BY
"I want to do something myself"	Control & agency	Shared decisions; exercise, sleep, diet, smoking/alcohol support
"The chemo makes me so sick"	Symptom relief	Optimise antiemetics; review analgesia; low-risk add-ons (see p.4)
"I just feel so anxious"	Emotional support	Mindfulness, relaxation, talking therapies, clinical nurse specialist
"I want something natural"	Safety & gentleness	Honest chat about "natural ≠ safe"; signpost reputable info

Teaching aid — not clinical guidance. The push/pull framework is adapted and modernised from the 1999 Macmillan report (Kohn). Verify management against current NICE/CKS guidance and local policy.

3 What actually helps — and with what

The picture has moved a long way since 1999. The clearest modern guidance (Society for Integrative Oncology & ASCO) matches **specific therapies to specific symptoms**. Always as an *add-on* — never a replacement.

SYMPTOM	WHAT HAS THE BEST EVIDENCE	READ THIS AS
Anxiety & depression	**Mindfulness-based interventions** (strongest), plus yoga, relaxation, hypnosis, music therapy.	Offer / actively support
Cancer pain	**Acupuncture, massage and hypnosis** as add-ons. Acupuncture for aromatase-inhibitor joint pain in breast cancer.	Reasonable add-on
Cancer-related fatigue	**Exercise** and mind-body approaches (mindfulness, yoga) have the most support.	Encourage
Chemo nausea & vomiting	**P6 acupressure / acupuncture** may add modest benefit (mainly delayed symptoms). Evidence mixed, certainty low.	Add-on only — never instead of antiemetics
Stress & low wellbeing	**Aromatherapy, massage, reflexology** — pleasant, can ease anxiety short-term.	Low-risk comfort; don't oversell

✓ **Strongest single message**

Mind-body approaches lead the field. Mindfulness, relaxation, yoga and exercise have the best evidence, the lowest risk and the widest use — and patients can start them today.

▲ **Honest framing for patients**

"This won't treat the cancer, but it may help you cope with *(the symptom)* — and it's safe alongside your treatment." Honesty keeps trust and keeps use disclosed.

◎ **Where does the evidence come from?**

No single NICE guideline covers complementary therapies in cancer. The strongest current source is the **SIO–ASCO** guideline series — pain (2022), anxiety & depression (2023) and fatigue (2024) — alongside **Cancer Research UK** for patient-facing safety. Use these where NICE is silent, and always check prescribing against the **BNF**.

4 The everyday traffic light

A quick way to place any therapy a patient mentions. The question is not "does it work miracles?" but **"is it safe alongside treatment, and is it honest?"**

● GREEN · Support it

Low risk, some real evidence, helps people cope — fine alongside treatment.

- ✓ Mindfulness, meditation, relaxation
- ✓ Gentle yoga and tailored exercise
- ✓ Massage and aromatherapy (qualified therapist)
- ✓ Acupuncture for specific indications (p.4)

● AMBER · Allow, but don't oversell

Generally low-harm but weak evidence. Fine for comfort; be clear it won't treat the disease.

- ▸ Reflexology
- ▸ Spiritual healing / therapeutic touch
- ▸ P6 acupressure wristbands (as antiemetic add-on)
- ▸ Most "wellbeing" touch therapies

● RED · Advise against / handle with care

Real potential for harm, or no credible evidence. Step in.

- × **Homeopathy** — not recommended, not NHS-funded
- × High-dose antioxidant supplements during chemo/RT
- × Unregulated herbal products (interaction risk)
- × Any **alternative** used to replace treatment; "cure" clinics

◆ Spotlight: homeopathy — the clearest change since 1999

Then: available on the NHS through five homeopathic hospitals, and GPs could prescribe remedies.

Now: NHS England (2017) advises it **should not be prescribed** — the Specialist Pharmacy Service found no robust evidence. The High Court upheld this in 2018.

In practice: do not prescribe homeopathy on the NHS. If a patient asks, be honest but kind — and redirect to the things that genuinely help them cope.

5 Natural does not mean safe

This is the message that matters most. A "natural" product is still a pharmacologically active substance — and in someone on cancer drugs, that can be dangerous.

▲ **The core safety rule**

You must ask every patient what supplements and herbal products they take, and check for interactions before treatment. Herbal use is common, usually undisclosed, and can quietly make cancer drugs stronger, weaker or more toxic.

The six herbal culprits to know

These six have **documented, clinically relevant interactions** with cancer treatment in humans. Treat any of them as a red flag in a patient on systemic anti-cancer therapy.

St John's Wort
Potent enzyme inducer — weakens many drugs

Grapefruit (juice)
Blocks drug breakdown — raises levels/toxicity

Ginseng
Bleeding risk; alters drug handling

Garlic (supplements)
Bleeding risk; affects drug levels

Echinacea
Alters liver enzyme handling of drugs

Milk thistle
Can interfere with drug metabolism

◆ **The big one: St John's Wort**

A popular over-the-counter remedy for low mood — and a **powerful inducer of the CYP3A4 enzyme**. It speeds up the breakdown of many drugs, dropping their levels so they **stop working**.

It can reduce the effectiveness of:

- × Several cancer drugs (e.g. irinotecan, imatinib, docetaxel)
- × Hormonal contraception — risk of pregnancy
- × Warfarin, ciclosporin and tacrolimus
- × HIV antiretrovirals

Patients on these drugs must not take St John's Wort. Ask specifically — many see it as "just a supplement" and won't mention it.

6 Two more traps, and the red flags

▲ Antioxidant supplements during treatment

High-dose **vitamins A, C, E and selenium** may, in theory, shield cancer cells from chemo- and radiotherapy, which work partly through oxidative damage. The evidence is not settled. Advise: a normal balanced diet is fine; **avoid high-dose antioxidant supplements during active treatment** unless the oncology team agrees.

▲ Abandoning conventional treatment

The single most dangerous scenario. Choosing **alternative** therapy *instead of* conventional treatment is linked to **worse survival**. You must not endorse it. Explore the fear behind it, correct false promises gently, and keep the door open so the patient comes back.

◆ Red flags — when to worry and act

- × Patient stopping, refusing or delaying conventional treatment for an "alternative"
- × Herbal or supplement use with **warfarin, ciclosporin, chemotherapy, antiretrovirals or hormonal contraception**
- × Promises of a "cure", costly overseas clinics, IV vitamin or "detox" regimens
- × Restrictive "cancer diets" driving weight loss or malnutrition
- × An unqualified or unregistered therapist treating a vulnerable patient
- × A symptom being attributed to therapy when it could be disease progression

Recognise → Act → Refer

RECOGNISE

- ▸ Patient using or considering any therapy
- ▸ Herbal / supplement use
- ▸ Signs of drifting from conventional care

ACT

- ✓ Ask, listen, document
- ✓ Check interactions; advise honestly
- ✓ Keep conventional treatment going
- ✓ Signpost reputable info (CRUK, Macmillan)

REFER / ESCALATE

- ▸ Interaction risk → oncology / pharmacy
- ▸ Considering stopping treatment → team urgently
- ▸ Distress → CNS, psychology, palliative care

Teaching aid — not clinical guidance. Sources: Cancer Research UK safety guidance (2024); SIO–ASCO guidelines. Confirm interactions in the BNF and discuss with the oncology team before acting.

7 The conversation: the four A's

How you talk about this decides whether use stays **visible and safe** or goes underground. Be curious, not combative — dismissiveness hides the very interactions you need to find.

A1
Ask

Routinely & openly. "Lots of people try other things alongside treatment — anything you're using or thinking about?"

A2
Acknowledge

Validate the need — control, comfort, hope. Never mock or dismiss it.

A3
Advise

Be honest: what may help, what's unproven, what's unsafe. Check interactions.

A4
Agree & safety-net

Agree a plan; keep treatment going; "tell us before you start anything new"; review.

◎ **Worked example**

Mrs A, 58, on tamoxifen and feeling low, mentions she's started St John's Wort and wants "something natural instead of the tablets."

- **Ask & acknowledge:** thank her for telling you; recognise the low mood and the wish to feel in control.
- **Advise:** explain St John's Wort can *weaken* several drugs and interact with treatment — so it isn't the safe option it seems. Address the depression properly.
- **Agree & safety-net:** stop the St John's Wort, agree a plan for her mood, confirm she **continues tamoxifen**, and review. Offer mindfulness or talking therapy as the "natural" support she wanted.

✓ **Do**

- ✓ Ask everyone, without judgement
- ✓ Meet the need behind the request
- ✓ Document use and check interactions

× **Don't**

- × Ridicule or dismiss — it drives use underground
- × Assume "supplement" means harmless
- × Let an unproven therapy delay real treatment

8 What's changed since 1999

◆ **From the 1999 snapshot to today**

THEME	1999 (ORIGINAL REPORT)	NOW
Homeopathy	On the NHS via five homeopathic hospitals; GP-prescribable	**Not recommended or NHS-funded** (2017); hospitals closed or rebranded
The framing	"CAM"; evidence base "small"	**Integrative oncology** — evidence-informed, with formal guidelines
For distress	Relaxation & imagery, little tested	**Mindfulness** front-line; acupuncture has named indications
Safety focus	Mostly therapist training & regulation	**Herb–drug interactions** now central (esp. St John's Wort)
Regulation	Largely unregulated; self-regulation emerging	Voluntary registers (CNHC); osteopaths & chiropractors regulated by law

Key sources

- **Original modernised:** Kohn M. *Complementary therapies in cancer care.* Macmillan Cancer Relief, 1999.
- **Cancer Research UK** — Complementary & alternative therapies; safety; St John's Wort (2024).
- **SIO–ASCO** integrative oncology guidelines — pain (2022), anxiety & depression (2023), fatigue (2024).
- **NHS England** — Items which should not routinely be prescribed: homeopathy (2017); High Court ruling (2018).
- **BNF / Stockley's / NICE CKS** — for checking specific drug interactions and prescribing.

A note on sources: NICE has no single guideline dedicated to complementary therapies in cancer care. Where NICE/CKS is silent, this aid uses named specialist sources (SIO–ASCO, Cancer Research UK, NHS England) and states them. All prescribing and interaction details must be confirmed against the BNF before use.

◆ **Five things to carry into clinic**

- **Complementary** sits alongside; **alternative** replaces and risks harm.
- **Ask everyone** — most use is hidden.
- **Natural ≠ safe** — check interactions, especially St John's Wort.
- **Mind-body** approaches help most, with least risk.
- **Never let** an unproven therapy delay real treatment.