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Horse Chestnut Seed Extract for Venous Insufficiency

By Lynn Keegan, RN, PhD, HNC-BC, FAAN

Dr. Keegan is Director, Holistic Nursing Consultants, Port Angeles, WA; she reports no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

VENOUS INSUFFICIENCY IS A DISABLING CONDITION IN WHICH THE blood has problems being moved back up the lower extremities from the legs to the heart. Vein valves usually push the flow of blood toward the heart. When these valves are damaged, the blood leaks and pools in the legs and feet. The condition may also be caused by a deep vein thrombosis. Chronic venous insufficiency (CVI) is a long-term condition that occurs because of partial vein blockage or blood leakage around the valves of the veins. Symptom generally include swelling of the legs; dull aching, heaviness, or cramping in legs; pain that worsens when standing; and pain that lessens when raising the legs. Persons with CVI also may have skin color changes around the ankles, redness of legs and ankles, thickening of the skin on legs and ankles, and ulcers on the legs and ankles.[1]

Impairment of the cutaneous microcirculation is a major predisposing factor in inflammation and ulceration in patients with CVI. Increase of capillary filtration rate predisposes to the formation of edema, and local lymphedema, a complication of CVI, is often under diagnosed.[2] Venous leg ulceration (VLU) is the most serious consequence of CVI and is responsible for almost 70% of chronic leg ulcers.[3] Chronic leg ulcers are extremely common and account for a large proportion of all lower extremity ulcers. The relatively high prevalence of chronic leg ulcers impacts health care costs and affects patients' lives significantly.[4] Progress has been made in understanding the pathophysiology, clinical features, and diagnosis of these ulcers, but the basic principles of care have remained consistent for almost 50 years *(see Sidebar, page 27)*.[4]

History and Traditional Use

The use of extracts from the seed of the horse chestnut (*Aesculus hippocastanum* L.) is the most promising alternative therapy for

Dr. Balk (peer reviewer) reports no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

treating CVI and the resulting leg ulcers. Horse chestnut seed extract (HCSE) traditionally has been used to treat patients with CVI and to alleviate its associated symptoms, including lower leg swelling.[5]

The horse chestnut tree belongs to the same family as the sweet chestnut and Ohio buckeye trees. The fruit of the sweet chestnut is edible; the fruits of the Ohio buckeye trees are toxic. Native to Greece and Albania, the tree was introduced in the United States in the 1740s as a shade tree. It grows up to 35 meters high and bears long clusters of white flowers in May and a prickly fruit in the fall. The fruit contains three large seeds; the extract of these seeds has been used in Europe since the 1800s as an oral remedy for various venous diseases.

Mechanism of Action

The efficacy of HCSE preparations is believed to be due to an inhibitory effect on the catalytic breakdown of capillary wall proteoglycans.

The anti-inflammatory effects of Japanese horse chestnut (*Aesculus turbinata*) seeds were examined in vivo and in vitro.[6] The extract inhibited croton oil-induced swelling of the mouse concha. HCSE inhibited cyclooxygenase (COX)-1 and COX-2 activities, but had no effect on 15-lipoxygenase and phospholipase A2 activities. Inhibition of COX-2 occurred at a lower concentration of HCSE than for COX-1. Japanese horse chestnut seeds contain coumarins and saponins, but these chemicals did not inhibit COX activities. These results suggest that the anti-inflammatory effect of Japanese horse chestnut seeds is caused, at least partly, by the inhibition of COX. The inhibitor of COX in this seed may be a chemical other than coumarins and saponins.

Contraction forces generated by non-muscle cells such as fibroblasts play important roles in determining cell morphology, vasoconstriction, and/or wound healing. However, few factors, such as lysophosphatidic acid and thrombin, that induce cell contraction forces are known. Another Japanese study analyzed various plant extracts for ingredients that induce generation of cell contraction forces in fibroblasts populating collagen gels.[7] The researchers found that HCSE induced such contraction forces in fibroblasts.

Clinical Trials

The primary treatment of choice for VLU is compression therapy; however, serious clinical issues demand the development of new treatments.

Four clinical trials in patients with CVI and one study in patients with varicose veins demonstrated HCSE's effectiveness in reducing lower-leg edema and the subjective alleviation of leg pain, heaviness, and itching. In these trials HCSE proved to be safe, well-tolerated, and acceptable to patients with mild-to-moderate venous insufficiency.[5]

HCSE's clinical feasibility in VLU was explored in an Australian two-stage trial.[8] The second stage was a descriptive survey exploring current opinion and utilization of natural therapies, venotonics, and HCSE in VLU. A questionnaire mailed to 122 district nurses, 73 medical practitioners, and 53 patients with VLU resulted in a response rate of 32%, 31.5%, and 81%, respectively. The authors found that natural therapy and HCSE use for VLU was minimal in all groups. Half of the groups supported venotonics, with a similar proportion of nurses and clients utilizing venotonics in practice. However, medical practitioners were less likely to utilize venotonics for VLU. Although clinicians indicate that clinical evidence may influence the utilization of HCSE in clinical practice, the evidence currently does not exist. Positive findings from well-designed trials may ameliorate the integration of natural medicine into mainstream practice.

Another Australian study evaluated the clinical efficacy of orally administered HCSE for treating VLUs.[9] In a prospective, triple-blind, randomized placebo-controlled trial, 54 patients with VLUs from a large South Australian community nursing service were randomly allocated to receive HCSE (n = 27) or placebo (n = 27) for

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12 weeks. Ulcers were assessed at weeks 0, 4, 8, and 12 utilizing a wound assessment tool and the Alfred/Medseed Wound Imaging System. The difference between groups in the number of healed leg ulcers and change in wound surface area, depth, volume, pain, and exudate was not statistically significant. However, HCSE had a significant effect on the percentage of wound slough over time and on the number of dressing changes at week 12.

To determine whether an alternative venous ulcer treatment using HCSE and conventional therapy involving dressings and compression was more cost-effective than using conventional therapy alone, a 12-week cost-benefit analysis of HCSE therapy was conducted.[10] The study, using data from a 12-week prospective, randomized, placebo-controlled trial conducted in South Australia in 2002-2004, involved 54 patients with venous ulceration. Taking into account the cost of HCSE, dressing materials, travel, staff salaries, and infrastructure for each patient, HCSE therapy combined with conventional therapy was found to be more cost-effective than conventional therapy alone. This study confirms that dressing change frequency has a significant impact on the total cost of wound care and suggests that district nursing service operation efficiency may be enhanced by HCSE use.

One of the more significant studies—a systematic review from the Cochrane Library—reviewed the efficacy and safety of oral HCSE vs. placebo or reference therapy for treating CVI.[11] Following a search of the Cochrane Peripheral Vascular Diseases Review Group's Specialized Register, the Cochrane Central Register of Controlled Trials, Medline, Embase, Allied and Complementary Medicine, and Phytobase for randomized controlled trials of HCSE for CVI, trials were included if they compared oral HCSE mono-preparations with placebo or reference therapy in people with CVI. Trials assessing HCSE as one of several active components in a combination preparation, or as a part of a combination treatment, were excluded.

Standard Care for Venous Ulcers

THE STANDARD OF CARE FOR VENOUS ULCER TREATMENT IS compression therapy to reverse the effect of venous hypertension and occlusive dressings to maintain a moist wound-healing environment and treat ulcer bed abnormalities. The treatment with the highest level of evidence for venous ulcers is the use of multilayered elastic bandages for compression in patients with normal arterial flow. Treating the ulcer bed with cadexomer iodine dressings is also supported by evidence from randomized controlled trials, whereas newer dressings provide fewer well-proven alternative opportunities to speed the healing of venous ulcers.[1]

The Association for the Advancement of Wound Care (AAWC) Government and Regulatory Task Force developed a content-validated venous ulcer guideline based on best available evidence supporting each aspect of venous ulcer care. After compiling all-inclusive lists of elements in venous ulcer algorithms published before August 2002, the Task Force objectively rated and summarized up to five best references from MEDLINE, CINAHL, and EMBASE literature searches covering each aspect of care. Sixteen multidisciplinary wound care professionals and educators used judgment quantification to content validate all steps. A 2004 e-mail survey of AAWC members (n = 1,514) clarified effects of under-reimbursement on evidence-based venous practice. The Venous Ulcer Guideline containing all elements with A-level evidence plus those with a Content Validity Index > 0.75 now resides on the AAWC and the Agency for Healthcare Research and Quality National Guideline Clearinghouse web sites. However, a review of U.S. health care environment components, including reimbursement policies, and the results of the survey identified many barriers to implementation of A-level evidence supported steps (sustained graduated high compression, autolytic debridement, and moist wound environments) in practice. Sufficient evidence supports improved venous ulcer care in the United States but inadequate and/or inconsistent reimbursement policies impede quality evidence-based venous ulcer practice, delaying healing and increasing the burden of venous ulcers on society.[2]

Treatment of microcirculatory dysfunction can be done by pharmacologic intervention or compression therapy or using a combination of both.[3] ❖

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There seemed to be an improvement in CVI-related signs and symptoms with HCSE compared to placebo. Leg pain was assessed in seven placebo-controlled trials. Six reported a significant reduction of leg pain in the HCSE groups compared with the placebo groups, while another reported a statistically significant improvement compared with baseline. One trial suggested a weighted mean difference of 42.4 mm measured on a 100 mm visual analogue scale. Leg volume was assessed in seven placebo-controlled trials. Meta-analysis of six trials (n = 502) suggested a weighted mean difference of 32.1 mL in favor of HCSE compared to placebo. One trial indicated that HCSE may be as effective as treatment with compression stockings. Adverse events usually were mild and infrequent. The evidence presented implies that HCSE is an efficacious and safe short-term treatment for CVI.

Table

Dosage and formulation

Oral	300 mg (containing 50-75 mg escin per dose) every 12 hours for up to 12 weeks. A dose of 600 mg/d HCSE also has been studied.
Topical	A gel preparation of HCSE applied to the skin has been studied for bruising, without clear benefits.
Intravenous/ Intramuscular	Severe allergic reaction (anaphylactic shock) has been reported with intravenous use. Horse chestnut leaf has been associated with liver inflammation (hepatitis) after injection into muscle.

Source: MayoClinic.com. Drugs & Supplements: Horse chestnut (*Aesculus hippocastanum* L.). Available at: www.mayoclinic.com/health/horse-chestnut/NS_patient-Horsechestnut. Accessed Jan. 7, 2007.

Side Effects

Standardized HCSE generally is considered to be safe in adults at recommended doses for short periods of time. Stomach upset, muscular (calf) spasm, headache, dizziness, nausea, and itching have been reported. Contact skin irritation (dermatitis) has been reported following application of HCSE to the skin.

HCSE may cause an allergic reaction in patients with known allergy to horse chestnuts, esculin, or any of its ingredients (flavonoids, biosides, trisides of quertins, and oligosaccharides, including 1-ketose and 2-ketose). Anaphylactic shock has been reported with intravenous use.[12]

There is not enough scientific evidence to recommend use of horse chestnut in children. Deaths have been reported in children who ate raw horse chestnut seeds or tea made from horse chestnut leaves and twigs. Unprocessed horse chestnut seeds, flowers, branch bark, and leaves have not been shown effective for any indication. These contain esculin and have been associated with significant toxicity and death. Symptoms of HCSE poisoning may include vomiting, diarrhea, headache, confusion, weakness, muscle twitching, poor coordination, coma, or paralysis. HCSE standardized to escin content should not contain significant levels of esculin, and should not have the same risks.

HCSE may cause lowered blood sugar, so caution is advised in patients with diabetes or hypoglycemia, and in those taking drugs, herbs, or supplements that affect blood sugar. Serum glucose levels may need to be monitored by a qualified health care provider, and medication adjustments may be necessary.

In theory, HCSE may increase the risk of bleeding. Caution is advised in patients with bleeding disorders or taking drugs that may increase the risk of bleeding. Monitoring is recommended and dosing adjustments may be necessary. Liver and kidney toxicity has been associated with HCSE. Aflatoxins, considered to be cancer-causing agents, have been identified in commercial skin products containing horse chestnut, but not in HCSE.[12]

Dosage and Formulation

Dosage and formulation information is available in the table above.

Summary and Conclusion

Although standard care for CVI consists largely of compression treatment, this often causes discomfort and has been associated with poor compliance.[11] Treatment of CVI is multifactorial. Compression, interventional and operative approaches, along with possible systemic treatments, are available. The efficacy of systemic venotonic medications, mostly phytotherapeutic agents, is controversial. Nonetheless, in a number of clinical and laboratory studies, an effect was seen after use for 8-12 weeks. When administered appropriately, venotonic agents can show anti-edematous, anti-inflammatory, antioxidative, and proteolytic effects as well as reduce capillary leakage. Furthermore, they increase vein tone and lymph flow. Venotonic agents should be considered if compression therapy alone is insufficient, contraindicated, or intolerable.[13]

When taken for short periods of time in recommend-

ed dosage and form, HCSE seems to offer a viable alternative for those seeking relief from the discomfort and disability of chronic venous insufficiency. ❖

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NIH-Funded HALT Study Finds Black Cohosh Ineffective for Treating Menopausal Symptoms

By Donald Brown, ND

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Source: Newton KM, et al. Treatment of vasomotor symptoms of menopause with black cohosh, multibotanicals, soy, hormone replacement therapy, or placebo. *Ann Intern Med* 2006;145:869-879.

Abstract: In a randomized, double-blind, placebo-controlled trial, the effects of black cohosh or a multibotanical combination product with or without a high-soy diet were compared with hormone therapy or placebo for the treatment of vasomotor symptoms associated with menopause. The study was completed with 351 women (ages 45-55 years) with two or more vasomotor symptoms per day; 52% of the women were in menopausal transition (≥ one skipped menses within the preceding 12 months) and 48% were postmenopausal (no bleeding within 12 months, or follicle-stimulating hormone level > 20 IU/mL if the participant had undergone hysterectomy without bilateral oophorectomy).

Women were randomized to one of five groups: 1) black cohosh (*Actea racemosa*; CimiPure®, 70% ethanol extract standardized to 2.5% triterpene glycosides; Pure World, Inc., Hackensack, NJ) rhizome/root extract, 160 mg/d; 2) an encapsulated multibotanical formulation delivering the following daily doses of these herbs: black cohosh, 200 mg; alfalfa (*Medicago sativa*), 400 mg; chaste tree (*Vitex agnus-castus*) berry, 400 mg; dong quai (*Angelica sinensis*) root, 400 mg; false unicorn (*Chamaelirium luteum*) root, 200 mg; licorice (*Glycyrrhiza glabra*) root, 200 mg; oats (*Avena sativa*) straw, 400 mg; pomegranate (*Punica granatum*) fruit, 400 mg; Siberian ginseng (*Eleutherococcus senticosus*) standardized to 0.8% eleutherosides E and B) root, 400 mg; and also 4 mg of boron (multibotanical [ProGyne™]was supplied by Progena Professional Formulations, Albuquerque, NM); 3) multibotanical formula plus a high-soy diet (12-20 g of soy protein per day as instructed by phone counseling); 4) conjugated equine estrogen, 0.625 mg/d, with (for women with a uterus) or without (for women without a uterus) medroxyprogesterone acetate, 2.5 mg/d; or 5) placebo.

The primary outcome measures were change from baseline (measured over a two-week run-in period) to three, six, and 12 months (each measured for four weeks) and change from

baseline to average for all follow-ups with regard to the mean frequency and intensity of vasomotor symptoms (daytime hot flashes plus night sweats) and the mean Wiklund Vasomotor Symptoms (WVS) Subscale score. Also evaluated was change from baseline to follow-up (months 3, 6, and 12 and average change) for daytime hot flash rate, night sweat rate, and total Wiklund Menopause Symptom Scale (WMSS) score.

There was a decrease between baseline and three months for the average adjusted number of vasomotor symptoms per day and the WVS subscale score in all groups. There was no statistically significant difference in the average adjusted change in vasomotor symptoms intensity between the herbal interventions (groups 1, 2, and 3) and placebo at three, six, or 12 months, or for the average over all the follow-up time periods. The one exception was that the multibotanical plus soy diet group actually had significantly worse symptom intensity at 12 months compared to placebo ($P = 0.016$). The average difference in vasomotor symptoms per day between the placebo and herbal treatment groups was less than one symptom per day at three months and less than 0.6 symptoms per day for the average over all the follow-up time periods. Hormone therapy reduced vasomotor symptoms significantly at three months compared to placebo ($P < 0.001$) as well as vasomotor symptoms per day for the average over all the follow-up time points ($P < 0.001$). There were no significant differences in the WVS Subscale score between any of the herbal interventions and placebo at three, six, and 12 months or of the average over all follow-up time periods. It was significantly lower for the hormone therapy group compared to placebo at all follow-up time periods.

Additional analyses found no statistically significant differences in hot flashes per day or night sweats per day between any of the herbal interventions and placebo at all time points except at three months when the black cohosh group had 0.38 fewer night sweats per day than the placebo group ($P = 0.03$). The difference between the herbal treatments and placebo was less than 0.6 hot flashes per day and less than 0.4 night sweats per day at any time points—these differences became smaller when averaged over all time points. This resulted in three fewer hot flashes and one fewer night sweat per day for the hormone therapy group compared to placebo. While differences in the WMSS were significant compared to placebo at all time points for the hormone therapy group, there were no difference at any time point for the herbal intervention groups. Women assigned to hormone therapy reported more breast pain ($P < 0.001$) and menstrual disorders ($P = 0.04$) compared to placebo. Other upper and lower gastrointestinal adverse events were similar between all five groups. Too few serious adverse events occurred to make meaningful group comparisons.

Comments

Funded by a grant from the National Institute on Aging and the National Center for Complementary and Alternative Medicine, the Herbal Alternatives for Menopause Trial (HALT) was a much anticipated collaboration between Group Health, the University of Washington, Fred Hutchinson Cancer Research Center, and Bastyr University in the greater Seattle area. The study was designed to "investigate the effects of three naturopathic approaches for vasomotor symptom relief and hormone replacement therapy compared with placebo." As most readers are probably aware at this juncture, not only were the results negative but a corresponding editorial in the *Annals of Internal Medicine*[1] and stories in the mainstream press largely focused on the fact that black cohosh was ineffective for treating hot flashes. Upon publication of the study, herbal and integrative medicine experts (e.g., Mary Hardy, MD, Francis Brinker, ND, and Gail Mahady, PhD) questioned the design as well as the results of the study and suggested that it was inconsistent with previous positive studies with black cohosh.[2] One of the lead investigators in the HALT study, Jane Guiltinan, ND, responded by pointing out that non-industry sponsored black cohosh trials that were placebo-controlled trials were largely negative.[3]

Of course, yours truly was one of those "experts" with an opinion. First and foremost, I'm disappointed in the design of the study. While I'm the first to acknowledge the fact that naturopathic interventions are hard to study in a controlled clinical trial, there were too many variables and too many groups in this study. By dividing the total number of subjects across five treatment arms, the statistical power of the study suffers. To their credit, the investigators acknowledge this limitation in their paper by writing, "The study was too small to detect small changes in symptom frequency (less than 1.5 hot flashes per day)." As noted in the summary above, the study set a criteria for inclusion at a minimum of two hot flashes per day, a relatively low level at which reductions are more difficult to produce or monitor.

Also of concern is the choice of black cohosh extract and the dosage chosen. With preclinical safety data, positive and negative clinical trials, as well as postmarketing surveillance data on established extracts such as Remifemin® (Schaper and Bruemmer, Salzgitter, Germany, imported by Enzymatic Therapy, Green Bay, WI) and Klimadynon® (BN 1055, Bionorica, Neumarkt, Germany, imported by Bionorica USA, Eugene, OR), why would the researchers choose to use an extract with no data whatsoever? It's interesting to note that in a three-month open-label, monitoring study of Remifemin, a dose comparison of 40 mg/d and 127 mg/d found a similar effect on vasomotor symptoms associated with menopause.[4] With 40 mg/d clearly established in earlier trials as an efficacious dose, it's not clear why the higher dose of 160 mg/d was chosen for this study.

I'm also confused by the addition of the multibotanical product. Perplexing is the fact that the investigators discovered after the study had started that laboratory analysis failed to detect any dong quai, false unicorn, or pomegranate in the product. That disconcerting fact aside, I'm unaware of any data or even historical rationale that supports the use of ingredients such as chaste tree or dong quai for vasomotor symptoms associated with menopause. Why not use a more established comparison supported by clinical research such as red clover?

So, what we're left with is a study that really tells us very little other than the fact that hormone therapy effectively treats hot flashes and that there is a large placebo response (about 30% in this trial) in this study population. If the critique is that previous positive black cohosh studies are biased and industry-sponsored (so are most drug studies by the way), then why not complete a definitive U.S. study with black cohosh that uses an established extract? The opportunity for high-quality and objective research exists with funding from agencies such as the National Institute on Aging and the National Center for Complementary and Alternative Medicine. However, based on the track record of either poorly designed studies and/or poorly chosen products/ingredients for those studies, isn't it time for a critical view of how government funds are being spent on CAM research?

Conclusion

Although the above study clearly shows superiority of hormone therapy for the management of vasomotor symptoms of menopause such as hot flashes, many female patients in this population are aware of the health risks associated with taking hormones. Unfortunately, this study fails to provide a clear answer for alternatives such as black cohosh, a high-soy diet, and a multibotanical product. The results of this study must be taken in the context of all black cohosh trials—many showing efficacy at 40 mg/d for commercially available products—however, a critical view of this study points to the need for government-funded trials that build on work

CME Objectives

After reading *Alternative Therapies in Women's Health*, the health care professional will be able to:

1. evaluate alternative medicine and complementary therapies for women's health concerns;
2. identify risks and interactions associated with alternative therapies;
3. discuss alternative medicine options with patients;
4. offer guidance to patients based on latest science and clinical studies regarding alternative and complementary therapies.

CME Instructions

Physicians participate in this continuing medical education program by reading the article, using the provided references for further research, and studying the questions at the end of the article. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity, you must complete the evaluation form provided and return it in the reply envelope provided at the end of the semester to receive a certificate of completion. Upon receipt of your evaluation, a certificate will be mailed.

CME Questions

12. Venous leg ulceration is the most serious consequence of CVI and is responsible for what percentage of chronic leg ulcers?

a. 50%
b. 60%
c. 70%
d. 80%

13. Which of the following is the primary treatment choice for venous leg ulceration?

a. Aspirin
b. Cadexomer iodine dressings
c. Compression therapy
d. Horse chestnut seed extract

14. When administered appropriately, horse chestnut seed extract may exhibit which of the following effects?

a. Anti-edematous
b. Anti-inflammatory
c. Antioxidant
d. All of the above

15. The Herbal Alternatives for Menopause Trial (HALT) was too small to detect small changes in symptom frequency.

a. True
b. False

Answers: 12. c, 13. c, 14. d, 15. a.

already done on alternative therapies such as black cohosh instead of ill-advised attempts to reinvent the wheel. ❖

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News Briefs

Many Women with Depression Use CAM Therapies, Study Says

A recent study found that more than half of women with depression use complementary and alternative medicine (CAM).The study, published in the March 2007 issue of *Psychiatric Services*, focused specifically on manual therapies, such as chiropractic treatments, massage, and acupressure; herbs; and vitamins. The researchers assessed a multiethnic sample of 220 women with depression as part of a nationally representative telephone survey of 3,068 women.

The researchers found the 54% of these women with depression reported past-year use of CAM. African-American women were less likely to use CAM therapies in general, compared with non-Hispanic white women. Other factors significantly associated with CAM use in general included being employed, being single, and having self-perceived poor health.

The relationships between the sociodemographic factors and use of each of the three individually examined types of therapies differed from their relationships with use of CAM in general, the researchers say. The reasons the women most commonly cited for using these therapies included wanting treatments to be based on a "natural approach," wanting treatments to be congruent with their own values and beliefs, and past experiences in which conventional medical therapies had caused unpleasant side effects or had seemed ineffective.

Mental health and other health professionals need to increase their own awareness of the types of CAM therapies that their patients may be using and to improve communication with their patients about the benefits and potential risks of these therapies, the researchers conclude.

Study Investigates Use of CAM Therapies by Women Living with Lung Cancer

The use of complementary and alternative medicine (CAM) therapies by women with lung cancer varies according to the women's symptoms and symptom burden, says a study published in the January/February 2007 issue of *Cancer Nursing*.

The study looked at types and frequencies of specific CAM therapies used by women with lung cancer to manage symptoms, and examined differences in demographic and clinical characteristics between CAM users and non-CAM users. Participants included 189 women with non-small cell lung cancer and one or more of eight symptoms.

The researchers found that 44% (84 women) used CAM therapies, including prayer (34.9%), meditation (11.6%), tea (11.6%), herbs (9.0%), massage (6.9%), and acupuncture (2.6%). CAM use was greatest for difficulty breathing and pain (54.8% each), with prayer the most commonly used CAM for all symptoms.

Significant differences were found for age, symptom frequency, and geographic location. Women who were younger, experienced more symptoms, and lived on the West Coast or South (vs. Northeast) were more likely to use CAM. ❖