Complementary medicine in the management of diabetes

This is the fourth of a series of articles looking at the available evidence for complementary medicine relating to the theme topic in Australian Family Physician.

Finding a more holistic and natural way to manage chronic conditions is a common reason for many patients to explore complementary therapies. Obviously the most important factor for type 2 diabetes is lifestyle management, particularly exercise and diet; but if these fail there is a need for medical treatment. Is there current evidence to support complementary medicine (CM) for the management of type 2 diabetes? Do these approaches serve as alternatives or adjuncts to conventional care? This article looks at three reviews to help answer these questions.

Herbs do have a traditional use for diabetes management. One antidiabetic drug developed from a herb is metformin, a biguanide made from French lilac (Galega officinalis). Ginseng (Panax spp.) is best supported by evidence, but problems arise in the research regarding the need to develop a basis for standardisation that ties the composition of herbs to efficacy. In absence of such standardisation, the use of herbs in diabetes must be approached cautiously.1 Herbs often vary in variety, cultivation, strength, and administration, and hence make it often difficult to extrapolate from a research trial to clinical practice.

A systematic review2 on the efficacy and safety of herbal therapies and vitamin and mineral supplements for patients with diabetes found 108 trials examining 36 herbs (single or in combination) and nine vitamin/mineral supplements. Of these, 42 were randomised controlled trials and 16 nonrandomised trials. Of these 58 trials, the direction of the evidence for improved glucose control was positive in 76% (44 of 58). Very few adverse effects were reported. Although current evidence is still limited on any particular herb, the best evidence for efficacy is available for Coccinia indica and American ginseng. Chromium has been the most widely studied mineral supplement. Of these, 42 were randomised controlled trials and 16 nonrandomised trials. Of these 58 trials, the direction of the evidence for improved glucose control was positive in 76% (44 of 58).

In conclusion, lifestyle remains the mainstay of diabetic treatment; however, there is gathering evidence to support the use of CM for type 2 diabetes. It would no doubt be advisable that a general practitioner has some basic training in the use of potentially therapeutic herbs and supplements if they wish to integrate them into their practice. Given such training it would not be unreasonable to offer suitably motivated and informed patients a trial of CM approaches as first line therapy and reserve pharmacotherapy for when control is not adequate. Practitioners should always check for any potential drug-herb interactions and also instruct patients to be diligent with monitoring and review.

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References

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