Acupuncture for osteoarthritis of the knee

Editor – I read with interest the report by Tukmachi and colleagues of their study of acupuncture for osteoarthritis (OA) of the knee. Patients were selected who had grade IV changes according to Kellgren and Lawrence’s radiological grading of OA of the knee, rather than on signs and symptoms. Can the authors explain why they used this criterion, which is not applicable in most clinics?

Two ways of stimulating the acupuncture needles are described, ie manual and electroacupuncture, but the authors do not describe the criteria that were used to decide which of these modalities was selected, nor which was more effective. Obviously, stimulating GB34 manually is far easier and (therefore more practicable) than applying electroacupuncture.

The authors describe first treating the patient supine, needling the anterior part of the knee, then turned face down for the posterior aspect, for a period of 20 to 30 minutes. It is not made clear whether and when the acupuncture needles and electroacupuncture leads are removed from the posterior aspect of the knee, or when the patient is turned prone to treat the posterior aspect.

Am I in the minority in observing that putting into practice a methodology that is published in reports of clinical trials of acupuncture is, as a rule, disappointing? Is that because the description of the methodology is not followed correctly, or is it that the selection of patients we treat is not the same as that of the author?

On the positive side, the paper was helpful in reminding us of the importance of obtaining de qi when stimulating needles manually, of combining manual and electrical acupuncture to treat both aspects of the knee, and of repeating treatments at monthly intervals to maintain the beneficial effect described by Christensen and colleagues.

Reference list

Reply from first author

Editor – We would like to thank your reader for his interest in our paper. The following are the answers to his queries.

With regards to selection of patients, we based that on a previous published study which used Kellgren and Lawrence grading for selection rather than signs and symptoms.

We regret if the description of treatment given in our paper was unclear, and appreciate the opportunity to describe it again. Two modes of needle stimulation were carried out on every patient: first, point GB34 was briefly stimulated manually, to elicit an electric shock sensation. Then, electrical stimulation was given to the same point in combination with SP9. Since every patient received the same treatment, it was not necessary to apply specific criteria for selecting treatment. The choice of GB34 for brief manual stimulation was based on our previous study which suggested that such stimulation is very effective in relieving pain and stiffness. The present study was designed to study the effectiveness of acupuncture on symptoms of knee osteoarthritis and not to compare different combinations of acupuncture points and their mode of stimulation in osteoarthritis.

Clearly, acupuncture treatment (whether manual or electrical) cannot be carried out on both anterior and posterior aspects of the knee simultaneously when the patient is lying down. We indicated in our paper that the total treatment time was 20 to 30 minutes per session for each patient: first, we treated the anterior aspect of the knee for 10 to 15 minutes and then removed the needles.
with their electrical connections. Second, we asked the patient to turn face down for treatment of the posterior aspect for another 10 to 15 minutes.

We believe that the treatment we have described for knee osteoarthritis is easy to follow and has considerable practical value because it is similar to another previous published study in this field.

Reference list

Tension pneumothorax related to acupuncture

*Editor* – We read with interest the case published in the March edition of the journal, reporting the development of tension pneumothorax after needling of the points LU1 and BL13.1 The article stated that tension pneumothorax was diagnosed on chest x ray.

The diagnosis is not a radiological one, nor is it dependent on the size of pneumothorax; severity may actually correlate poorly with x ray findings. Tension pneumothorax develops when a one way valve allows air into the pleural space during inspiration, but does not allow air out during expiration. The development is commonly heralded by a rapid deterioration in cardiopulmonary status due to impaired venous return, reduced cardiac output and hypoxaemia.2 Although the onset of pain and breathlessness was considered by the medical acupuncturist to be due to ‘tension in the meridians’, we suspect that in a true case of tension pneumothorax the signs and symptoms would have alerted the acupuncturist to suspect a more urgent diagnosis.

The ideal management for a tension pneumothorax does not include an unsupervised taxi journey, but is an emergency requiring immediate high concentration oxygen, a cannula in the pleural space via the second anterior intercostal space in the mid-clavicular line and subsequent insertion of an intercostal drain with an underwater seal.2 We believe that this was a case of iatrogenic simple pneumothorax and not tension pneumothorax. It is an important distinction to make, with different management algorithms and levels of urgency. Pneumothorax may occur after thoracic needling and acupuncturists should appreciate the importance of appropriate management.

Reference list

Reply from the author

*Editor* – I am grateful for the comments of Whale and Hallam concerning my case report on tension pneumothorax related to acupuncture.1 The diagnosis of tension pneumothorax was made in the intensive care unit of the hospital where the patient was treated. I agree that the clinical status is much more important than the radiological findings in forming the diagnosis, although a lateral shift of the mediastinal organs in the thorax is one accepted criterion of tension pneumothorax. However, in this patient the diagnosis is in little doubt as there had been a deterioration of the patient’s cardiopulmonary status, which necessitated a week’s treatment in intensive care with an intercostal drain and an underwater seal.

I agree that the unsupervised taxi journey was a completely inappropriate reaction of the acupuncturist. One of the main points of publishing the report is that even experienced therapists should be aware of the possibility of causing a pneumothorax by acupuncture, especially in slim patients. Therefore all acupuncturists should...
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