LETTERS

Acupuncture in chronic non-responding anxiety/depression patients: a case series

BACKGROUND

During the course of 2007 it became clear through Community Mental Health Team meetings that a number of staff had chronic anxiety/depression patients who required a very high level of input. This group was characterised by high service use, resistance to medication regimes, resistance to “talking therapies” such as cognitive behavioural therapy (CBT), long, unbroken involvement with the Mental Health Service and both staff and patient feeling “stuck”.

It was decided to form a support group to try to deal with these resource-intensive individuals. Inclusion criteria were discussed and defined as: >1 year of involvement without improvement; >2 forms of medical management without effect; experienced CBT without effect; daily or near daily contact with Mental Health Services; and both patient and service user feeling they had run out of options.

METHOD

The group recruited four individuals out of those identified in discussions within the Community Mental Health Team and invited them to attend. Two of the subjects had been static for >2 years, the other two >1 year. The design was loosely CBT, with thought processes challenged and corrective methods of thinking reviewed as potential agents of change. The most recent Hospital Anxiety and Depression Scale (HADS) scores prior to treatment were: patient one—A8, D6, patient two—A15, D12 and patient three—A13, D15. The fourth patient, who subsequently left the group, had no recent HADS scores. HADS scores of 0–7 are “normal”, 8–10 “borderline” and 11+ “significant”; therefore all patient’s demonstrated borderline or significant clinical indicators. HADS scores were to be collected at baseline and conclusion, but this did not occur.

During the course of the support group sessions, methods of physically managing their symptoms were discussed, and all members of the group expressed an interest in acupuncture. As this point a literature review was conducted and the excellent Pilkington et al. article was identified. This was used in conjunction with other articles in developing a treatment regime.

The main problem was that the articles described varying locations, frequency and duration of treatments, and failed to offer any guidance as to why you would chose one of over 30 points over another, beyond the recurring phrase “practitioners experience”. Unfortunately the point that occurred with the greatest frequency, GV20 was dismissed as an option due to the levels of anxiety exhibited in this group.

The points selected were all used bilaterally for a systematic effect, being:
- LI4—Large intestines are believed to house Qi;
- LI11—depression and mania.
- HT7—anxiety, hysteria, mania and palpitations.

The rationale for selecting these points were that they were all acknowledged points, with a reasonable frequency of repetition within the articles examined, they were in areas that required the minimum of undressing (which would decrease the anxiety experienced and allow for a group setting throughout for support mechanisms), and would allow the participants to remain seated with footstools to encourage relaxation throughout.

The design consisted of six sessions over six weeks, 20 minutes initially to assess patient’s reaction, increasing to 30 for the remaining five sessions. A strong de qi sensation was achieved through use of 0.20 mm×25 mm sterile, single use copper handle needles inserted to a depth of 1–5 cm and maintained through manual stimulation. The patients were treated as a group at their request. One patient dropped out for personal reasons after the second session, but the remaining members completed the course. No adverse effects were reported.

RESULTS

The patients’ symptoms were assessed using a visual analogue scale (VAS), with 0 as the “worst” they have ever felt and 10 being the “best”. The VAS results are shown in fig 1.

DISCUSSION

The most important note that must be made is that the participants in this group felt as if they had improved. In all individuals this was manifested in different ways. One had engaged in the social life that she had enjoyed previously, another developed improved links with her family. The effects continued into the next six months with one patient organising to move house to a more central location in town. Each felt that they were more prepared to cope in the normal day-to-day activities they had wanted to enjoy prior to the sessions. As a group they identified the acupuncture as an important factor in their new attitude.

While this case study has obvious flaws in terms of sample size, outcome measures and no control group, this offers an objective, standardised, repeatable treatment that (in this case) offers hope of relief in a small but resource intensive group. These individuals do not occupy the “sexy” areas of self-harm, suicide, schizophrenia and so on, but are sad, lonely and anxious to the degree that their lives lose meaning and direction. The grandmother waiting for a phone call, the widow with no need to get out of bed in the morning and the wife who just doesn’t know what to do with herself.

As the population of chronic non-responding patients is small, and occupy a group likely to have variable attendance, it would require a multi-centre trial to ensure that any research performed would have the power and validity to make a definitive

![Figure 1] As can be seen, all patients had an improvement. The patients who had the worst scores at the start had the greatest increase, lifting both from feeling “the worst they’d ever been” to “normal” (5/10 equating to a normal day).
conclusion. Please contact the author if you would be interested in taking this further.

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Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.


REFERENCES


How acupuncture may relieve infantile colic symptoms—melatonin, serotonin and circadian rhythmicity

Reinthal et al’s study of minimal acupuncture effects on infantile colic was a great support for paediatric acupuncture. Although acupuncture has long been used for infantile colic, there were no randomised controlled trials until Reinthal et al’s study. Six years before that, Zhao1 had reported treatment of infantile morbid night crying with acupuncture at point PC9 in 100 cases, which were not referred to in Reinthal et al’s study.

In the Reinthal et al study, the effect of needling of the chosen point LI4 was attributed to the motor and autonomic nerve system, spinal reflexes and also to the segmental innervation of the viscera. The conclusion was therefore focused on the potential reduction of the intestinal peristaltic movements. However, it’s worth mentioning why infantile colic recovers spontaneously at about the age of three months.

It has been hypothesised that the melatonin timing mechanisms, which code for day length, are initiated prenatally by the maternal pineal gland, and three months postnatally the melatonin nocturnal secretion rhythm is maintained by the infant’s pineal gland.2 Peak serotonin concentration causes intestinal cramps associated with colic because serotonin increases intestinal smooth muscle contractions. Melatonin has the opposite effect of relaxing intestinal smooth muscles. Both serotonin and melatonin exhibit a circadian rhythm with peak concentrations in the evening. However, serotonin intestinal contractions are opposed by melatonin during the first three months because only serotonin circadian rhythms are present at birth. Melatonin circadian rhythms appear at three months of age as the cramps of colic disappear.3

It is now clear that melatonin is a key regulator of clock gene expression in the suprachiasmatic nucleus, because modulation of the endogenous profile of melatonin secretion changes clock gene profiles.4 Like melatonin, serotonin is associated with alterations in circadian rhythmicity. Injection of serotonergic receptor agonists have been shown to decrease expression of two clock genes.5

It has been shown that electro-acupuncture attenuates stress-induced defecation in rats with chronic visceral hypersensitivity via serotonergic pathway and modulate the availability of 5-hydroxytryptamine to restore the balance between 5-hydroxytryptamine synthesis and removal.6

Further, it has been demonstrated that five weeks of acupuncture treatment (as in the Reinthal et al study) was associated with a significant nocturnal increase in endogenous melatonin secretion and significant improvements in polysomnographic measures of sleep onset latency, arousal index, total sleep time and sleep efficiency.7

It can be assumed that acupuncture relieves infantile colic symptoms by regulating the serotonin and melatonin secretions and thereby the circadian rhythm. For such an effect, regulation of the circadian rhythm genes is mandatory. Further studies are needed to clarify the relationship of the clock genes, acupuncture and infantile colic.

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Competing interests: None.

Provenance and peer review: Not commissioned; externally peer reviewed.


REFERENCES

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*Acupunct Med* 2009 27: 133-134
doi: 10.1136/aim.2008.000323

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