Acupuncture is being increasingly used for a multiplicity of symptoms in patients with cancer and those requiring palliative care. An evidence base has been accumulating over recent years for symptoms such as acute and chronic pain, nausea and vomiting, xerostomia, vasomotor symptoms, fatigue and dyspnoea. Many symptoms occur in patients with cancer long after their initial treatment, which usually consists of a combination of surgery, radiotherapy and chemotherapy. Today, 45% of patients worldwide survive at least 5 years beyond their initial diagnosis and cancer is increasingly regarded as a chronic disease. As treatments become more successful, patients face the additional challenges of dealing with both the physical and psychological sequels of their condition.1

Yet, anticancer treatment remains an intense experience for many patients and causes numerous side effects. Acupuncture, being a non-drug treatment, provides at least a partial solution for the increasing proportion of patients who turn to complementary and alternative therapies for help with symptom control at variable times after their diagnosis. Acupuncture has been used in pain management in our large Oncology Hospital for over 30 years, initially treating only pain but gradually also used in the treatment of non-pain symptoms such as hot flushes, dyspnoea and radiation-induced bowel and bladder problems. A wide range of symptoms have been treated with varying degrees of success, including radiation-induced proctitis and bowel problems, radionecrotic ulcers (which classically never heal) and radionecrosis of the jaw in patients on bisphosphonates – some would make very interesting case reports still waiting to be written up.

The majority of patients who are referred to us have more than one symptom needing treatment. This can present considerable challenges for clinical trials: for example, when trying to recruit participants, the inclusion criteria may demand a single symptom only, such as fatigue, however, the fatigue may in fact be caused by another problem such as disturbed sleep patterns from hot flushes. Studies that specify that treatment should be given only to the presenting symptoms, as with palliative care studies, could raise ethical difficulties. There is an argument for greater acceptance of pragmatic trials in this area to help influence medical opinion.

It is not surprising to note the immediate effect of acupuncture on reducing global symptoms such as fatigue, anxiety and dyspnoea, in the pilot study of Lim et al when acupuncture was compared with nurse-led supportive care.2 While this is a somewhat uncommon comparison to choose and difficult to quantify in trial terms, no one can deny the importance of reducing these generalised symptoms at the end of life. We also notice that the analgesic effects of acupuncture wear off more quickly towards the end of life, in contrast to effects on other symptoms such as dyspnoea and vasomotor symptoms, and we often speculate on the possible mechanisms contributing to this difference.

There are many fascinating unanswered questions in this clinical area. Also in this issue, Donald et al have used acupuncture in a retrospective case series for chemotherapy-induced peripheral neuropathy (CIPN) – a condition that has caused widespread morbidity and yet remains a relatively poorly researched area for which no standard effective medical treatment has been agreed on.3 They show that acupuncture can reduce these debilitating symptoms in their patient population, possibly through release of various endogenous transmitters including nerve growth factor, γ-aminobutyric acid and adenosine. Oncologists have altered dose scheduling recently, which has led to a reduction in the incidence of CIPN, though some agents such as bortezomib (Velcade) continue to give some of the worst symptoms in patients with multiple myeloma. It is encouraging to see that acupuncture may also be beneficial in helping to alleviate the troublesome symptoms associated with non-cancer conditions such as HIV where the gastrointestinal symptoms associated with antiretrovirals can greatly adversely affect quality of life.4

Patient safety is of paramount importance in this group of patients who are particularly susceptible to the effects of acupuncture and who may have complex and ever-changing patterns of symptoms. For this reason, in 2006, we published guidelines for providing acupuncture treatment specifically for patients with cancer, which included contrasting advice about patients who are prone to or who have lymphoedema, extending an earlier article on patient safety and acupuncture.5 6 A significant number of patients with lymphoedema have been treated in our hospital over the years using ipsilateral paravertebral needling but by avoiding needling of the ipsilateral limb directly. In practice, we no longer needle an arm in which axillary sampling or dissection has taken place because of the theoretical risk of causing lymphoedema.

Lymphoedema is a challenging symptom and Cassileth et al have provided a stimulating article with positive preliminary findings and a prospective randomised controlled trial is planned for further work. In contrast to our practice, the ipsilateral limb was needled in this study.

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Once established, lymphoedema is particularly difficult to treat but were one to already have some lymphoedema could acupuncture theoretically make the lymphoedema any worse? Perhaps a prospective trial in this area could include a further comparison group without needling in the affected limb.

A problem encountered with treating patients with cancer is that, while the benefit is mostly maximal after a complete course of treatment, it is important to continue to provide ongoing ‘top-ups’ indefinitely as patients’ benefits wear off over time. We have overcome these problems by introducing various methods including massaging studs in patients with dyspnoea and teaching self-needling for up to 6 years and longer in patients with hot flushes maintaining a flexible approach to match treatment with patients’ lifestyles.

The question ‘Who pays for ongoing treatments?’ will be an important area of debate in the future. Potentially, acupuncture ‘prescriptions’ could be provided for GPs and other trained healthcare professionals to provide ‘top-ups’ nearer to the patient’s home after an initial course of treatment. Training of these peripheral secondary providers would be very important in order for this treatment to be given safely but potentially acupuncture could be much more readily available to patients with cancer as a result. Our hope is that, in the future, the relatively simple and effective treatment option of acupuncture could be provided outside the hospital setting at a local level which might be the most convenient and probably cost-effective option for patients and the NHS.

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