Acupuncture and constitutional diagnosis: where now?

Adrian White

The process of diagnosis based on clinical history and examination is known to be fallible. There are plenty of examples of this fallibility in conventional medicine, and it only took a few minutes searching PubMed to find a study showing that clinical diagnosis of pneumonia was only 75% reliable when compared with the ‘gold standard’ of x-ray image appearance.1

Similarly, Traditional Chinese Medicine (TCM) diagnosis has proved less than perfect in the past. One fairly typical study found 47–80% reliability in a clinical trial.2 In the absence of a gold standard, reliability has to be tested against another clinician, raising the chance of error. Also, much of the variability may be due to choosing conditions with multiple aetiology and presentations. With awareness of the problems leading to improved study design, diagnostic reliability seems to be improving. For example, inter-rater reliability in rheumatoid arthritis patients improved from 32% in 2005 up to 73% in 2008.3 More recently, Birkefl et and colleagues found low agreement in group 3) with primary depression which improves with activity. Clinical experience suggests these groups have different prognoses. The treatment approaches should be tailored for the different subgroups, including predominant lifestyle changes with needles as a last resort.

Interestingly, subgroups of FM populations can also be identified by Western diagnosis, and these subgroups seem to match the TCM diagnoses reasonably well. The validated 10 item scale known as the Fibromyalgia Impact Questionnaire (FIQ) can reveal two profiles: one with pain but low levels of anxiety, depression and morning tiredness; and one with high levels of pain, fatigue, morning tiredness, stiffness, anxiety and depressive symptoms.4 Seidel and Mueller suggested four subgroups in FM: 1) where pain is prominent, hypersensitivty is present, and psychological disturbance is minimal – somewhat like Qi and Blood stagnation; 2) where depression is prominent and secondary to the condition, like Liver Qi stagnation; 3) where depression is primary, which is apparently Qi and Blood deficiency; and 4) somatofom disorder which has no obvious correlate.5

Seidel and Mueller also suggest that treatment should usefully be tailored to the subgroup: subgroup 1) for example, would need strong analgesia and perhaps HT3 receptor antagonists – to which readers of this journal would add acupuncture; whereas patients in group 3) with primary depression need effective doses of antidepressant therapy, not just the low doses often used for pain; and group 4) would be best offered behaviour therapy.

There is nothing new or remarkable about this concordance between eastern and western diagnostic systems, since they are using similar diagnostic information. Some years ago, Coyle and Smith matched TCM diagnosis and pathological aetiology of infertility in women.6 Diagnoses are only labels written within one’s own terms of reference.

The question whether subgroups of FM patients differ in their responsiveness to acupuncture was the starting point for the project of Mist et al, who thought that the essentially negative systematic reviews of acupuncture for FM might conceal important treatment effects in particular subgroups, since these subgroups have not been kept separate in clinical trials.

Interesting questions arise, including whether differences between FM subtypes are due to basic constitutional differences or to a response to the environment — nature or nurture. Evidence on the Korean system of Sasang characteristics (which categorises personalities into four subgroups) suggests that subgroups are determined, at least in part, genetically: one of the subtypes can be linked statistically to polymorphism in a drug transporter gene.7 This information could clearly be useful in predicting a response to drug treatments in particular Sasang groups. In acupuncture, mice of different genetic strains show different degrees of analgesia to electroacupuncture.8 Patient characteristics such as extraversion, agreeableness, openness to experience and female gender were associated with placebo response under some circumstances.9

Significant advance in predicting treatment response seems tantalisingly close. We need no longer worry too much about having a primary aim of demonstrating the reliability of TCM diagnosis, though future studies need to be designed carefully, learning from the methods in this paper. In which other conditions can TCM and western diagnoses be matched? Headache would be a prime target. Does TCM diagnosis bring valid additional

Correspondence to Adrian White, Department of Primary Care, Peninsula Medical School, N21 ITTC Building, Tamar Science Park, Plymouth PL6 8BX, UK; Adrian.white@pms.ac.uk

Acupunct Med December 2011 Vol 29 No 4

Commentary
diagnostic sub-subgroups that can make a difference to the patients’ prognosis with acupuncture treatment?

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.

Accepted 27 October 2011
Published Online First 12 November 2011
doi:10.1136/acupmed-2011-010100

REFERENCES


Acupuncture and constitutional diagnosis: where now?

Adrian White

*Acupunct Med* 2011 29: 247-248 originally published online November 12, 2011
doi: 10.1136/acupmed-2011-010100

Updated information and services can be found at:
http://aim.bmj.com/content/29/4/247

**References**

This article cites 10 articles, 3 of which you can access for free at:
http://aim.bmj.com/content/29/4/247#BIBL

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/