Group acupuncture for osteoarthritis; a practical option?

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Knee pain due to osteoarthritis is an increasing health problem.1,2 Acupuncture is a promising treatment for osteoarthritis that may provide symptomatic relief without the adverse cardiovascular events associated with the use of non-steroidal anti-inflammatory drugs (NSAIDs). When the UK National Institute of Health and Clinical Excellence (NICE) reviewed the evidence for its 2008 osteoarthritis guideline,3 they concluded that it seemed likely that acupuncture can provide some short-term to medium-term relief for some people living with osteoarthritis. However, in contrast with NICE back pain guidance,4 they did not make a positive recommendation for acupuncture. Importantly, as reported in one of the linked papers,5 the approach to the health economic analysis in the NICE osteoarthritis guideline compared verum and sham acupuncture whereas the NICE back pain guideline compared acupuncture with usual care. The Osteoarthritis Research Society International has recommended that ‘acupuncture may be of symptomatic benefit’6 and a subsequent Cochrane review of acupuncture7 concluded that there were small benefits from acupuncture when compared to a sham treatment, and that these effects were not clinically relevant and might have been an artefact due to inadequate blinding. There were larger, clinically important, benefits when acupuncture was compared to a waiting list control. At least one subsequent study also supports the notion that acupuncture can be effective for osteoarthritis,8 and is an option that is cost effective.9 Notwithstanding the promising evidence supporting the effectiveness of acupuncture, it is not a treatment option favoured by NHS commissioners. This reluctance may, in part, be due to the perception that acupuncture works through the non-specific effects of the therapeutic encounter; ‘the placebo effect’. That there are studies showing that the acupuncturist’s approach to the patient can influence the effectiveness of treatment supports this hypothesis.10 Although acupuncture may be cost effective for knee osteoarthritis with a cost per quality adjusted life year of less than £4000, well below the NICE threshold of £20 000, the acquisition cost of acupuncture may also be a barrier to its wider use. The use of group interventions for chronic painful disorders is well established.11–13 This is due to the recognised positive effect of the group dynamic and the reduced acquisition cost of treatment. Might then group acupuncture sessions be a worthwhile approach to maximise the non-specific effects of acupuncture treatment and make acupuncture financially attractive to commissioners?

Tantalising initial data published in this issue provides some proof of concept for group acupuncture interventions as a viable treatment option.14–16 An interview study of people living with knee osteoarthritis who had been referred to an orthopaedic surgeon and attended a group acupuncture clinic found that such clinics were acceptable to patients and that the group environment seemed to have a positive additional effect.14 However, it was recognised that group treatment might not suit everyone. In a linked longitudinal observational paper,15 the same group found improvements in patient reported outcomes that were maintained for up to 2 years. Many of their subjects were people who might have been considered for knee replacement. Even a small reduction in knee replacement rates from such a service might be cost saving for commissioners. Given that up to 15% of people with knee replacements are dissatisfied with outcome there might also be a patient benefit from reducing knee replacements.17 Clearly, without a control group it is not possible to draw firm conclusions from these data because they do not account for regression to the mean or the short-term to medium-term natural history of those consulting for knee osteoarthritis. A small randomised trial (n=56) of individual acupuncture for patients waiting knee replacement, also reported in this issue,16 failed to show a difference in clinical outcomes but did, in a post hoc analysis, find a suggestion that those receiving acupuncture might be more likely to withdraw from the surgical waiting list.

In conclusion, there is some evidence to suggest that acupuncture provides a worthwhile additional clinical benefit for knee osteoarthritis when compared to a usual care control, and a suggestion that it might reduce the demand for joint replacement surgery. Group acupuncture is a promising new approach to delivering such treatment with a modest acquisition cost. Further work is needed to find out if group acupuncture is an effective and cost effective option for the treatment of knee osteoarthritis.

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