The development of group acupuncture for chronic knee pain was all about providing frequent electroacupuncture in UK National Health Service (NHS) primary care. I am writing to remind readers how and why these group clinics were first set up in an attempt to ensure that any future randomised controlled trials (RCTs) of acupuncture for chronic knee pain use the optimum parameters for treatment.

I first approached Dr Saul Berkovitz (consultant physician) in 2005 to engage support for a new model of supplying acupuncture treatment, following on from the good results of the study by Vas et al published in the *BMJ* in 2004. It was termed the high volume acupuncture clinic (HVAC), and the aim was to provide electroacupuncture (EA) for chronic knee pain for 6–8 patients at a time in a large clinical room. I felt that the evidence, and my clinical experience, supported EA, and that optimum treatment was probably around 30 min per session. If it took about 8–10 min to place needles and set up the EA per patient, then one practitioner could treat 6–8 patients per hour at most. For safety and convenience it seemed best to do this in one large room so that the throughput could be maintained.

Knee pain was chosen initially because the evidence from RCTs was positive and improving, and because I guessed that there would not be too much controversy if we chose to use a standard treatment protocol that involved EA to points near the knee. We also judged that anatomical exposure of the knees could be acceptable to most patients, and that the technical aspects of the treatment would be relatively easy to teach.

The clinic was first run as a showpiece for the reopening of the Royal London Homeopathic Hospital following its refurbishment. It soon became operational and was run initially by Saul Berkovitz, Chris Perrin (nurse manager) and Reiko Ito (nurse practitioner). Data were collected from the first cohort of patients, and published in this journal (figure 1).

The clinic was very popular, and the outcomes were in line with the large data sets from Germany. So it was with some surprise that we read the subsequent UK National Institute for Health and Clinical Excellence (NICE) guidelines (CG59), which recommended that EA should not be used in osteoarthritis, based entirely on modelling cost effectiveness. The matter was debated vigorously in these pages. Despite CG59 and the surrounding controversy, the HVAC was popular with patients and the concept grew to include headaches and musculoskeletal pain, then facial pain and women’s health. They are now called Group Acupuncture clinics, and are based at the renamed Royal London Hospital for Integrated Medicine.

Returning to the subject of EA for chronic knee pain, the original idea of developing a clinic to provide frequent and adequate treatment has been validated to some extent by the latest research. Mavrommatis et al have performed a trial very similar in design to that by Vas et al, where the

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**Figure 1** This image shows a nurse practitioner (Liova Cepillo) setting up electroacupuncture for a patient with chronic knee pain in a small group room with five treatment couches separated by curtains.
intervention involved EA to muscles around the knee (as performed in the HVAC or Group clinic), and demonstrated good results. Furthermore, a regression analysis performed on an updated systematic review of sham controlled RCTs indicated that EA was the only aspect of treatment tested that correlated with a positive outcome for knee pain (White et al, BMAS Autumn Meeting 2011). This correlation is also reflected in the sensitivity analysis of the Cochrane review by Manheimer et al, where the effect size (standardised mean difference) of EA was 0.50 and acupuncture without EA was 0.11.

So the take-home message is: don’t forget the EA when treating osteoarthritis of the knee.

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