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, Birkenfel and colleagues found low reliability for some TCM diagnoses in the linked study, Mist and colleagues

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Acupuncture therapy, not just the low doses often used for pain; and group 4) would be best offered behavioural 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.4 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.9 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.10 Patient characteristics such as extraversion, agreeableness, openness to experience and female gender were associated with placebo response under some circumstances.11

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


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

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