

Australian Journal of Acupuncture and Chinese Medicine

CONTENTS

- 3** Editorial by [Christopher Zaslowski](#)
- 4** Interview with Dr Winston Wang by [Dr Bruce Stafford](#)
- 7** Research Protocol: Utilisation and the Effects of Acupuncture during Systemic and Radiation Cancer Treatment in the Public Hospital by [Dr Byeongsang Oh](#)
- 12** Moxibustion plus pharmacotherapy for Chronic Obstructive Pulmonary Disease by [Meaghan E Coyle](#), [Lei Wu](#), [Anthony Lin Zhang](#) and [Charlie Changli Xue](#)
- 21** Case Study: A sting in tropical waters off a remote Fiji Island resolved by Chinese medicine by [Luke McPherson](#) and [Dr Suzanne Cochrane](#)
- 26** Book Review: Aspects of Spirit by [Christopher Zaslowski](#)
- 27** Book Review: Restoring order in health and Chinese medicine by [Christopher Zaslowski](#)
- 28** Research Snapshot- an examination of studies involving acupuncture in labour by [Simone Ormsby](#)
- 30** Research Snapshot- study to examine the role of acupuncture to reduce symptoms of lymphoedema after breast cancer: a randomised controlled trial by [Luke McPherson](#)
- 32** Commentaries on the regulation and the current situation in Spain regarding acupuncture and TCM by [Dr Ramon Calduch](#)
- 34** Conference Report by [Suzanne Cochrane](#)
- 35** Upcoming International Conferences
- 36** AJACM Instructions for authors
- 39** Advertise with AJACM



The Australian Journal of Acupuncture and Chinese Medicine (AJACM) is the official journal of the Australian Acupuncture and Chinese Medicine Association Ltd (AACMA). It is Australia's only peer-reviewed journal for the acupuncture and Chinese medicine profession.

All articles, other than current research and clinical applications, research snapshots, book reviews, conference reports, standards and guidelines, and national and international news, have undergone the peer-review process. AJACM is indexed in the EBSCO, Informit and Scopus databases.

AJACM Management Committee

Prof. Hong Xu, AACMA President
Kerry Watson, AACMA Vice-President
Xiaodong Yu, AACMA Director

Managing Editor

Melinda Lyons (BBusiness (Marketing)/BMedia and Communications)

Publication, design and production

Published by the Australian Acupuncture and Chinese Medicine Association Ltd (AACMA)
ABN 52 010 020 390
Design and production Eclipse Advertising

Contact information

AJACM
PO Box 1635
COORPAROO DC QLD 4151
AUSTRALIA

Phone: +61 7 3457 1800
Fax: +61 7 3394 2399
E-mail: ajacm@acupuncture.org.au
Web: www.ajacm.com.au

For information regarding subscriptions and advertising, please see end pages.

The ideas and opinions expressed in the Australian Journal of Acupuncture and Chinese Medicine do not necessarily reflect the views, ideas or opinions of the AJACM or AACMA. All articles and advertisements are published in good faith. The publisher, AACMA, makes no warranty or representation that the products or services advertised in or with this journal are accurate, true or fit for their purpose and persons must make their own enquiries.

ISSN 1833-9735

ACTING EDITOR IN CHIEF

A/Prof Christopher Zaslowski,
PhD, DipAcu, PGDipCHM, BAppSc(Physio), MHLthScEd
University of Technology, Sydney, Australia

EDITORIAL BOARD

John Deare, MAppSc(Acu), BHSc(CompMed)
Australian Acupuncture and Chinese Medicine Association Ltd, Australia
In private practice, Southport, Australia

Peter Ferrigno, PhD, BA, DipEd, BSW, DipAcu, GradDipHerbMed, MA(Res)
In private practice, Melbourne, Australia

Yun-Fei Lu, PhD, BMed(TCM), MMed(TCM)
Endeavour College, Australia

Prof Hong Xu, PhD, BMed
Victoria University, Australia

Suzanne Cochrane, PhD, BSW, DipTCM, BAS
University of Western Sydney, Australia

INTERNATIONAL ADVISORY BOARD

Prof Alan Bensoussan, PhD, MSc, AdvCertAc(Nanjing), DipAc, DipEd, BSc
National Institute of Complementary Medicine, Australia

Stephen J Birch, PhD, LicAc
Stichting (Foundation) for the Study of Traditional East Asian Medicine, The Netherlands

Prof Seung-Hoon Choi, OMD, PhD
President Korea Institute of Oriental Medicine, Republic of Korea

Prof Marc Cohen, MBBS(Hons), PhD(TCM), PhD(ElecEng), BMedSc(Hons)
RMIT University, Australia

Prof Liangyue Deng
World Federation of Acupuncture-Moxibustion Societies, China

Richard Hammerschlag, PhD
Oregon College of Oriental Medicine, USA

Prof Kenji Kawakita, PhD, BSc
Meiji University of Oriental Medicine, Japan

Prof Lixing Lao, PhD, CMD, LicAc
University of Maryland Baltimore, USA

A/Prof Chun Guang Li, PhD, BMed, MMed
RMIT University, Australia

Prof Zhenji Li
World Federation of Chinese Medicine Societies, China

Hugh MacPherson, PhD, BSc
University of York, United Kingdom

Prof Dong-Suk Park, PhD
Kyung Hee University, Republic of Korea

Charlotte Paterson, PhD, MSc, MBChB
Peninsula Medical School, United Kingdom

A/Prof Xianqin Qu, PhD, MCardiol, BMed
University of Technology, Sydney, Australia

Prof Basil D Roufogalis, DSc, PhD, MPharm
University of Sydney, Australia

Volker Scheid, PhD
University of Westminster, United Kingdom

Beiyong Wang, BMed
State Administration of Traditional Chinese Medicine, China

Prof Lingling Wang, MMed, BMed
Nanjing University of Traditional Chinese Medicine, China

Prof Charlie Xue, PhD, BMed
RMIT University, Australia

Jerry Zhang, PhD, BMed
RMIT University, Australia

Prof Zhongzhen Zhao, PhD, MSc, BSc
Hong Kong Baptist University, Hong Kong, China

From the Deputy Editor Associate Professor Christopher Zaslowski

As deputy editor for the AJACM I must apologise for the late publication of this issue.

Unfortunately in late 2014, we received the notification from the previous Editor-in-chief, Dr Zhen Zheng that she was stepping down from this role in order to pursue further research in acupuncture and Chinese medicine at RMIT University.

Dr Zheng did an outstanding job in initiating and guiding the journal along what was at times a rocky journey from its inception in 2006 to her final issue in 2014. She had major input into developing and managing many of the manuscript processes including rigorous peer review process.

The AJACM editorial board would like to thank her for all her hard work and wish her a productive and successful future.

We also had the resignation of Ms Judy James from the management committee who also steered the journal in many ways by managing the human and physical resources necessary to enable a regular publishing schedule.

The AJACM editorial board would also like to thank her for all her hard work in the eight years she was involved with the journal.

Finally we would like to welcome Drs Kerry Watson, Xiaodong Yu and Professor Hong Xu to the AJACM management committee. The editorial board look forward to their contribution over the next few years.

As you have noticed we are also changing the way we disseminate the journal with this issue being the first fully digital issue.

In order to address rising publication and postage costs we are now enabling practitioners through the AACMA website to access the electronic journal at no additional cost.

We will still be printing a small number of paper copies for those AACMA members and others that may wish to purchase a paper journal.

This is the way of the future so we hope the readers embrace the new digital age and continue to read the journal, digital cover to digital cover.

This issue has some interesting articles, one which is a protocol for a study looking at the utilisation and the effects of acupuncture during systemic and radiation cancer treatments in a public hospital.

With the increasing use of acupuncture as an adjunct for cancer care this is a relevant read.

We also have a systematic review of randomised controlled trials from a RMIT research group on the effect of moxibustion plus pharmacotherapy for chronic obstructive pulmonary disease.

Also an interesting read of relevance when reflecting on our international peers' professional developments a review of the current state of regulation of acupuncture in Spain.

In addition we have our regular book reviews and research snapshots.

We hope you enjoy reading this 2016 issue and we endeavour to have the second biannual issue out later this year in December.

**Associate Professor Chris Zaslowski
Deputy Editor**

Interview with Dr Winston Wang

Interview conducted by
Dr Bruce Stafford*

Introduction

Dr Wen Cheng Wang (Winston Wang) has over 40 years of experience in Chinese medicine, with a special interest in traditional Chinese orthopaedics.

He uses a unique method of pulse diagnosis called 'Huang Jia Yi Quan Thousand Steps Pulse'. This style of pulse diagnosis was developed by the Huang family, a medical dynasty in China, which has passed down the method over eight generations.

Dr Wang holds a master's degree in traditional Chinese orthopaedics from Liao Ning University of Traditional Chinese Medicine.

Along with his son James, Dr Wang runs a busy private practice in Melbourne, Australia with special interests in Chinese orthopaedics, internal conditions and cancer. He is currently:

- President of the Chinese Traditional Orthopaedics Association of Australia;
- Vice-president of the World Federation of Chinese Orthopaedics;
- Vice-president of the International Pulse Diagnosis Association and
- Honorary Professor of Chinese Orthopaedics at Liao Ning University of Traditional Chinese Medicine.

The Questions

How is Huang Jia Yi Quan Thousand Steps Pulse different from the standard 28 pulses?

Huang Jia Yi Quan Thousand Steps Pulse consists of 1-521 pulses, allowing the practitioner to determine a level of detail not possible with the standard 28 pulses. The technique and focus is completely different from the 28 pulses. For example, through the liver pulse, the practitioner can diagnose patient stress levels, anger, hepatitis (both chronic and acute), liver injury, fatty liver, cirrhosis, tumour, sleeping problems, anxiety and depression. You can read any area of the body including organs, spine, limbs, eyes, skin, bone and nose.

The level of detail is particularly effective when treating musculoskeletal issues as the pulse is used to find the exact location of the problem. For example, it can identify the exact cervical vertebra that is causing neck pain and headaches. The pulse also determines the treatment required. The practitioner can then treat more efficiently with fewer needles in the right location and use of the correct herbs, with faster results for the patient.

How did you learn Huang Jia Yi Quan Thousand Steps Pulse?

I studied under Prof Huang Chuan Gui in China. Prof Huang is an 8th generation Huang Jia Yi Quan Thousand Steps Pulse descendent. He has the rank of General in the People's Liberation Army (PLA) and is currently the Chief of Medicine of a military hospital in Yunnan, China.

Numerous hospitals throughout China are affiliated with Prof Huang under the Huang Jia Yi Quan brand.

Prof Huang started learning Chinese medicine under his father from the age of four. After joining the army as a general recruit, the PLA recognised his extensive and hidden medical knowledge when he effectively treated sick or injured soldiers during exercises. He has since spent his career as a doctor in the PLA, initially in a clinical setting, but now more and more in a management role.

*Correspondent authors email: admin@groupj.com.au

He treats government leaders, party officials and high-ranking officers. A 20-part television series depicting his life was produced and aired in China.

Normally, Huang Jia Yi Quan Thousand Steps Pulse is handed down only from father to son. Only one boy from each generation is chosen to inherit the knowledge. Since Prof Huang's son chose not to study Chinese medicine, Mr Huang appointed me as his formal successor. I have been a student of Prof Huang since 1999 and have travelled to China frequently for many years to learn directly from him and to hone my skills in the teaching hospitals there.

What role does pulse diagnosis take in your practice?

Of the four traditional Chinese medicine (TCM) methods of diagnosis, pulse diagnosis is the most important in my practice. I believe that pulse diagnosis is the essence of TCM but is also the most complex and difficult to master of all of the methods of diagnosis.

The pulse mirrors internal conditions and pathological changes and characteristics. Clinically, pattern differentiation can be very complex and a set of incongruous symptoms can be difficult to diagnose.

However, the pulse always reflects the condition of the body to reveal the true pathology. Under the Huang Jia Yi Quan Thousand Steps Pulse method, a practitioner can readily determine the exact pathology/pattern at hand. Some examples are:

Case #1 – Male 74 - Jaw fracture

This patient was presented with a fractured jaw caused by impact he suffered on a post when the bus he was riding on suddenly stopped. For five days he could not open his mouth, had to drink through a straw, couldn't eat solid food, sleep or talk properly. He was on strong pain killers and antibiotics. He came to see me five days after the accident.

The pulse revealed that while the jaw was fractured and inflamed, there was also significant qi and blood stagnation in the neck. Based on the pulse, I needled three points in the neck. After 15–20 minutes of treatment, he could open his mouth and started talking normally. That night he ate a normal dinner and got eight hours sleep for the first time since his injury.

After three days he came back to see me and reported he was much better. He just had some residual soreness around the fracture. I checked his pulse again and it had completely changed. I treated him again with three needles. After a week or so, I noticed he had not come back for a follow up appointment so I called him. He said he was fixed and had no need to come back.

Case #2 – Female 40 – Lower abdomen pain

This patient presented with severe lower abdomen pain that was radiating to the anus. Pain medication was having no effect. I checked her pulse and felt that the gall bladder pulse was abnormal. I used only two needles on the gallbladder channel to treat her. In two minutes the pain reduced and after 10 minutes the pain had gone entirely.

Case #3 – Male 62 – Coccyx fracture

He had sustained a coccyx fracture from a fall off a ladder. He could not sit or lie on his back because of the pain. He could only lie on his stomach. Three days after the accident he came to see me. I checked his pulse to identify the exact location of the problem and used three needles in the lower back area only, without any acupuncture on the coccyx.

In 20 minutes (after needle removal) he was able to move freely, sit normally and lie on his back. He came back after three days for another treatment. A week later I rang him to see how he was – he said he was fine and was out doing the gardening.

Case #4 – Female 44 – Chronic migraines

This lady had experienced bad migraines for 20 years. She had tried physiotherapy, chiropractic and also acupuncture, but she would only get a temporary improvement and the problem always came back. I checked her pulse and found the source of the problem was in her neck and I used two needles to treat her. One week later she was 100% and has had no migraines since.

What is the difference between Chinese and Western orthopaedics?

Firstly, there is definitely a place for both Western and Chinese orthopaedics and each has strengths in different areas and for different conditions. Western orthopaedics relies on scans and X-rays to determine the problem and then treats the local condition accordingly with various medications, injections and/or procedures.

Traditional Chinese orthopaedics relies on observation and palpation. Emphasis is placed on treating the surrounding soft tissues, associated internal organs and regulating the relevant meridians as well as treating the bone or local condition itself. I have added pulse diagnosis to the diagnosis and treatment.

For example, bone fracture affects the whole area around the bone including surrounding muscles, ligaments and tendons as well as associated organ function. By treating the body as a whole, stasis and pain can be reduced more quickly and bone can recover faster leading to faster overall patient recovery. This is also the case for osteoarthritis where most of the pain comes from soft tissue injury.

What is the role of Chinese orthopaedics in Australia?

My experience is that Chinese medicine often leads to better and faster patient outcomes in many orthopaedic cases. Chinese medicine treatment is less invasive, results in less residual damage, complications, side-effects and comes at a lower cost, so it makes a lot of sense for people to explore this avenue before surgery. In this way, Chinese medicine could help reduce the total cost of healthcare associated with orthopaedics in Australia.

How do you see Chinese medicine progressing in Australia?

A treatment modality progresses at the same rate as the results it obtains for its patients. So, as more patients get results from Chinese medicine treatments, more and more Australians will continue to see Chinese medicine practitioners. I believe that the reputation of Chinese medicine is getting better every year but the professions

ability to maintain this will depend entirely on the quality of its practitioners. There is a wide variation in skills and knowledge in Australia.

As a profession we must continue to improve our knowledge and skills through post-graduate training to improve our clinical techniques and outcomes. Western medicine does this well through its registrar system where doctors complete higher training under a highly experienced specialist. The Western medicine funding model is also better set up for this, whereas the Chinese medicine profession tends to rely more on a 'master/student' approach, which requires a special commitment of both the teacher and student.

I believe more and more people will turn to Chinese medicine for treatment of chronic problems like depression, anxiety, menopause and osteoarthritis. Practitioners need to be highly skilled to apply the right treatment to get the results needed to propel the profession forward.

What are the keys to a successful practice?

The key to a successful practice is patient results. It is the primary source of credibility, reputation and referrals. Getting results requires ongoing learning and experience to improve your technique. I have been doing this for over 40 years and I am still learning and improving what I do.

康

CHINESE HERBAL &
ACUPUNCTURE SUPPLIES

We offer personalised service, shipping Australia wide, an outstanding product range & prompt delivery.
We also offer Professional Development Seminars (CPE Points) for practitioners.

Distributors for:
HERBAL INTERNATIONAL
SUNHERBAL
CATHAY HERBAL

For product orders, seminar bookings and inquiries:
Ph: 07 3852 2288
887 Ann St, Fortitude Valley, QLD 4006
admin@chineseherbalsupplies.com.au

www.chineseherbalsupplies.com.au - new website coming soon!

Research Protocol:

Utilisation and the Effects of Acupuncture during Systemic and Radiation Cancer Treatment in the Public Hospital

By: Dr Byeongsang Oh*, University of Sydney

ABSTRACT

The use of acupuncture and complementary, alternative medicine (CAM) among cancer patients is increasing. However the utilisation and the effects of acupuncture during systemic cancer and radiation treatment have not been properly evaluated in the public health care system in Australia.

The Northern Sydney Cancer Centre (NSCC) at the Royal North Shore Hospital (RNSH) has introduced acupuncture for cancer patients as a pilot project for standard care. The aim is to evaluate the utilisation rate and the effects of acupuncture during cancer treatment. Patients receiving cancer treatment at NSCC, RNSH from June 2014 to May 2015 were approached and invited to participate in the study.

The utilisation rate of acupuncture will be measured by the number of patients who received acupuncture treatment out of the total number of patients who received information about availability of acupuncture free of charge during systemic and radiotherapy cancer treatments.

The effects of acupuncture will be measured with anxiety and depression, stress, fatigue and quality of life, with the Hospital Anxiety and Depression Scale (HADS), Perceived Stress Scale (PSS), and European Organisation for Research and Treatment of Cancer Quality of Life (EORTC QLQ-C30) using a pre and post-test design.

The study findings will provide information about the utilisation and potential effects of acupuncture on cancer patients undergoing systemic and radiotherapy cancer treatments within a public health care system in Australia.

This is the first study exploring the utilisation rate of acupuncture in cancer patients. Findings can be used for the development of evidence-based, holistic health strategies for comprehensive cancer care.

KEYWORDS cancer, acupuncture, anxiety and depression, stress, fatigue, quality of life.

Introduction

The rate of cancer has risen worldwide over the past decade^(1,2). Although advancements of modern medical technology has ensured that a multitude of therapies are available for people with cancer, some treatments have significant side effects and many cancer-related symptoms are difficult to manage.

A substantial proportion of patients have turned to acupuncture as a way to treat their disease^(3,4). Acupuncture accounts for a significant proportion of CAM use among cancer patients, with estimates up to 36 percent⁽⁵⁻⁷⁾.

Emerging evidence from randomised controlled trials (RCT) has shown that acupuncture can alleviate symptoms and reduce side effects commonly experienced by cancer patients during treatment. These symptoms include:

- effective management of depression⁽⁸⁾
- reductions in chemotherapy-induced nausea and vomiting⁽⁹⁾
- chemotherapy-related neutropenia⁽⁹⁾
- chemotherapy-related hot flushes^(11,12)
- cancer fatigue⁽¹³⁾
- cancer pain⁽¹⁴⁾
- joint pain and stiffness from cancer treatment^(14,15)
- radiation-induced xerostomia⁽¹⁰⁾
- improvements to overall well-being⁽¹⁶⁾.

*Correspondent authors email: Byeong.oh@sydney.edu.au

Acupuncture is increasingly being introduced into standard care as well as being included in a number of oncology clinics and hospices in the UK⁽¹⁰⁾ and US^(2,11,12).

Two cancer centres in university teaching hospitals and few private cancer centres in Sydney have introduced acupuncture as part of standard cancer care in response to growing interest in the role of acupuncture among cancer patients.

Although most Australian oncology departments have not yet fully recognised the value of acupuncture in cancer care, the Northern Sydney Cancer Centre (NSCC), of the Royal North Shore Hospital (RNSH) has commenced an acupuncture service for cancer patients in April 2014.

Method

PATIENTS AND SETTING

The Northern Sydney Cancer Centre (NSCC) of the Royal North Shore Hospital (RNSH) will play host to the study.

The study will evaluate the utilisation of acupuncture by patients during cancer treatment. The research team members will approach and invite patients who meet the inclusion criteria which is diagnosis of cancer (at any stage), planned to receive and/or be receiving a systemic and/or radiation cancer treatment, and ages 18 years or older to participate in the study.

To assess the effects of acupuncture during cancer treatment, the primary researcher will examine the eligibility of participants including the inclusion criteria and the addition of the participant having the ability to complete the survey questionnaire, the ability to understand and the willingness to sign a written consent form.

The exclusion criteria includes previous recipients of acupuncture during cancer treatment in the last six weeks, severe coagulopathy or bleeding disorder, dermatological disease within the acupuncture area, active infection, needle phobia rendering patient unable to receive acupuncture and inability to understand the nature of the study sufficiently to allow completion of all study assessments.

To assess the effect of acupuncture, eligible participants will receive and return the questionnaire designed to measure anxiety and depression, stress, fatigue and quality of life.

Procedure

To evaluate the utilisation of acupuncture, patients will be given information about the availability of acupuncture services and study information during their hospital visit. Those who decide to participate in the study will answer the questionnaire.

The first question will ask whether patients are considering having acupuncture or not, and if not, the reasons for not considering it.

The next eight questions will ask demographic profile information (gender, age, ethnicity, education, income, occupation, cancer diagnosis and extent of disease and medical treatment received) and the last question will ask for three major reasons for patients considering having acupuncture.

If patients are interested in receiving acupuncture during their cancer treatment, they will be advised to discuss it with their oncologist during their consultation and to ask them to make a booking for acupuncture treatment.

All patients that are referred by oncologists to the acupuncture treatment at NSCC, RNSH will be invited to answer an additional questionnaire to assess the effects of acupuncture during their systemic and radiotherapy treatments.

The acupuncture consultation will be conducted by qualified acupuncturists who are registered as acupuncturists with the Chinese Medicine Board of Australia (CMBA).

Outcome measurements of anxiety and depression, stress and QOL will be collected at two time points (baseline, and week six).

All patients are eligible to receive acupuncture treatment once a week for six weeks during systemic and radiation cancer treatment.

All patients will be assured that their participation or non-participation would not affect their acupuncture treatment and standard cancer treatment at the hospital in any way.

Study design and outcome

This is a quasi-experimental clinical trial. The sample size is calculated by convenience depending on the people who enter the unit for acupuncture treatments from June 2014 to May 2015.

The utilisation rate of acupuncture will be evaluated by number of patients who received acupuncture treatment out of the total number of patients who received information about availability of acupuncture free of charge during systemic and radiation cancer treatment at NSCC.

The effects of acupuncture on anxiety and depression, stress, fatigue and QOL will be measured with validated, reported outcome instrument tools such as the Hospital Anxiety and Depression Scale (HADS), Perceived Stress Scale (PSS), FACIT-Fatigue, and the European Organisation for Research and Treatment of Cancer Quality of Life (EORTC QLQ-C30).

The HADS contains the Anxiety and Depression subscales⁽¹³⁾. The Cronbach's alpha coefficient for both subscales exceeds 0.83. HADS was found to perform well in assessing the symptom severity of anxiety disorders and depression in both somatic, psychiatric and primary care patients and in the general population⁽¹³⁾.

The PSS is commonly used in health and behavioural health contexts for examining patient reported stress experience and psych neurological responses⁽¹⁴⁾.

The Cronbach's alpha and test-retest reliability coefficients for the scale are 0.87 and 0.86. Cancer related fatigue is generally assessed by the Functional Assessment of Cancer Therapy: Fatigue (FACT-F).

The questionnaire has strong internal consistency (Cronbach's alpha coefficient range exceeding 0.93) and acceptable test-retest reliability ($r=0.87$)⁽¹⁵⁾.

The EORTC QLQ-C30 is a questionnaire developed by the European Organisation for Research and Treatment of Cancer to assess the QOL of cancer patients.

This 30 item instrument has five functional scales (physical, role, cognitive, emotional, and social), three symptom scales (fatigue, pain, and nausea and vomiting), a global health and quality of life scale, and a number of single items assessing additional symptoms commonly reported by cancer patients (dyspnoea, loss of appetite, insomnia, constipation and diarrhoea), and perceived financial impact of the disease.

Questions one to 28 have four point response scales. Questions 29 and 30 record global health status on a seven point response scale (EORTC QOL-C30 Scoring Manual, 2001).

The EORTC QLQ-C30 has demonstrated high reliability and validity in different groups of cancer patients. The reliability and validity of the English and translated versions of the questionnaires were tested by Cronbach's alpha (0.61–0.96) and item-scale correlation (0.63–0.93)⁽¹⁶⁾.

Intervention

Patients will receive individualised acupuncture treatment including body acupuncture, ear acupuncture and scalp acupuncture based on their main complaint and ongoing cancer treatment.

Patients will receive a maximum of six weeks acupuncture treatments once per week free of charge at NSCC, RNSH.

Patients will be allowed to take their usual medication prescribed by oncologists and medical practitioners as needed and including other CAM therapies while they receive acupuncture treatment.

During the consultation, the acupuncturist will evaluate the patients' clinical symptoms according to traditional Chinese medicine diagnosis procedures.

The first treatment will take an average of 60 minutes including a traditional Chinese medicine diagnosis. The follow-up visit procedure will take an average of 40 minutes, including evaluation and treatment.

The acupuncture needles will be inserted with bilateral rotation until de qi sensation is elicited. The needling technique includes twirling, thrusting, and lifting.

The designation of acupuncture points will adhere to the first edition of the Standard Acupuncture Nomenclature⁽¹⁷⁾.

Acupuncture will be administered by the qualified acupuncturists registered in the Division of Acupuncture by the CMBA and who have received accreditation from the RNSH and received oncology acupuncture training in hospitals.

Data analysis

Descriptive statistics will be used to characterise the demographic profile of patients who considered having acupuncture and those who did not consider it.

The utilisation rate of acupuncture will be assessed by the percentage of the number of patients who received acupuncture treatment out of the total number of patients who received information about availability of acupuncture free of charge during systemic and radiation cancer treatment at NSCC from June 2014 to May 2015.

The outcome measurements looking at QOL of patients during cancer treatment will be measured by the HADS, PSS, FACT-F and EORTC QLQ-C30 at two time points (baseline, and week six) and analysed.

Differences in mean change scores from baseline will be assessed using a paired t-test and a one-way repeated ANOVA.

If there is a high proportion of missing QOL data, the data will be analysed by using a pattern mixture model, which incorporates non-ignorable missing data as, described in Schluchter and in Schluchter, Greene and Beck^(18,19).

Subgroup analysis of utilisation and effect of acupuncture will be also performed based on cancer treatment (chemotherapy versus radiotherapy) and cancer diagnosis (brain, head and neck, breast, colorectal, central nervous system, and prostate cancer).

Discussion

In our previous study, we found that the use of acupuncture by cancer patients is growing in Australia⁽⁹⁾.

In response to demand for evidence based acupuncture by cancer patients, the NSCC at RNSH has commenced free acupuncture services to cancer patients during their systemic or/and radiation therapies who are referred by their oncologist.

To evaluate the acupuncture service, this study is designed to assess the utilisation and effects of acupuncture during cancer treatment on patients' symptoms and quality of life in a public hospital setting.

The result of the study will provide valuable information to design future randomised clinical trials (RCT) using acupuncture.

This study will provide important data (effect size and standard deviation (SD) for future RCTs with a larger sample size.

It will also gather information on the feasibility of recruitment and retention of cancer patients for acupuncture trials at Australian public hospitals and assess their willingness and ability to complete a battery of outcome assessments related to depression and anxiety, stress, fatigue and QOL.

The major limitation of this study is it does not have a control group to compare the outcome of acupuncture effects due to the limited available resources.

Another weakness of this study is related to dosage level.

In the study, patients are eligible to receive a maximum of six acupuncture treatments, one per week, during their cancer treatment regime while most published high quality acupuncture trials were given twelve weeks treatment or more and had long term follow up^(20,21).

Also, because the patients are allowed to continue with their concurrent complementary and alternative treatments, a clear effect of the acupuncture will be unknown.

The current study also has numerous strengths.

This is the first study to evaluate the utilisation and effects of acupuncture use by overall cancer patients regardless of gender, cancer diagnosis and stage of cancer referred by their oncologist in an Australian public health care system for free while most acupuncture service are 'pay for service' oriented.

A recent study identified that one of the major barriers to using acupuncture was affordability⁽²²⁾.

Therefore, this study result will provide generalisable information about utilisation and the effects of acupuncture by cancer patients.

As such, the findings provide critical information on the current treatment context in which the use of acupuncture in addition to current standard cancer care is becoming more apparent.

Patients in this study will receive acupuncture treatment based on their individual symptoms according to TCM pattern diagnosis.

In TCM, practitioners treat patients based on their individual symptoms but not standard acupuncture points based on diagnosis of disease.

Recent acupuncture clinical trials conducted with selection of standard acupuncture points also suggested that acupuncture may be more effective if patients are allowed to have additional acupuncture points based on symptoms of individual patients^(20,21,23).

CLINICAL COMMENTARY

Acupuncture has the potential to improve quality of life of cancer patients.

The demand of acupuncture by cancer patients is growing.

However, there is as of yet no Australian tertiary institution offering formal training program of acupuncture for cancer care.

Considering acupuncture is gradually coming to Australian hospitals, following US and European countries, it is time for acupuncturists to receive oncology acupuncture training to ready them with scientific evidence for care of cancer patients at hospitals as well as private clinics.

References

1. Jemal A, Center MM, DeSantis C, Ward EM. Global Patterns of Cancer Incidence and Mortality Rates and Trends. *Cancer Epidemiology Biomarkers & Prevention*. 2010;19(8):1893-907.
2. American Cancer Society. *Cancer Facts & Figures 2009*. Atlanta, GA: American Cancer Society, 2009.
3. Beith JM, Oh B, Hale AK, Ramya V. Acupuncture Use in Women with Breast Cancer. *Medical Acupuncture* 2011;23(3):151-7 doi:10.1089/acu.2011.0798.
4. Oh B, Butow P, Mullan B, Clarke S, Tattersall M, Boyer M, et al. Patient-doctor communication: The use of complementary and alternative medicine by adult patients with cancer. *Journal of the Society for Integrative Oncology*. 2010;8(2):56-64.
5. Morris KT, Johnson N, Homer L, Walts D. A comparison of complementary therapy use between breast cancer patients and patients with other primary tumor sites. *Am J Surg*. 2000;179(5):407-11.
6. Lafferty WE, Bellas A, Corage Baden A, Tyree PT, Standish LJ, Patterson R. The use of complementary and alternative medical providers by insured cancer patients in Washington state. *Cancer*. 2004;100(7):1522-30.
7. Saxe GA, Madlensky L, Kealey S, Wu DP, Freeman KL, Pierce JP. Disclosure to physicians of CAM use by breast cancer patients: findings from the Women's Healthy Eating and Living Study. *Integr Cancer Ther*. 2008;7(3):122-9.
8. Mehling WE, Jacobs B, Acree M, Wilson L, Bostrom A, West J, et al. Symptom Management with Massage and Acupuncture in Postoperative Cancer Patients: A Randomized Controlled Trial. *J Pain Symptom Manage*. 2007;33(3):258-66.
9. Lu W, Dean-Clower E, Doherty-Gilman A, Rosenthal DS. The Value of Acupuncture in Cancer Care. *Hematol Oncol Clin North Am*. 2008;22(4):631-48.
10. Standish LJ, Kozak L, Congdon S. Acupuncture Is Underutilized in Hospice and Palliative Medicine. *Am J Hosp Palliat Care*. 2008;25(4):298-308.
11. Johnstone PA, Polston GR, Niemtzw RC, Martin PJ. Integration of acupuncture into the oncology clinic. *Palliat Med*. 2002;16(3):235-9.
12. Leng G. A year of acupuncture in palliative care. *Palliat Med*. 1999;13(2):163-4.
13. Bjelland I, Dahl AA, Haug TT, Neckelmann D. The validity of the Hospital Anxiety and Depression Scale: An updated literature review. *Journal of Psychosomatic Research*. 2002;52(2):69-77.
14. Siqueira Reis R, Ferreira Hino AA, Romelio Rodriguez Anez C. Perceived Stress Scale: Reliability and Validity Study in Brazil. *J Health Psychol*. 2010;15(1):107-14.
15. Yellen SB, Cella DE, Webster K, Blendowski C, Kaplan E. Measuring fatigue and other anemia-related symptoms with the Functional Assessment of Cancer Therapy (FACT) measurement system. *Journal of Pain and Symptom Management*. 1997;13(2):63-74.
16. Parmar V, Badwe RA, Hawaldar R, Rayabhannavar S, Varghese A, Sharma R, et al. Validation of EORTC quality-of-life questionnaire in Indian women with operable breast cancer. *National Medical Journal of India*. 2005;18(4):172-7.
17. World Health Organization, editor. *WHO Standard Acupuncture Point Locations in the Western Pacific Region*. 1st ed: World Health Organization; 2008.
18. Schluchter MD. Methods for the analysis of informatively censored longitudinal data. *Statistics in Medicine*. 11(14-15):1861-70.
19. Schluchter MD, Greene T, Beck GJ. Analysis of change in the presence of informative censoring: application to a longitudinal clinical trial of progressive renal disease. *Statistics in Medicine*. 2001;20(7):989-1007.
20. Walker EM, Rodriguez AI, Kohn B, Ball RM, Pegg J, Pocock JR, et al. Acupuncture Versus Venlafaxine for the Management of Vasomotor Symptoms in Patients With Hormone Receptor-Positive Breast Cancer: A Randomized Controlled Trial. *Journal of Clinical Oncology*. 2010;28(4):634-40.
21. Crew KD, Capodice JL, Greenlee H, Brafman L, Fuentes D, Awad D, et al. Randomized, Blinded, Sham-Controlled Trial of Acupuncture for the Management of Aromatase Inhibitor-Associated Joint Symptoms in Women With Early-Stage Breast Cancer. *Journal of Clinical Oncology*. 2010;28(7):1154-60.
22. Zhang Y, Lao L, Chen H, Ceballos R. Acupuncture Use among American Adults: What Acupuncture Practitioners Can Learn from National Health Interview Survey 2007? *Evidence-Based Complementary and Alternative Medicine*. 2012;2012:8.
23. Pfister DG, Cassileth BR, Deng GE, Yeung KS, Lee JS, Garrity D, et al. Acupuncture for Pain and Dysfunction After Neck Dissection: Results of a Randomized Controlled Trial. *Journal of Clinical Oncology*. 2010;28(15):2565-70.

Moxibustion plus pharmacotherapy for Chronic Obstructive Pulmonary Disease

Meaghan E Coyle*, PhD RMIT University, Melbourne
Anthony Lin Zhang, PhD RMIT University, Melbourne

Lei Wu, PhD, RMIT University, Melbourne
Charlie Changli Xue, PhD RMIT University, Melbourne

ABSTRACT

Chronic obstructive pulmonary disease (COPD) is a major cause of mortality and morbidity globally. Moxibustion has been used for respiratory diseases such as asthma however, there are few clinical studies of moxibustion for COPD.

The aim of this report is to examine the efficacy and safety of moxibustion in combination with pharmacotherapy for the treatment of COPD. Five English databases and four Chinese databases were searched.

Studies of moxibustion plus pharmacotherapy which reported on the outcomes of symptom severity (e.g. Borg or Medical Research Council scales), lung function (FEV1 or FVC, L or percent predicted), health-related quality of life (e.g. St George's Respiratory Questionnaire), exercise capacity (six minute walk test), acute exacerbations, BODE index, effective rate or adverse events. Methodological quality was assessed using the Cochrane Collaboration's risk of bias assessment tool. Data were analysed with RevMan 5.2 software.

Five studies (514 participants) were included. Lung function was higher after treatment in those who received moxibustion plus pharmacotherapy compared with pharmacotherapy alone.

A similar finding was seen for the outcome effective rate. No adverse events were reported. However, the reporting of study detail was poor and methodological weakness was noted. While benefit of combining moxibustion with pharmacotherapy was seen for some outcomes, the clinical relevance of the findings remains uncertain.

Moxibustion combined with pharmacotherapy may increase lung function and effective rate more than pharmacotherapy alone and was well tolerated. Further research through large and rigorously designed clinical trials is needed to confirm the potential benefit of moxibustion plus pharmacotherapy for COPD.

KEYWORDS Moxibustion, moxa, pulmonary disease, chronic obstructive, COPD

Introduction

Chronic obstructive pulmonary disease (COPD) is a major cause of disability in Australia⁽¹⁾. It is the fifth largest contributor to the burden of disease⁽²⁾.

COPD is characterised by progressive deterioration in lung function, with symptoms including dyspnoea, cough and sputum production⁽³⁾. In Australia, COPD which is sufficient to impact on breathing and daily activities (GOLD Stage II) is reported to affect more than 7.5 percent of people aged over 40 years, and 29.2 percent of people over 75⁽⁴⁾, although the overall prevalence of COPD is likely to be higher.

COPD is not reversible, but the symptoms can be managed to improve physical functioning and quality of life and to limit acute exacerbation⁽¹⁾.

Current western medical management includes smoking cessation and pharmacotherapy^(3,5), and provides relief for many people with COPD.

Side effects have been noted with some medications, particularly corticosteroids (e.g. associated with skin thinning, lowered bone density and some psychiatric events)⁽⁶⁾ and theophylline (e.g. gastrointestinal events)⁽⁵⁾, and this may contribute to the increasing use of complementary therapies in people with COPD⁽⁷⁾.

*Correspondent authors email: Meaghan.coyle@rmit.edu.au

Moxibustion is a Chinese medicine therapy which involves the burning of an herb (typically Mugwort, *Artemisia vulgaris*) close to or on the skin until the skin becomes red and warm due to local vasodilation⁽⁸⁾.

The therapy aims to produce a sensation of heat in the local area that is tolerable to the patient. Moxibustion may be applied to acupuncture points, along acupuncture meridians or to broad areas of the body.

The therapy is used clinically to warm cold and to regulate Qi in the meridians and internal organs^(9,10). Research from China has demonstrated a range of biological activities, including bronchodilation, relief of cough and as an expectorant⁽¹¹⁾.

Moxibustion has been used for respiratory diseases such as asthma⁽¹²⁾, however there are few clinical studies of moxibustion for COPD.

A search of the literature did not identify any systematic reviews evaluating the clinical benefit of this intervention. Whilst moxibustion may be a first line treatment choice for some, the majority of people with COPD are using medication to manage their disease, and some seek moxibustion to complement their pharmacotherapy.

As such, this review examined the efficacy and safety of moxibustion in conjunction with pharmacotherapy in randomised controlled trials.

Methods

A search was undertaken of five English databases (PubMed, Embase, AMED, CINAHL and CENTRAL) and four Chinese databases (CBM, CQVIP, CNKI and Wanfang Data).

Search terms were grouped into three search blocks: intervention (moxibustion, acupuncture and variants), condition (COPD and variants) and study design (randomised controlled trials and variants).

As moxibustion is frequently used with acupuncture or on acupuncture points, search terms related to acupuncture therapy were included in order to maximise yield, although studies which combined moxibustion with other acupuncture related therapies or Chinese herbal medicine were excluded from this review.

In addition, clinical trial registries were searched to identify other relevant studies (ANZCTR, ChiCTR, EU-CTR, clinicaltrials.gov).

Randomised controlled trials were eligible for inclusion in this review if the intervention was moxibustion in combination with western medication (pharmacotherapy) for COPD, where the co-intervention in the treatment arm was the same as the comparator arm.

For example, trials comparing moxibustion plus theophylline with theophylline alone were eligible, while trials comparing moxibustion plus theophylline with corticosteroids were excluded.

In addition, studies were eligible for inclusion when the diagnosis of COPD was according to international guidelines^(3,5), if they used pharmacotherapy recommended in clinical practice guidelines and reported on specified outcomes.

Outcomes of interest included symptom severity (e.g. dyspnoea measured on the Medical Research Council (MRC) dyspnoea scale, Dyspnoea Visual Analogue Scale (DVAS) or Borg scale), lung function (FEV1 or FVC, reported in either litres or as percentage predicted), health related quality of life (St George's Respiratory Questionnaire (SGRQ) or other quality of life scale), exercise capacity (measured on the six minute walk test (6MWT)), acute exacerbations, BODE index (a composite measure of disease risk, Body mass index, Obstruction, Dyspnoea and Exercise capacity), effective rate and adverse events.

Published data were extracted onto a defined form. Items included characteristics of the study and participants, details of the intervention and co-intervention/comparator, outcome measures and results.

Methodological quality was assessed using the Cochrane Collaboration's risk of bias assessment tool, using the domains random sequence generation, allocation concealment, blinding of participants, blinding of personnel, blinding of outcome assessment, incomplete outcome data and selective reporting.

Results for included studies were entered into RevMan 5.2 software (Cochrane Collaboration, Copenhagen, Denmark) for analysis.

A random effects model was used, as was intention-to-treat analysis (ITT) for studies where attrition occurred. Continuous data were presented as mean difference (MD) and 95% confidence interval (CI), and dichotomous data were presented as relative risk (RR) and 95% CI.

Sensitivity and sub-group analysis (based on sequence generation and co-intervention types) were planned for studies with substantial heterogeneity (i.e. $I^2 > 50\%$).

We planned to undertake visual inspection of funnel plots to explore publication bias, however this was not possible as fewer than 10 studies were included in the review.

Results

In total, 3,083 citations were identified through literature searches of electronic databases and other sources (see Appendix 1).

After removal of duplicates, the titles and abstracts of 1,878 citations were reviewed, and 1,215 were excluded.

Full text was retrieved for 363 articles, and five studies (514 participants) met the eligibility criteria for this review^(13,17). Details of the studies are described in Table 1. All studies were efficacy studies and were conducted in China, one trial included three arms (two intervention arms)(13) while the remaining four included two arms.

All studies included people with stable COPD, two included those with moderate to severe COPD^(13,14), two with mild to moderate COPD^(15,16), and one study did not specify the severity of COPD in participants⁽¹⁷⁾.

The median of mean age among all studies was 64.3 years, and the majority were male (383, 170 female), although one study reported gender only for those who completed the study⁽¹⁶⁾.

Intervention and co-intervention/comparator

Treatment duration ranged from daily for 30 days⁽¹³⁾ to monthly for 12 weeks/three months⁽¹⁵⁻¹⁷⁾ (see Table 2).

None of the studies included a follow-up period after treatment cessation.

Three studies applied moxibustion to the Governor Vessel meridian (*Du Mai*)⁽¹⁵⁻¹⁷⁾, and two studies specified the acupuncture points to which moxibustion was applied^(13,14).

The acupuncture points BL 13 *Feishu* and ST 36 *Zusanli* were used in two studies each^(13,14), and there was no overlap in other acupuncture points stimulated by moxibustion.

Two studies used routine care as the co-intervention and comparator^(13,14), and theophylline (aminophylline) was used in four studies⁽¹⁴⁻¹⁷⁾.

Methodological quality (risk of bias assessment)

Overall, the reporting of study detail was poor (see Figure 2), with only two studies reporting the method of sequence generation (random number table)^(15,17).

None of the studies reported the method of allocation concealment or blinding of outcome assessment, and were assessed as unclear risk.

None of the studies blinded participants or personnel to group allocation and were assessed as high risk for this domain.

Two studies reported participant withdrawal^(14,16) and while one mentioned intention-to-treat analysis, this was not performed⁽¹⁶⁾. Li et al⁽¹⁴⁾ stated nine participants were lost to follow up.

Both studies were assessed as unclear risk of bias for incomplete outcome data, and the remaining studies were assessed as low risk.

All studies reported on the specified outcomes and were assessed as low risk.

Outcome measures

Lung function was measured in all studies. Two studies reported on both symptom severity and exercise capacity^(14,15), two reported on effective rate^(13,17), and one study reported on BODE index⁽¹⁵⁾. None of the included studies reported on health related quality of life or acute exacerbations.

One study reported on adverse events, with no adverse events occurring⁽¹⁷⁾.

Effects of the intervention

For one study which reported the results of symptom severity on MRC scale as a grade⁽¹⁴⁾, data were converted to mean and standard deviation for analysis.

One study included two moxibustion treatment arms using different acupuncture points; these were considered sufficiently similar to combine for analysis of reported outcomes FEV1 and effective rate⁽¹³⁾.

Combining results for the two treatment arms was undertaken using the approach outlined in the Cochrane Handbook of Systematic Reviews⁽¹⁸⁾.

Meta-analysis was possible for five outcomes (see Table 4).

Moxibustion plus pharmacotherapy resulted in greater benefit on lung function (FEV1 % predicted; 5 studies, 544 participants, MD 3.82%, 95% CI 2.67%, 4.96%, I²=0%) (see Figure 2) and effective rate (2 studies, 300 participants, RR 1.18, 95% CI 1.06, 1.30, I²=0%) (see Figure 3) compared with pharmacotherapy alone, although this did not meet the minimum clinically important difference of 12–15% (for FEV1 % predicted) suggested by Pellegrino et al⁽¹⁹⁾. Intention to treat analysis to account for participant withdrawal in the Zhang⁽¹⁶⁾ and Li⁽¹⁴⁾ studies did not alter the results.

The addition of moxibustion to pharmacotherapy did not increase efficacy on exercise capacity, acute exacerbations or BODE index.

Theophylline (aminophylline) was used in four studies (either alone or in combination with mucolytic agents), and subgroup analysis was performed for studies which included this drug.

Of all comparisons, the greatest effect size was found when moxibustion was combined with theophylline and a mucolytic agent improved lung function (FEV1% predicted; 2 studies, 285 participants, MD 4.73%, 95% CI 3.23%, 6.23%, I²=0%), however there was no benefit when the co-intervention was theophylline alone (2 studies, 169 participants, MD 3.06%, 95% CI -0.61%, 6.74%, I²=0%).

Adverse events

One study reported on adverse events⁽¹⁷⁾, with none occurring during the duration of the trial.

Discussion

The addition of moxibustion to pharmacotherapy resulted in an improvement in lung function as measured on FEV1 (% predicted), and an improvement in effective rate of the treatment.

The finding of a difference between groups in lung function at the end of treatment was unexpected, as COPD is characterised by a progressive worsening of lung function⁽³⁾, and is typically challenging to reverse. Although a statistically significant difference was detected, this was not a clinically relevant difference.

The combination of moxibustion with theophylline and a mucolytic agent resulted in a greater effect on FEV1 percent predicted than either moxibustion plus theophylline, or all pharmacotherapy alone.

While both theophylline and mucolytic agents are recommended individually in clinical practice guidelines⁽³⁾, there are no recommendations for the use of both in combination.

The reasons for the additional benefit of moxibustion with theophylline and mucolytic agents are unclear, and further research on this treatment combination in larger scale, rigorously designed clinical trials may provide critical data to determine efficacy and possible mechanism of action.

The finding of a benefit of combining moxibustion with pharmacotherapy on effective rate is difficult to interpret, as neither study included in the meta-analysis provided a definition on which the judgement of efficacy was made.

One study reported that no adverse events were observed⁽¹⁷⁾. However, as this was not reported in the remaining four studies, it is difficult to establish evidence for safety of the intervention from this review.

Possible risks associated with moxibustion include burns to the skin and blistering, however the risk of these events occurring is greatly reduced when performed by a qualified practitioner.

Furthermore, there is disagreement about whether burns resulting from moxibustion constitute an adverse event. Blistering of the skin after direct moxibustion can be considered a desirable response⁽²⁰⁾, and a gauge of the clinical efficacy of the treatment.

A recent systematic review of case reports on the safety of moxibustion found skin burns to be the most common risk from moxibustion (43 cases in 6 articles)⁽²⁰⁾.

As this review was based on case reports, where the denominator is not reported, the incidence of adverse events associated with moxibustion is still largely unknown.

While smokeless moxa products are available, the traditional technique of moxibustion produces smoke.

Smoke from moxibustion has been reported to be safe for patients and practitioners by some, yet harmful in others⁽²⁰⁾.

As COPD is thought to be caused by exposure to noxious gases⁽³⁾, the question of whether smoke from moxibustion may exacerbate COPD remains unanswered.

While moxibustion appears to be a safe treatment option for people with COPD, research is needed to explore whether smoke resulting from moxibustion may exacerbate COPD.

Two studies applied moxibustion to specific acupuncture points^(13,14), and two points were common to both (BL 13 *Feishu*, ST 36 *Zusanli*).

This is consistent with clinical studies of acupuncture for COPD⁽²¹⁾. Given that efficacy was also demonstrated on FEV1 % predicted when moxibustion was applied to the Governor Vessel meridian (*Du Mai*), the acupuncture points or meridians which best treat COPD remains unclear.

Several mechanisms of action of moxibustion have been proposed that may be relevant to COPD.

Moxibustion has been found to emit long-wave infrared radiation (IR-C), stimulating heat receptors in the superficial skin⁽²²⁾.

Thermal effects on internal organs are likely to occur from reflex mechanisms, as little infrared radiation penetrates the skin⁽²³⁾.

Essential oil extracted from *Artemisia argyi* has some pharmacological effects on bronchodilation, antitussive and expectorant⁽¹¹⁾.

In examining the mechanism of moxibustion in treating asthma, Chen⁽⁸⁾ suggests moxibustion may antagonise inflammatory mediators and regulate immune function.

More generally, moxibustion is reported to have anti-inflammatory or immunomodulatory effects on chronic inflammation in humans⁽²⁴⁾.

Pharmacological effects of moxibustion may also be altered by the addition of Chinese herbs (medicinal moxibustion), as was used in three studies included in this review¹⁵⁻¹⁷⁾. However, there is little research exploring the mechanism of medicinal moxibustion.

The findings of this review are limited by the small number of included studies and participants, and poor reporting of details relating to study design (such as sequence generation and AE reporting).

While all studies used moxibustion, differences were noted in the herbs used, and the details of application were not well reported.

This limits translation of the findings to clinical practice.

An inherent challenge in conducting clinical trials of moxibustion is the difficulty in developing a credible placebo.

Where moxibustion is combined with pharmacotherapy, it is not practical or feasible to blind study participants and personnel to group allocation.

The inclusion of validated and objective outcome measures may reduce the potential for bias where blinding has not occurred, as was the case in this review.

A diverse range of pharmacotherapy was seen in the included studies, which may have influenced the results.

For example, the use of theophylline may have contributed to short term improvements in lung function, but have little effect on long term outcomes.

As none of the studies included a follow up assessment after cessation of treatment, the potential long term benefits of combining moxibustion with pharmacotherapy remain uncertain.

Conclusion

This review found statistically significant improvements in one measure of lung function and in effective rate when moxibustion combined with pharmacotherapy was compared with pharmacotherapy alone.

The clinical significance of this finding remains uncertain, and based on the findings of this review, there is insufficient evidence to support the routine use of moxibustion for COPD.

Acknowledgements

We wish to acknowledge Dr Shaonan Liu, Dr Xuhua Yu, and Dr Sharon Chen for assisting with the database searching, data extraction and risk of bias assessment.

This work was funded by a project grant from the National Health and Medical Research Council (NHMRC), project grant No. 616609, and an International Research Grant from the Guangdong Provincial Academy of Chinese Medical Sciences at the Guangdong Provincial Hospital of Chinese Medicine in Guangzhou, China.

CLINICAL COMMENTARY

Chronic obstructive pulmonary disease (COPD) is a major cause of disability in Australia.

This review examined the efficacy and safety of moxibustion combined with pharmacotherapy for COPD.

A comprehensive literature search identified five studies (514 participants).

Some benefits were seen on lung function and effective rate; however, the clinical relevance of these is uncertain.

Moxibustion plus pharmacotherapy did not improve exercise capacity or the number of acute exacerbations.

Although moxibustion appeared to be well-tolerated, only one study reported on adverse events.

Methodological flaws, poor reporting and lack of strong evidence of clinical benefit preclude recommendation for the use of moxibustion plus pharmacotherapy for COPD.

Appendix 1. Sample search strategy (PubMed)

1. "pulmonary disease, chronic obstructive"[MeSH Terms] OR "bronchitis, chronic"[MeSH Terms] OR "pulmonary emphysema"[MeSH Terms] OR ("pulmonary emphysema"[MeSH Terms] OR "emphysema"[MeSH Terms]) OR COPD[TW] OR Chronic Obstructive Pulmonary[TW] OR COAD[TW] OR AECB[TW] OR COBD[TW] OR Chronic Obstructive Airway[TW] OR Chronic Obstructive Lung[TW] OR Chronic obstructive bronchopulmonary[TW] OR Chronic obstructive respiratory[TW] OR Chronic Airflow Obstruction[TW] OR Chronic bronchitis[TW] OR Pulmonary emphysema[TW] OR Lung emphysema[TW] OR Chronic Airflow limitation[TW]))
2. ("acupuncture"[MeSH Terms] OR "acupuncture"[All Fields] OR "acupuncture therapy"[MeSH Terms] OR ("acupuncture"[All Fields] AND "therapy"[All Fields]) OR "acupuncture therapy"[All Fields]) OR ("meridians"[MeSH Terms] OR "meridians"[All Fields]) OR ("electroacupuncture"[MeSH Terms] OR "electroacupuncture"[All Fields]) OR ("moxibustion"[MeSH Terms] OR "moxibustion"[All Fields]) OR ("auriculotherapy"[MeSH Terms] OR "auriculotherapy"[All Fields]) OR (("prunus"[MeSH Terms] OR "prunus"[All Fields] OR "plum"[All Fields]) AND ("flowers"[MeSH Terms] OR "flowers"[All Fields] OR "blossom"[All Fields])) OR ("acupressure"[MeSH Terms] OR "acupressure"[All Fields]) OR ("acupuncture, ear"[MeSH Terms] OR ("acupuncture"[All Fields] AND "ear"[All Fields]) OR "ear acupuncture"[All Fields]) OR ("ear"[All Fields] AND "acupuncture"[All Fields])) OR (("ear"[MeSH Terms] OR "ear"[All Fields]) AND ("acupressure"[MeSH Terms] OR "acupressure"[All Fields])) OR ("acupuncture, ear"[MeSH Terms] OR ("acupuncture"[All Fields] AND "ear"[All Fields]) OR "ear acupuncture"[All Fields]) OR ("acupuncture"[All Fields] AND "ear"[All Fields]) OR "acupuncture, ear"[All Fields]) OR ("acupuncture therapy"[MeSH Terms] OR ("acupuncture"[All Fields] AND "therapy"[All Fields]) OR "acupuncture therapy"[All Fields]) OR moxa[All Fields] OR ("lasers"[MeSH Terms] OR "lasers"[All Fields]) OR "laser"[All Fields]) AND ("acupuncture"[MeSH Terms] OR "acupuncture"[All Fields] OR "acupuncture therapy"[MeSH Terms] OR ("acupuncture"[All Fields] AND "therapy"[All Fields]) OR "acupuncture therapy"[All Fields])) OR (seven[All Fields] AND ("Star"[Journal] OR "star"[All Fields]) AND ("needles"[MeSH Terms] OR "needles"[All Fields] OR "needle"[All Fields])) OR ("acupuncture analgesia"[MeSH Terms] OR ("acupuncture"[All Fields] AND "analgesia"[All Fields]) OR "acupuncture analgesia"[All Fields]) OR ("acupuncture points"[MeSH Terms] OR ("acupuncture"[All Fields] AND "points"[All Fields]) OR "acupuncture points"[All Fields]) OR electro-acupuncture[All Fields] OR (electro[All Fields] AND ("acupuncture"[MeSH Terms] OR "acupuncture"[All Fields] OR "acupuncture therapy"[MeSH Terms] OR "acupuncture therapy"[All Fields]) OR ("transcutaneous electric nerve stimulation"[MeSH Terms] OR ("transcutaneous"[All Fields] AND "electric"[All Fields] AND "nerve"[All Fields] AND "stimulation"[All Fields]) OR "transcutaneous electric nerve stimulation"[All Fields] OR "tens"[All Fields]) OR ("transcutaneous electric nerve stimulation"[MeSH Terms] OR ("transcutaneous"[All Fields] AND "electric"[All Fields] AND "nerve"[All Fields] AND "stimulation"[All Fields]) OR "transcutaneous electric nerve stimulation"[All Fields] OR ("transcutaneous"[All Fields] AND "nerve"[All Fields] AND "stimulation"[All Fields]) OR "transcutaneous electric nerve stimulation"[MeSH Terms] OR ("transcutaneous"[All Fields] AND "electric"[All Fields] AND "nerve"[All Fields] AND "stimulation"[All Fields]) OR "transcutaneous electrical nerve stimulation"[All Fields]) OR electro-stimulation[All Fields] OR (electro[All Fields] AND stimulation[All Fields]) OR pharmacopuncture[All Fields] OR (point[All Fields] AND ("injections"[MeSH Terms] OR "injections"[All Fields] OR "injection"[All Fields])) OR ("catgut"[MeSH Terms] OR "catgut"[All Fields]) AND embedding[All Fields])
3. "randomized controlled trial"[pt] OR "controlled clinical trial"[pt] OR "randomized"[tiab] OR "placebo"[tiab] OR "drug therapy"[sh] OR "randomly"[tiab] OR "trial"[tiab] OR "groups"[tiab] 4. #1 AND #2 AND #3

Table 1. Characteristics of included studies

FIRST AUTHOR; PUBLICATION YEAR; COUNTRY; SETTING	STUDY DESIGN; BLINDING; NUMBER OF ARMS	TREATMENT DURATION; TOTAL NUMBER OF TREATMENTS; FOLLOW-UP DURATION	STAGE; SEVERITY; DURATION OF CONDITION (MEAN (SD) OR RANGE)	NO. OF PARTICIPANTS RANDOMISED/ ASSESSED; DROPOUTS	AGE (MEAN (SD) OR RANGE); GENDER (M/F)	CM INTERVENTION	CO- INTERVENTION/ CONTROL
Cheng; 2012; China; inpatients	RCT; OL; 3	30d; 30; no follow up	I1: Stable COPD; moderate-severe; 16.5 (5.8)y	I1: 30/30; 0	I1: 65.1 (10.5); 21/9	I1: Moxibustion at heat sensitive points; I2: Moxibustion	Routine care
			I2: Stable COPD; moderate-severe; 17.5 (8.0)y	I2: 30/30; 0	I2: 64.7 (11.6); 22/8		
			C: Stable COPD; moderate- severe; 17.8 (5.0)y	C: 30/30; 0	C: 64.9 (10.7); 20/10		
Li; 2011; China; both inpatients and outpatients	RCT; OL; 2	12w; 24; no follow up	I: Stable COPD; moderate- severe; 14.3 (6.3)y	I: 44/39; 5	I: 64.3 (7.7); 31/13	Moxibustion	Routine care
			C: Stable COPD; moderate- severe; 13.4 (6.9)y	C: 40/36; 4	C: 62.8 (6.9); 28/12		
Zhang; 2012a; China; outpatients	RCT; OL; 2	12w; 3; no follow up	Stable COPD; mild- moderate; NS	I: 50/45; 5 C: 50/44; 6	I: 65.2 (6.0); 33/12 C: 65.3 (6.1); 30/14	Moxibustion	Drug therapy
Zhang; 2012b; China; inpatients	RCT; OL; 2	12w; 3; no follow up	I: Stable COPD; mild- moderate; 4.9 (1.5)y C: Stable COPD; mild- moderate; 4.7 (1.4)y	I: 40/40; 0 C: 40/40; 0	I: 55.7 (8.3); 25/15 C: 55.6 (7.6); 26/14	Moxibustion	Drug therapy
Zhou; 2011; China; both inpatients and outpatients	RCT; OL; 2	3m; 3; no follow up	I: Stable COPD; NS; 12.8 (6.5)y C: Stable COPD; NS; 13.5 (5.2)y	I: 108/108; 0 C: 102/102; 0	I: 55.9 (10.2); 75/33 C: 57.6 (9.3); 72/30	Moxibustion	Drug therapy

C: co-intervention/comparator; I: intervention; OL: open-label; NS: not specified

Table 2. Details of the intervention and co-intervention/comparator

FIRST AUTHOR, PUBLICATION YEAR	SYNDROME DIFFERENTIATION	CM PRINCIPLE OF TREATMENT	INTERVENTION	DETAILS	CO-INTERVENTION AND COMPARATOR	DOSAGE AND ADMINISTRATION
Cheng, 2012	NS	NS	11: Moxibustion at heat sensitive points: Fengmen BL12, Feishu BL13, Pishu BL20, Shenshu BL23, Zhiyang GV9, Mingmen GV4 and heat sensitive non-acupuncture points; I2: Moxibustion: Fengmen BL12, Feishu BL13, Pishu BL20, Shenshu BL23, Lieque LU7, Taiyuan LU9, Zhongwan CV12, Zusanli ST36, Sanyinjiao SP6, Taixi KI3, Fenglong ST40	11: Once per day; I2: Once per day	Routine care: anti-inflammatory, bronchodilator, mucolytic, antitussive	NS
Li, 2011	NS	NS	Moxibustion: Feishu BL13, Dingchuan EX-B1, Zusanli ST36	5 Zhuang (cone) per point, 2 times per week	Routine care: Theophylline, carbocisteine	Theophylline 0.2g q12h, carbocisteine tablets 0.5g tid
Zhang, 2012a	NS	NS	Moxibustion: rou gui, sheng jiang; Governor Vessel meridian	Once per month	Drug therapy: Theophylline	0.1g bid
Zhang, 2012b	NS	NS	Moxibustion: she xiang, sheng jiang; Governor Vessel meridian	Once per month	Drug therapy: Theophylline	0.1g bid
Zhou, 2011	Lung and Kidney Qi deficiency	NS	Moxibustion: rou gui, chuan xiong, sheng jiang; Governor Vessel meridian	Once per month	Drug therapy: Oxygen therapy, aminophylline and ambroxol hydrochloride	Oxygen therapy, aminophylline: 0.1g bid, po; ambroxol hydrochloride: 30mg tid, po

bid: twice daily; I: intervention; NS: not specified; po: orally; q12h: 12 hourly; tid: three times daily

Table 3. Outcome measures

First author, publication year	LUNG FUNCTION		SYMPTOM SEVERITY			HEALTH RELATED QUALITY OF LIFE		EXERCISE CAPACITY	OTHER			ADVERSE EVENTS
	FEV1	FVC	Dyspnoea scale (other)	Borg scale	mMRC	SGRQ	Other (Cai's QoL, CRDQ)	6MWT	AECOPD	BODE index	Effective rate	
Cheng, 2012	+	-	-	-	-	-	-	-	-	-	+	NS
Li, 2011	+	-	-	-	+	-	-	+	-	-	-	NS
Zhang, 2012a	+	-	-	-	-	-	-	-	-	-	-	NS
Zhang, 2012b	+	-	-	-	+	-	-	+	-	+	-	NS
Zhou, 2011	+	+	-	-	-	-	-	-	-	-	+	No adverse events

Table 4. Effects of intervention: moxibustion plus pharmacotherapy versus pharmacotherapy

OUTCOME	NUMBER STUDIES (REFERENCES)	NUMBER PARTICIPANTS RANDOMISED/ ANALYSED	EFFECT ESTIMATE	EFFECT ESTIMATE (INTENTION-TO-TREAT ANALYSIS)
FEV1 (L)	3 (Cheng 2012, Zhang 2012a, Zhou 2011)	430/419	MD 0.07 [-0.05, 0.19], I2=64%	MD 0.07 [-0.04, 0.18], I2=64%
FVC (L)	1 (Zhou 2011)	210/210	MD 0.38 [0.29, 0.47]	Not applicable
MRC scale	2 (Li 2011, Zhang 2012b)	164/155	MD -0.15 [-0.34, 0.04], I2=0%	MD -0.15 [-0.34, 0.04], I2=0%
6MWT	2 (Li 2011, Zhang 2012b)	164/155	MD 23.69 [-2.14, 49.51], I2=0%	MD 24.48 [-1.47, 50.43], I2=6%
BODE index	1 (Zhang 2012b)	80/80	MD 0.34 [-0.76, 1.44]	Not applicable

References

1. Abramson M, Crockett AJ, Dabscheck E, Frith PA, George J, Glasgow N, et al. The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease V2.36. 2013.
2. Australian Institute of Health and Welfare. Australia's Health: The eleventh biennial health report of the Australian Institute of Health and Welfare. Canberra: Australian Institute of Health and Welfare; 2008.
3. Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. 2013.
4. Toelle BG, Xuan W, Bird TE, Abramson MJ, Atkinson DN, Burton DL, et al. Respiratory symptoms and illness in older Australians: the Burden of Obstructive Lung Disease (BOLD) study. *The Medical journal of Australia*. 2013;198(3):144-8.
5. American Thoracic Society, European Respiratory Society. Standards for the Diagnosis and Management of Patients with COPD. American Thoracic Society 2004.
6. McEvoy CE, Niewoehner DE. Adverse effects of corticosteroid therapy for copd : A critical review. *Chest*. 1997;111(3):732-43.
7. George J, Ioannides-Demos LL, Santamaria NM, Kong DC, KS. Use of complementary and alternative medicines by patients with chronic obstructive pulmonary disease. *MJA*. 2004;181:248-51.
8. Chen R, Chen M, Jun X, Yi F, Chi Z, Zhang B. Comparison of heat-sensitive moxibustion versus fluticasone/salmeterol (seretide) combination in the treatment of chronic persistent asthma: design of a multicenter randomized controlled trial. *Trials*. 2010;11:121.
9. Kaptchuk TJ. *Chinese medicine: The Web that has no Weaver*. London: Random House; 1983.
10. WHO Regional Office for the Western Pacific. WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region. World Health Organization; 2007.
11. Xie Q, Bian R, Yang Q, al e. Studies on the respiratory pharmacology of essential oil extracted from *Artemisia aryl-bronchodilating, antitussive and expectorant effects*. *Chinese Journal of Modern Applied Pharmacy*. 1999;16(4):16-9.
12. Deng H, Shen X. The mechanism of moxibustion: ancient theory and modern research. *Evidence-based complementary and alternative medicine : eCAM*. 2013;2013:379291.
13. Cheng A, CX S. Chronic obstructive pulmonary disease treated by the new moxibustion. *Chinese Journal of Gerontology*. 2012;32(15):3291-2.
14. Li B, Deng Z, Dong J, Tong X. Clinical observation of treating stable chronic obstructive pulmonary disease combination of traditional Chinese and western medicine. *Journal of Herbal Medical University*. 2011;32(1):10-3.
15. Zhang J. Effects on BODE index of lung-kidney qi deficiency of stable COPD treated by moxibustion at the governor vessel. *Journal of Emergency in Traditional Chinese Medicine*. 2012;21(6):1005-6.
16. Zhang J, Zhong L. Clinical study on lung-kidney qi deficiency of stable COPD treated by moxibustion at the governor vessel channel. *Journal of New Chinese Medicine*. 2012;44(8):117-8.
17. Zhou Q, Yang Q. Moxibustion on the governor vessel for lung and kidney qi deficiency type in chronic obstructive pulmonary disease: a randomized controlled trial. *Chinese Acupuncture and Moxibustion*. 2011;31(1):31-4.
18. Higgins JPT, Green S, editors. *Cochrane Handbook for Systematic Reviews of Interventions Version 5.1.0 [updated March 2011]*. The Cochrane Collaboration, 2011. Available from www.cochrane-handbook.org2011.
19. Pellegrino R, Viegi G, Brusasco V, Crapo R, Burgos F, Casaburi R, et al. Interpretative strategies for lung function tests. *Eur Respir J*. 2005;26(5):948-68.
20. Xu J, Deng H, Shen X. Safety of moxibustion: a systematic review of case reports. 2014;2014:783704.
21. Coyle M, Shergis J, Huang ET-Y, Guo X, Di YM, Zhang AL, et al. Acupuncture therapies for chronic obstructive pulmonary disease: A systematic review of randomized, controlled trials. *Altern Ther Health Med*. 2014;20(5):in press.
22. Pach D, Brinkhaus B, Willich S. Moxa sticks: thermal properties and possible implications for clinical trials. *Complementary Therapies in Medicine*. 2009;17:243-6.
23. Kim SY, Chae Y, Lee SM, Lee H, Park HJ. The effectiveness of moxibustion: an overview during 10 years. *Evidence-based complementary and alternative medicine : eCAM*. 2011;2011:306515.
24. Cho ZH, Hwang SC, Wong EK, Son YD, Kang CK, Park TS, et al. Neural substrates, experimental evidences and functional hypothesis of acupuncture mechanisms. *Acta neurologica Scandinavica*. 2006;113(6):370-7.

Case study: A sting in tropical waters off a remote Fiji Island resolved by Chinese medicine

By Luke McPherson, BApSci(TCM), BHsC(Hons) and
Dr Suzanne Cochrane, PhD, School of Science and Health, University of Western Sydney

ABSTRACT

Thirty seven year old female breast feeding a five month old baby presented herself with a painful sting on her upper right arm. After two days of applying hydro cortisone cream 'Sinacot', the site of the sting was still extremely painful and inflamed with red papules. Diagnosis was a skin rash due to toxic heat. Treatment was acupuncture and Chinese herbal medicine. Results concluded that after three treatment sessions the rash and pain disappeared.

Introduction

An unidentified sting is a painful problem and can affect many facets of patient health.

The patient in this case was snorkelling on a remote island in Fiji when she felt a searing burn on her upper right arm. The pain subsided, so she continued to snorkel. Upon getting out of the water the pain returned, and there was a series of raised papules that were red and inflamed.

The patient used a pain scale to describe the pain where 0 equalled no pain – 10 being the most severe pain imaginable. The patient put her pain in the 7 range.

The patient sought medical advice from a medical practitioner via telephone, and was advised to apply hydro cortisone cream 'sinacot' on the affected area four times per day.

She was still in pain and the rash was still as red and inflamed as the first day of the sting so she sought treatment from a traditional Chinese medicine (TCM) practitioner.

Literature review

A search was performed on the databases Cinahl, PubMed, Google Scholar, and Science Direct using the key words: 'Jellyfish sting and traditional Chinese medicine' and 'Jellyfish sting and acupuncture.'

This yielded no useable article to include in the review.

*Correspondent authors email: 98067291@student.uws.edu.au

The search was then expanded to 'Jellyfish sting' and 'Jellyfish'. Again no useable articles were retrieved.

The key terms were then further expanded to include 'Chinese medicine for acute dermatitis' and 'acupuncture for acute dermatitis'. This time four relevant articles were retrieved.

In a study by Salameh⁽¹⁾ twenty (n=20) patients who had mild-to-severe atopic dermatitis were given a combined treatment of acupuncture and Chinese herbal medicine.

The patients received acupuncture treatment twice a week and the Chinese herbal formula three times daily for a total of 12 weeks.

Using the Eczema Area and Severity Index (EASI), to measure the changes in the patients' atopic dermatitis; it was reported that after 12 weeks of treatment an improvement in EASI was noted in all twenty patients.

The mean EASI fell from 4.99 to 1.81. The median percentage of decrease was 63.5 percent⁽¹⁾.

In a study by Pfab⁽²⁾ they compared the use of acupuncture against an antihistamine itch therapy (cetirizine) on type I hypersensitivity itch and skin reaction in atopic dermatitis using a patient and examiner-blinded, randomized, placebo-controlled, crossover trial design.

The mean itch intensity of the acupuncture group was significantly lower than that of cetirizine group and the placebo group; concluding that acupuncture was a viable treatment for itch reduction in atopic dermatitis.

These results are in agreement with the case being reported, in that acupuncture reduced itch significantly.

Acupuncture is quite effective with relieving itch and reducing redness and wheals^(3,4).

Pfab⁽³⁾ tested this in a placebo controlled trial. In this study Pfab introduced an allergen stimulus to 30 patients with atopic eczema before (direct effect) and after (preventive effect) two experimental approaches or control observations: acupuncture at points Quchi (LI 11) and Xuehai (Sp 10) [verum acupuncture (VA), dominant side], 'placebo-point' acupuncture (PA, dominant side), no acupuncture (NA).

After 10 minutes Pfab⁽⁴⁾ used a laser Doppler to measure the wheal and flare size and skin perfusion, and the validated Eppendorf Itch Questionnaire (EIQ) was administered.

The acupuncture group showed significant reduction in itch, wheal and flare compared with the placebo and no acupuncture groups.

These two points (Quchi LI 11 and Xuehai Sp 10) were used effectively in the current case being reported.

Only one of the journal articles that were retrieved contained herbs. The others used acupuncture as the active treatment only.

The absence of research centred on the use of traditional Chinese medicine for the treatment of Jellyfish sting identifies there is a definite gap in the current literature that needs to be explored.

Chief complaint

The patient presented with severe pain with red raised papules on the upper right arm after being stung by unidentified sea life.

The sting had been present for approximately two days before seeking TCM treatment. The rash was hot, raised and extremely painful, with heat intensifying the itch.

The patient had self-administered a prescribed hydro-cortisone cream 'sinacot' to the area of inflammation with some limited results. The pain was constant, but provided greatest discomfort at night as it prevented sleep.

Previous treatment

The patient telephoned a medical practitioner who conducted a diagnosis via a telephone and advised to use hydro-cortisone cream 'sinacot'.

The medical practitioner was unable to advise of the type of marine animal that may have caused the sting, or the prognosis, without actually seeing the affected area.

Upon further investigation by the patient and later the TCM practitioner, the island dive shop owner was also unable to advise the nature of the sting, and he reported that neither he nor his staff had previously witnessed a reaction of this sort from a sting that originated from the waters of the Fijian island.

Other signs and symptoms that were caused by the sting caused the patient to have increased thirst levels particularly at night, restless sleep, low energy, hard dry stool, frequent urination, bitter taste in the mouth. Pulse was slippery, large, and slightly floating.

Diagnosis: Rash due to toxic heat

Treatment principle: Clear toxic heat. Due to the isolation of the island and lack of Chinese herbal medicinals, treatment was limited.

Herbs

Herbal formula was an external application. Xi Gua was mixed in with vitamin E cream, and then tested on a small area of skin to ensure there was no reaction.

The patient was advised to apply the cream liberally to the area every two hours. The vitamin E cream was used because that was the only base cream to mix with.

HERB	DOSE PER DAY	ACTION
Xi Gua	60g pulverised and strained then mixed with 90g of vitamin E cream	Clear heat, dry damp, resolve rash, alleviate pain

Follow up treatment

The patient returned the following day and reported a 90 percent reduction in pain, one hour after the acupuncture session and the first application of the Xi Gua cream.

Twenty four hours later the rash was visibly less inflamed and each papule had reduced in size.

POINT		TECHNIQUE	REASON
LI 1	Shangyang	Reducing	Clear heat from the channel
Lu 11	Shaoshang	Reducing	Clear heat from the channel
Lu 1	Zhongfeng	Even	Clear the channel
LI 20	Yingxiang	Reducing	Clear heat
Sp 10	Xuehai	Even	Clear blood heat
BI 17	Geshu	Even	Clear blood heat
(5)			

The patient reported that her pain now fluctuated between one and three. One just after application of the Xi Guan cream, and three as the next application was due.

The patient reported better sleep (around seven hours per night), more energy and a regular bowel movement of once per day.

The patient refused to use the hydro-cortisone cream 'sinacot' as she felt it to be ineffective and did not want to use unnecessary chemicals on her body particularly whilst breast feeding.

The treatment was repeated for the next three days, once a day. After the third treatment the patient reported that the pain scale was 0/10, and the papules on her upper right arm were flat. The patient was able to sleep and resumed her aquatic activities.

Discussion

This case reported the successful outcome of acupuncture and a modified Chinese herbal treatment for a condition where there exists scant literature.

There was no diagnosis in terms of a biomedicine diagnosis. Traditional Chinese medicine differential diagnosis was the only available means to explain the painful rash experienced by the patient.



In developing a treatment strategy the relevant literature that was available in journal articles and books were reviewed.

The sting could not be identified by a qualified medical practitioner where sea life stings and bites make up a large proportion of his clinic presentations, and they was open in stating they possessed a good working knowledge of marine life bites and stings.

Furthermore the sting could not be identified by professional scuba divers, or island locals.

In this situation, TCM differential diagnosis was the only way to rationalise the symptoms, and then develop a treatment plan.

The use of herbal medicine and acupuncture provided fast relief of the symptoms of intense pain and rash as well as the resultant discontinuation of pharmaceuticals whilst breast feeding.

This in turn improved the health of the patient by improving quality and quantity of sleep, increasing energy levels, improving bowel movements, and facilitating the enjoy the rest of the holiday.

Conclusion

In this case report traditional Chinese medicine differential treatment successfully reduced the pain, relieved the itch, and dissipated the skin rash.

The patient no longer required hydro-cortisone cream 'sinacot'.

Whilst biomedicine uses sophisticated technology, it is important that practitioners of Chinese medicine still utilise their own unique diagnostic and treatment approaches.

On a remote tropical island where biomedical testing facilities are non-existent, it was vital that the basics of TCM diagnostics and treatment were effective.

As mentioned in the literature review there are limited studies on the treatment of stings with TCM.

Acupuncture and Chinese herbal medicine are areas that require rigorous investigation into its effectiveness in treating reactions to stings and bites.

References

1. Salameh F, Perla, D., Solomon, M., Gamus, D., Barzilai, A., Greenberger, S., & Trau, H. The effectiveness of combined Chinese herbal medicine and acupuncture in the treatment of atopic dermatitis. *The Journal of Alternative and Complementary Medicine*. 2008;14(8):5.
2. Pfab F, Kirchner, M., Huss-Marp, J., Schuster, T., Schalock, P. C., Fuqin, J., Athanasiadis, G.I., Behrendt, H., Ring, J., Darsow, U., & Napadow, V. Acupuncture compared with oral antihistamine for type I hypersensitivity itch and skin response in adults with atopic dermatitis – a patient- and examiner-blinded, randomized, placebo-controlled, crossover trial. *Allergy*. 2012;7(4).
3. Pfab F H-MJ, Gatti A, Fuqin J, Athanasiadis GI, Irnich D, Raap U, Schober W, Behrendt H, Ring J, & Darsow U. Influence of acupuncture on type I hypersensitivity itch and the wheal and flare response in adults with atopic eczema – a blinded, randomized, placebo-controlled, crossover trial. *Allergy*. 2010;65:7.
4. Pfab F, Athanasiadis, G.I., Huss-Marp, J., Fuqin, J., Heuser, B., Cifuentes, L., Brockow, K., Schober, W., Konstantinow, A., Irnich, D., Behrendt, H., Ring, J., & Ollert, M. Effect of acupuncture on allergen-induced basophil activation in patients with atopic eczema: A pilot trial. *The Journal of Complementary and Alternative Medicine*. 2011;7(4):5.
5. Maciocia G. *The foundation of traditional Chinese medicine*. London: Churchill Livingstone; 1989.

Australasian Acupuncture and Chinese Medicine Annual Conference



20-22 MAY 2016, MERCURE HOTEL, PERTH, AUSTRALIA



CLINICALLY
RELEVANT
ACADEMIC
PROGRAM

The Australasian Acupuncture and Chinese Medicine Annual Conference 2016 is the peak annual convention and symposium for practitioners in the Asia-Pacific region.

The conference offers:

- a clinically relevant academic program
- highly regarded international speakers
- unique networking and learning opportunities.

Practitioners will deepen their understanding of the profession and leave with an awareness of the latest research, techniques and treatment protocols.

LOCATION

Located on the western coast of Australia, Perth is a cosmopolitan city offering amazing sunsets, beautiful wineries and stunning beaches. Try your luck at Crown Perth Casino and explore one of the world's largest inner city parks during your visit to Australia's sunniest capital.



HIGHLY
REGARDED
INTERNATIONAL
SPEAKERS



UNIQUE
NETWORKING
AND LEARNING
OPPORTUNITIES



DON'T MISS OUT, BOOK NOW.
PLEASE CALL +61 7 3457 1800
OR VISIT ACUPUNCTURE.ORG.AU



GET YOUR WORK NOTICED
AND PUBLISH YOUR RESEARCH

**IN AUSTRALIA'S ONLY PEER-REVIEWED JOURNAL
OF ACUPUNCTURE AND CHINESE MEDICINE**

The Australian Journal of Acupuncture and
Chinese Medicine (AJACM) welcomes submissions on:

- QUANTITATIVE AND QUALITATIVE RESEARCH
 - REVIEW ARTICLES • CASE REPORTS
- CASE SERIES • PHILOSOPHICAL DISCUSSION

Your research will be accessed and noticed by a wider, interested
community of your peers.

Articles published in AJACM are indexed in EBSCO, Informit and Scopus
and AJACM is included in the Excellence Research for Australia (ERA)
list as a quality peer-reviewed journal.

TO REGISTER YOUR INTEREST AND SUBMIT YOUR ARTICLE
PLEASE EMAIL AJACM@ACUPUNCTURE.ORG.AU, VISIT AJACM.COM.AU OR CALL 07 3457 1816.

Book Reviews

By Christopher Zaslowski, PhD, DipAcu, PGDipCHM, BAppSc(Physio), MHLthScEd
University of Technology, Sydney

Aspects of Spirit

by Elizabeth Rochat de la Vallee

If you have a strong interest in the perceptions and notions of the Chinese spirit and want to develop a deep understanding of them, this book is an excellent place to start.

Having attended Elizabeth's last Australian tour and reading most of her books I was looking forward to her latest book on the spirits of the Chinese body.

More specifically the concepts of the *hun*, *po*, *jing shen*, *yi* and *zhi*, the 'five spirits'.

Her scholastic knowledge shines through as she explores various medical and other classical texts in search of reference to these little known aspects of Chinese medicine.

The book is adapted from a series of three lectures delivered in London, United Kingdom.

The text is divided into sections with each section examining the Chinese character for each spirit, the usage of the term in philosophical classical texts such as the *Huainanzi* and the *Guanzi* and then specific medical interpretations extracted from *Suwen* and *Lingshu*.

The concept is approached from a broad perspective then narrowed down to their technical usage in Chinese medicine.

The book is filled with little gems and deep insights.

For example in discussing the coming and goings of the *hun*, the author notes "They do not need openings, apertures or orifices to enter and leave the body. By nature they rise up and one of their favourite places to leave is through the sutures of the skull, where in children the fontanelles are still open. They naturally have this movement upwards, so it is natural for them to leave through the top of the head. They are able to go and come back, as in dreams or meditation, or in some kind of trance or ecstatic state."

Or in discussing the concept of the *po* and its relationship to the colour white which is often associated with Chinese funerals "The phonetic part of *po* is the colour white (*bai*) possibly relating to the colour of the bones, which remain when the body has decayed back into the earth. After some years the bones become white and remain as the skeleton when everything else has disappeared.

In five element cosmology, white became the colour related to metal, to the west and to the lung.

As we grow old the colour of hair has the tendency to grow white. This is also seen in nature, where the arrival of white frosts and snow signify the winter with its action of burying within. So white is an indication of the gradual decline and return of the body to the earth.

The ability to make explicit ideas from an ancient culture far removed from the Western modern culture is not straightforward.

Elizabeth says "the ideas presented here are not easy to comprehend, whether in Chinese or English".

But the book makes a valiant attempt at identifying the cultural complexities and succeeds on most occasions in making these concepts comprehensible.

Restoring Order in Health and Chinese Medicine

by Stephen Birch, Miguel Angel Cabrer Mir and
Manuel Rodriguez Cuadras:

La Liebre de Marzo: Barcelona ISBN 978-84-92470-27-3

This is a fascinating and interesting book that sets out to explore the concepts of *qi* and the channels that circulate the *qi* through the human body.

Written by several authors (Birch, Mir and Cuadras) who take responsibility for most of the ten chapters they also have included additional contributions from Charles Chace and Dan Bensky (chapter five), Mark Bovey (chapter eight) as well as Dianne Sommers (chapter three).

The book commences with a chapter that explores the links between the mind, mental and emotional states and the physical body.

Extensively referenced the authors draw on both classical and modern texts attempting to explain the central concept of *qi* and its associated workings within the human body.

The scholarship is evident in that the concept of *qi* is explored from a historical points of view as well as in a speculative manner.

The second chapter also pursues this approach in exploring the concept of the *jingmai*, examining classical medical texts and highlighting relevant ideas that explore relationships to organs and acupoints (*xue*) and the analogy of the channels and *qi* movement to water flow.

Chapter three investigates the concept of the superior physician (*shangyi*) and how their special qualities have contributed to the development of Chinese medicine and to the technical aspects of acupuncture theory and treatment.

Chapter four returns to the *jingmai* and *qi* and focuses on *qi* movement, needling and the engagement of *qi* by the physician during treatment.

Wei qi, *yuan qi* and *ying qi* are all described in reference to their function and movement within the channels.

Chapter five by Chase and Bensky looks at the interpretation Chapter one of the *Lingshu* on the way of needling.

Line by line they outline the nuances and intricacies of needling as detailed in this section facilitating a deeper understanding of this important and foundational classical medical text.

The next chapter further develops the earlier concepts of *qi* and *jingmai* from a herbal perspective.

A case is made that there may exist historical relationships between herbal medicine and the ancient 'structuring concepts like *qi*, *jing* and *jingmai*'.

Chapter seven (titled *qi* and stillness) makes the statement that *taiji quan*, *qigong* and acupuncture all rely on movement, but that 'movement cannot exist without stillness'.

Analogies between the movement practices and acupuncture are described and the similarities identified.

Chapter eight draws together the previous themes and posits a way to scientifically explore and validate the traditional acupuncture concepts in a systematic and justifiable manner.

While acknowledging that the task is difficult, Birch and Bovey argue it is necessary if traditional East Asian medical concepts are to be acknowledged by a broader population.

Chapter nine summarises the main practical concepts drawing on the practical experience of the main authors and their martial arts backgrounds and how these experiences translate into delivering effective acupuncture.

The authors suggest several important practices (cultivating *yi*, timing, presence, sensitivity) which they believe are necessary for the development of acupuncture skills.

The final chapter ten, details a series of exercises to help keep the body relaxed and alert while administering acupuncture.

Black and white photographs and line drawings assist the reader in understanding and executing the exercises.

This book is one of the most in-depth and scholarly texts on acupuncture.

No book at this point in time has attempted to comprehensively explore the cultural and historical complexities of acupuncture in such an erudite manner.

If you are looking to enhance your understanding of acupuncture as well as improve your clinical effectiveness this book should be on your reading list.

Research Snapshot

Simone Ormsby*

National Institute of Complementary Medicine Western Sydney University

AN EXAMINATION OF STUDIES EVALUATING ACUPUNCTURE IN LABOUR HAVE DISCOVERED THE UTILISATION OF NON-CLASSICALLY INDICATED ACUPOINTS, SUCH AS GV20 (BAIHUI) IN 3 CLINICAL REPORTS⁽¹⁻³⁾.

In two of these GV 20 was selected for 'relaxation' purposes^(2,3). In the third report no rationale was provided for point choice. The overall stated objective were pain relief⁽¹⁾.

It was unclear in all three studies whether GV20 was needed in every case.

In terms of acupuncture training, midwives in one study had received four days of training specifically for pain relief in labour⁽²⁾.

Midwives in another study had been trained in 'acupuncture for midwives', however course duration was not specified⁽¹⁾ and in the remaining study, no reference was made to training or who performed the treatments⁽³⁾.

The primary outcome measure in all three studies was pain relief, with two studies additionally evaluating delivery outcomes^(1,2) and a different pair also examining relaxation^(2,3).

In one study needles were retained for either 20 minutes or for an unspecified time frame from 'conversion to conventional analgesia or delivery'⁽¹⁾, in another, for one to three hours, an unusual length of time⁽²⁾ and in the final study, times were not stated⁽³⁾.

Some positive findings were reported including significantly reduced need for pharmacological analgesia^(1,2), significantly reduced self-reported pain scores⁽¹⁾, significantly improved relaxation self-assessment⁽²⁾ and non-significant reductions in self-reported pain⁽²⁾.

Labour outcomes when assessed reportedly resulted in a reduction in labour duration in one study⁽¹⁾ and a reduced need for syntocinin augmentation in two^(1,3), yet findings in each case were not significant.

Eight different studies evaluating acupuncture in relation to various labouring outcomes did however report significant benefits in at least one outcome measured and in each case GV 20 was not utilised⁽⁴⁻¹¹⁾.

Whilst GV 20 had been selected for either pain relief or relaxation purposes in these three studies, it is conceivable that a lack of awareness of traditional indications for this point, such as threatened miscarriage⁽¹²⁾ and uterine and rectal prolapse, as well as the mechanism by which these issues may be rectified, that is the raising of yang⁽¹³⁾, compromised labouring outcomes.

Two additional unconventional point indications noted were LU 7 (lieque) for relaxation⁽²⁾ and LI 3 (sanjian) for analgesia⁽³⁾.

The 'relaxing function' for LU7 is not common but it may refer to action on the eight extraordinary vessels.

In this instance it was not coupled with KI 6 so its use for this purpose is not clear.

These research papers highlight the importance of adequate acupuncture training in regards to selection of points in studies, as point selection based on limited theoretical foundation and or functional lists that may not be comprehensive, may result in inappropriate point choices and inconclusive or negative findings.

Guidelines for reporting interventions in controlled trials of acupuncture (STRICTA)⁽¹⁴⁾ have been helpful in standardising the reporting of acupuncture training and expertise in clinical studies.

*Correspondent authors email:
simone.ormsby@westernsydney.edu.au

Reference List

1. Skilnand E, Fossen D, Heiberg E. Acupuncture in the management of pain in labor. *Acta Obstet Gyn Scan.* 2002;81(10):943-8.
2. Ramnerö A, Hanson U, Kihlgren M. Acupuncture treatment during labour - a randomised controlled trial. *BJOG - Int J Obstet Gy.* 2002;109(6):637-44.
3. Ziaei S, Hajipour L. Effect of acupuncture on labor. *Int J Gynecol Obstet.* 2006;92(1):71-2.
4. Fatemeh V, Zahra S. The effects of TENS applying on specific acupuncture points versus thoracic-lumbo sacral vertebrae on active phase of labor. *J Psychosom Obst Gyn.* 2010;31:125.
5. Aghamohammadi A, Behmanesh F, Zafari M, Tofighi M. Effect of using Transcutaneous Electrical Nerve Stimulation (TENS) in acupuncture points [Hegu (LI4) and Sanyinjiao (SP6)] on duration of the first stage of labor. [Arabic]. *Journal of Babol University of Medical Sciences.* 2011;13(2):19-24.
6. Liu J, Han Y, Zhang N, Wang B, Zhou Y, Yang D, et al. The safety of electroacupuncture at Hegu (LI 4) plus oxytocin for hastening uterine contraction of puerperants - a randomized controlled clinical observation. *J Tradit Chin Med.* 2008;28(3):163-7.
7. Gaudernack LC, Forbord S, Hole E. Acupuncture administered after spontaneous rupture of membranes at term significantly reduces the length of birth and use of oxytocin: A randomized controlled trial - Commentary. *Obstetrical and Gynecological Survey.* 2007;62(4):224-5.
8. Aghdam S, Daryabakhsh A. Effect of acupressure at Hugo point (LI4) on the process and outcomes of labor in nulliparous women. *Iranian Journal of Obstetrics, Gynecology and Infertility.* 2012;15(27):14-20.
9. Kashanian M, Shahali S. Effects of acupressure at the Sanyinjiao point (SP6) on the process of active phase of labor in nulliparas women. *J Matern-Fetal Neo M.* 2010;23(7):638-41.
10. Rabl M, Ahner R, Bitschnau M, Zeisler H, Husslein P. Acupuncture for cervical ripening and induction of labor at term - a randomized controlled trial. *Wien Klin Wochenschr.* 2001;113(23-24):942-6.
11. Hantoushzadeh S, Alhusseini N, Lebaschi A. The effects of acupuncture during labour on nulliparous women: a randomised controlled trial. *Aust NZ J Obstet Gyn.* 2007;47(1):26-30.
12. Maciocia G. *Obstetrics and Gynecology in Chinese Medicine.* London, United Kingdom: Churchill Livingstone; 1998.
13. Deadman P, Al-Khafaji M, Baker K. *A manual of acupuncture.* East Sussex: Journal of Chinese Medicine Publications; 1998.
14. MacPherson H, White A, Cummings M, Jobst K, Rose K, Niemtzow R. Standards for reporting interventions in controlled trials of acupuncture: the STRICTA recommendations. *Complementary Therapies in Medicine.* 2001;9(4):246-9.

Research Snapshot

Luke McPherson* BApSci (TCM) BHSci (Hons) PhD candidate, TCM Program,
School of Science & Health, Western Sydney University

STUDY TO EXAMINE THE ROLE OF ACUPUNCTURE TO REDUCE SYMPTOMS OF LYMPHOEDEMA AFTER BREAST CANCER: A RANDOMISED CONTROLLED TRIAL.

By Luke McPherson B Ap Sci (TCM) BHSci (Hons)
PhD candidate, TCM Program,
School of Science & Health, Western Sydney University

Authors: Caroline A Smith, Marie Pirota,
Sharon Kilbreath

Background

Lymphoedema is associated with an abnormal accumulation of protein-rich fluid due to impaired lymphatic transport.

It is a secondary condition that occurs in 20 percent of breast cancer patients as a result of treatment.

This protein rich swelling is susceptible to infection and compromises the health of the patient.

Presently there are no cures for lymphoedema, and interventions such as massage, compression garments, and gentle exercises are targeted to reduce swelling and pain.

Current treatment of lymphoedema requires specialist training and can be expensive for the patient.

Objective

To determine the feasibility, acceptability and safety of acupuncture to treat arm lymphoedema in women following treatment for breast cancer.

Methods

Twenty women with stable unilateral intransient lymphoedema present for at least six months were recruited from Sydney, Australia to participate in a randomised controlled trial (RCT) of acupuncture compared with usual treatment.

The women were diagnosed according to TCM pattern differentiation.

Each participant received 12 acupuncture treatments administered to body and arm points on the non-lymphoedematous limb over eight weeks, twice weekly for four weeks then once weekly for four weeks.

The acupuncture points selected included local and distal points, and a combination of standard points and individualised points based on the individual diagnosis.

Practitioners were requested to select three standardised points from the following:

1. points traditionally associated with regulation of systematic vessels, increased lymphatic circulation and a reduction in lymphoedema: CV12 Zhongwan, CV3 Zhongji, CV2 Qugu
2. points on the unaffected side to address heaviness, limitation of movement and pain in the upper limbs LI15 Jianyu, TE4 Yangchi, LU5 Chize, LI4 Yangxi
3. other general points used to treat oedema in general including ST36 Zusanli, SP9 Yinlingquan and SP6 Sanyinjiao. Other acupuncture points were used based on the individual diagnosis.

*Correspondent authors email: 98067291@student.uws.edu.au

Clinical outcomes were assessed at baseline and eight weeks including extracellular fluid, lymphoedema symptoms, well-being, and safety of treatment.

Other outcome measures included an assessment of interest to participate in the trial, identification of successful recruitment strategies, the suitability of eligibility criteria, and compliance with treatment attendance.

Results

Acupuncture as an intervention was acceptable in breast cancer patients with upper limb lymphoedema.

Compliance with the treatment protocol was high, with nine women completing all 12 treatments.

No major adverse occurrences, as defined by the study protocol and no study participant experienced an increase in swelling of >10 percent.

Conclusion

Lymphoedema is an obstinate symptom experienced by women recovering from breast cancer.

This study suggests that acupuncture may stabilise symptoms, with no major adverse events.

A large scale, multi-centred, placebo controlled, randomised trial is needed to confirm the results.

COMMENTARY

The research by Smith, Pirota, and Kilbreath was valuable in identifying the effectiveness and safety of acupuncture for lymphoedema.

The design of this trial was inspired as it truly tested the feasibility of using acupuncture for lymphoedema in breast cancer patients by assessing participants interest to participate in the trial, by identifying successful recruitment strategies, by reviewing the suitability of the eligibility criteria, and measuring compliance with treatment attendance.

The other aspect the researchers incorporated into the design of the trial was the TCM diagnosis and TCM treatment principles.

This aspect of the methodology allowed TCM diagnostic principles to govern the acupuncture selection.

This was expertly done as the design allowed a selection of points from three categories to be chosen by the TCM practitioner.

The use of a TCM diagnosis alongside a selection of acupuncture points allowed the success of TCM treatment protocols to be measured as well as minimising points so intervention effectiveness could also be measured.

Given that all participants in the acupuncture groups were stabilised, it highlights that TCM diagnosis and pattern differentiation can be effectively utilised in RCT's.

Due to the small number of participants in this trial the results would need to be confirmed in a large scale, multi-centred, placebo controlled, randomised trial.

Commentaries on the regulation and the current situation in Spain regarding acupuncture and TCM

Dr Ramon McCalduch

Dr Ramon is an anthropologist specialising in medicine. He is an economist, lawyer and auditor and is currently:

- Vice-president of the European Foundation of TCM (Spain);
- Chairman of the Supervision Board of WFCMS;
- Vice-president of EIC (WFCMS);
- Member of ISO/TC249 TCM and Chairman Advisory Group;
- Vice-president of the Pan-European Federation of TCM Societies (PEFOTS);
- President of the European Chamber of Commerce for TCM (ECCTCM) and
- Vice-president of World Federation of Acupuncture Societies (WFAS).

Since the presentation of the Natural Therapies Report, issued by a sector of the Health Commission of the Spanish Parliament, we have not seen a real interest for regulation.

However the report from the Commission of Non-conventional Medicines of the Board of Medical Doctors Association and some e-mails containing claims, submitted by groups from the complementary medicine field which has nothing to do with regulatory issues, have raised concerns.

I cannot detect any intention from the Spanish government to deal with this matter due to other priorities and the economic crisis.

Firstly the practice of acupuncture and traditional Chinese medicine (TCM) should be a sanitary medical practice.

This topic can't be ignored as it has been recognised both by the courts and the government by collective agreement from the sector that it is an activity which is not yet regulated.

In this case a sanitary inspection or control of the autonomous regions, after transferal of competencies to the state, they actually realise activities related to health care and must comply with the requirements of a health care centre.

From my point of view the confusion comes from an incorrect interpretation of the decree 1277/2003 which does not state that acupuncturists' activity must be realised exclusively by a medical doctor, but the classification of non-conventional medicines for health care centres (U101), requires a Western medical director.

They extrapolate the definition to all types of centres including the unqualified.

The non-medical acupuncturists, considered as paramedics, pay taxes and are registered in the public treasury in section 841 of Economic Activities, as "acupuncturist, naturopath and other paramedical services."

Recently they are subject to a section of the agreement that clearly states this sector is pending regulation.

The training in acupuncture is not covered by any Bachelor degree study program in Spain when it is considered a university degree in other countries all over the world such as Canada, PR China, United States, United Kingdom and Germany.

After examining the jurisprudence of the High Court, and after countless challenges of the Royal Decree 1277/2003, all have been rejected.

There is obviously a legal loophole and a high risk that authorities consider the centers of complementary therapies as health care centers, making the presence of a medical doctor compulsory for all of them.

Following the judgments of the Supreme Court, it seems that the practice of acupuncture is considered a health care activity that would be integrated into regulation and law.

The judgment of the High Court dated on 23 September 2009, would serve as a possible framework for continuous training.

In terms of education we can draw the conclusion that the profession is not regulated and does not require qualification.

We can also see it is not included in the national health system but it is recognised as such by treasury and labour (collective agreement for the sector) despite zero regulation.

When there is a lack of regulation, there are more unqualified practitioners with open centres than health professionals with qualifications (U10).

Clarity is taking place in our country with the intervention of health inspections which commonly occur due to a complaint by a competitor, collective or a patient.

In addition to this, when an unqualified professional tries to register a centre in its' city council, they are informed that they need an authorisation issued by the Ministry of Health.

The Department of Health can only issue authorisations for sanitary centres ruled by a Western doctor, according to the Decree 1277/2003 (U101).

So why is there so many unqualified centres where unconventional therapies are practiced?

This is because there are unqualified practitioners who are practising.

As most of the city councils do not engage in closing of centres, the practitioner assumes the risk of being subjected to a health inspection most often ending with the closure of the centre.

There are different criteria and some autonomous regions such as Catalonia consider acupuncture or traditional Chinese therapy, practised by unqualified professionals as a commercial service for users while treating patients.

The problem related to the city councils registration and the potential negative impact of an inspection by the health commission disappears.

There are no complaints of intrusion by criminal law against unqualified professionals.

The reason is that if the practitioner can demonstrate that she/he has got the necessary knowledge (via certification and academic program) for the treatment, the judgment will be favourable, because the studies are not regulated so there is no limitation for any health care professional.

Due to restrictions, a lot of practices choose to have a Western medical director to obtain accreditation of the centre as it shares cost and increases revenue.

As for regulation, some neighbor countries such as Portugal have recently been regulated.

This issue is being reviewed in Spain, France and Italy, but there is no way to be predict when the regulation will occur.

It has always been argued that the regulation of natural therapies in Spain will be determined by a European directive.

There is a division between northern Europe where there is a permissive attitude with a common law and a system of self-regulation by the sector itself, and the southern European countries, whose tradition is supposedly based on the Roman law and a system of professional associations.

There is already regulation approved in Australia, Chile, Mexico, Nicaragua, in many Asian countries and in most states of America.

In recent years some changes have taken place and may favour this issue which is helped by the influence of China who are interested in moving it further by the ISO International.

This is working to standardize TCM through MTC TC249.

While regulations are waiting to be put into place it is important that professionalism, seriousness and a high level education in TCM schools and training centres occurs.

With this evidence can be provided via documents from the practitioners providing the level of their competence for their license so they can practice.

Conference Report

Dr Suzanne Cochrane*, PhD, School of Science and Health, University of Western Sydney, Australia

In pursuit of wisdom: Ancient Chinese and Greek perspectives on cultivation

Suzanne Cochrane
15-18 January 2016 Sydney, Australia.

The conference was a great opportunity to network with scholars and gain a deeper understanding and knowledge of their fields.

As an international conference luminaries like Professor Lisa Raphals from the University of California and Professor Wang Keping from the Chinese Academy of Social Sciences were able to attend.

For four days all participants gathered in the same room and listened to each other's ideas and stories.

I was taken out of my comfort zone and exposed to more Greek philosophy which I found was very useful in reflecting on the different historical/philosophic traditions of traditional Chinese medicine (TCM) and that of Greek-based biomedicine.

One of the most illuminating panel discussions included Barbara Hendrichke on 'Nurturing life in the *Laozi* as understood by Han Fei', Rey Tiquia on 'Cultivating and aligning our *qi*' and Anthony Hooper on 'Cultivation, death and immortality in Plato's *Symposium*'.

Rey Tiquia's paper was the only paper that included a discussion of Chinese medicine showed how basic Chinese medical concepts can be enhanced to sound exotic and interesting for a non-Chinese medicine audience.

It is disappointing how little (and apparently how uncritically) the scholars of Chinese philosophy have explored medical texts that are so familiar to TCM practitioners like the *Neijing*.

Hendrichke and Hooper through careful scholarship showed the stark differences between Greek-origin philosophy (via Plato) and Chinese origin philosophy (via the *Laozi*).

Personally the contrast was in the importance of rational thought to the cultivation of the Platonic 'man' and the emphasis on embodiment and nature for the Daoist 'man'.

Will Buckingham, an English writer/philosopher and creative writing academic presented 'Writing in the service of life: Liu Xie and the practice of literature'.

This referred to Liu Xie's *Wenxin Diaolong* 文心雕龍, "The Literary Mind and the Carving of Dragons".

Writing in the sixth century, Liu Xie argued that writing is a *yangsheng* (self-nourishing) practice and that the written piece had a *qi* of its own.

It is worth contemplating how TCM practitioners can cultivate themselves more by writing for the AJACM and sharing the collective *qi* around!

The conference organisers were: Professor Rick Benitez, Philosophy Department, The University of Sydney; Dr Hyun Jin Kim, School of Historical and Philosophical Studies, The University of Melbourne; A/Professor Karyn Lai, School of Humanities and Languages, University of New South Wales.

*Correspondent authors email: s.cochrane@westernsydney.edu.au

Upcoming International Conferences

- | | |
|-----------------------|--|
| 3-7 May | Rothenburg, Germany
47th International TCM Kongress
tcm-kongress.de/en/programm/programmvorschau/index.htm |
| 20-22 May | Perth, Australia
Australasian Acupuncture and Chinese Medicine Conference
aacmac.org.au |
| 10-12 June | Sofia, Bulgaria
International Council of Medical Acupuncture and Related Techniques
icmart.org/events/upcoming-icmart-congress/upcoming-icmart-congress.html |
| 14-16 July | Pennsylvania USA
4th Global Acupuncture and Therapists Annual Meeting
acupuncture.conferenceseries.com/ |
| 13 August | Wellington, New Zealand
Acupuncture NZ AGM and Conference
acupuncture.org.nz |
| 24-25 October | Chengdu, Sichuan China
The 5th International Conference on the Modernization of Traditional Chinese Medicine |
| 5-6 November | WFAS World Federation of Acupuncture - Moxibustion Societies
wfas.org.cn/en/ |
| 11-13 November | Wellington, New Zealand
13th World Federation of Chinese Medicine Societies |
| 16-19 November | Nanjing, China
BIT's 3rd Annual world Congress of High Tech Acupuncture and Integrative Medicine
bitcongress.com/HTA&IM2016/ |

AJACM Instructions for Authors

The Australian Journal of Acupuncture and Chinese Medicine (AJACM) is the official journal of the Australian Acupuncture and Chinese Medicine Association Ltd (AACMA).

It is a peer-reviewed journal published biannually and it has an Editorial Board and an International Advisory Board.

The Instructions for Authors are available online from: acupuncture.org.au/ajacm.cfm.

Aims and scope

AJACM acknowledges the diversity of Chinese medicine theories and practice, and encourages the integration of research, practice and education.

It promotes the use of rigorous and appropriate research methodologies in the field of Chinese medicine.

AJACM publishes original research articles, general papers, reviews, case reports and case series that will contribute to current practice knowledge and encourage future research directions.

The Editorial Board also welcomes the submission of letters, opinions and commentaries.

Authors of randomised, controlled trials (RCTs) are encouraged to consult the CONSORT standards available from consort-statement.org/Statement/revisedstatement.htm.

Authors of systematic reviews are encouraged to consult the QUOROM statement: Moher D et al. Improving the quality of reports of meta-analysis of randomised controlled trials: the QUOROM statement. *Lancet* 1999;354:1896–1900 (Available from thelancet.com).

Case reports and case series are to follow the guidelines in Writing Chinese Medicine Case Reports: Guidelines for the Australian Journal of Acupuncture and Chinese Medicine by P Ferrigno, JD Ryan and JC Deare, available from acupuncture.org.au/ajacm.cfm.

The reporting of acupuncture treatment in clinical trials, case reports or case series needs to follow STRICTA guidelines, which are available from stricta.info/stricta.htm.

Similarly, reports of herbal interventions should follow the guidelines outlined in the CONSORT statement, which was reprinted in AJACM (2006) volume 1, issue 1 (pp. 35–9), and is also available from annals.org.

All human and animal research must have been conducted in accordance with the National Health & Medical Research Council's standards on research ethics, available from nhmrc.gov.au/ethics/index.htm, or equivalent standard if conducted outside Australia.

Authors should supply a copy of their ethics approval.

Organisation of manuscripts

General requirements

AJACM endorses the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, which is available from icmje.org/ijmje.pdf.

Length of manuscript

Original research, general articles and reviews should not exceed 3000 words, excluding abstract and reference list, without the permission of the Editorial Board.

Case reports and case series should not exceed 1500 words.

Letters to the Editor and Book Reviews should not exceed 500 words.

Title page

The title page should include contact details of the authors, the manuscript's full title, short title, abstract and keywords.

The title page should be included in the same file as the manuscript.

Abstract and keywords

Abstracts should not exceed 300 words and, where applicable, contain background, aims, design, subjects and settings, interventions, outcome measures, results, discussion and conclusion. Up to six keywords may be used.

Where possible, keywords should be those recommended in the *Index Medicus* Medical Subject Headings (MeSH) list.

Text

Manuscripts of original research or review articles should have Introduction, Methods, Results, Discussion, Acknowledgments and References.

Authors of other articles should use appropriate headings.

Clinical Commentary

All manuscripts should have a Clinical Commentary section, written in plain language for practitioners, describing the clinical relevance of the article.

This section should include two to three paragraphs and be no more than 100 words in length.

It will be included in the printed article as a break-out box.

Acknowledgments

Acknowledgments should:

- specify academic and/or technical contributions;
- list the types of financial support; and
- disclose any possible conflicts of interest.

References

AJACM adopts the Vancouver referencing system, a summary of which is available from library.curtin.edu.au/referencing/vancouver.pdf. The Journal encourages the use of citation managers such as EndNote.

In-text citations should use superscript Arabic numerals in the appearing order.

The use of footnotes is strongly discouraged.

Where there is supplementary comment in relation to a table or a figure, this should be presented below the table using alphabetical symbols.

References should be listed according to the order of their appearance in the text. Please refer to the following referencing examples.

1. WHO. Standard acupuncture nomenclature. 2nd ed. Manila: WHO Regional Office for the Western Pacific; 1993.
2. Cahn A, Carayon P, Hill C, Flamant R. Acupuncture in gastroscopy. *Lancet* 1978;28(1):182–3.

Abbreviation of journal titles should follow those used in the *Index Medicus*. Please consult the Entrez Journals Database, available from: ncbi.nlm.nih.gov/entrez/query.fcgi?db=Journals.

Figures and tables

Figures and tables should be numbered according to their order of appearance with Arabic numerals.

Figures must be provided as separate files.

Information provided in figures and tables should complement, but not duplicate, that in the text.

A figure is to have a title and a self-explanatory legend below it.

A table is to have a title above it. All symbols and abbreviations must be explained below the body of the table or figure.

Submission of manuscripts

Procedure

All manuscripts should include a cover sheet and be submitted electronically as an e-mail attachment to ajacm@acupuncture.org.au.

Authors should also send a hard copy of the manuscript with the signed original of the cover sheet to the Journal's postal address.

The Editor-in-Chief will e-mail the correspondent author to confirm receipt of the manuscript and provide a reference number which should be used in all communications about the manuscript.

The Editorial Board will conduct an initial in-house review. The correspondent author will receive in one month of submission an e-mail notifying whether the manuscript:

- has passed the in-house review and has been sent for peer review; or
- has not been accepted through the in-house review.

For articles sent for peer review, AJACM will notify the correspondent author within three months of one of the following four decisions:

- acceptance with no changes;
- acceptance with minor changes;
- acceptance subject to major changes; or
- rejection.

Authors will be given up to two months to amend the manuscript. Once the amended manuscript has been accepted for publication, a galley copy will be sent to the correspondent author for confirmation prior to publication.

The Editorial Board expects to receive the confirmation within seven days. Ten copies of reprints will be sent to the correspondent author after publication.

Format

Text and tables should be in Microsoft Word 2000 (or later version) format. ASCII, Rich Text Format or PDF files will not be accepted.

Manuscripts should be typed, double-spaced with a margin of 20 mm on the top, bottom and both sides. Text should be in Times New Roman 12 point.

Graphics should be in minimum 300 dpi. They are not to be embedded in the text file, and should be submitted as separate files in JPEG or TIFF format.

Cover sheet

All submissions must include a completed cover sheet, which is available from acupuncture.org.au/ajacm.cfm.

The cover sheet is a separate document to the title page.

This must be submitted as a signed hard copy included with the hard copy of the manuscript. In-house review will not proceed until a cover sheet has been received.

Copyright agreement

A completed copyright agreement form should be submitted once the paper has been accepted for publication.

The correspondent author is responsible for obtaining the signature of all authors.

An assignment of copyright form will be e-mailed to the correspondent author after the final version of the manuscript has been received and approved for publication.

Terminology and English

Acupuncture points should be named according to both Pinyin and the numerical code recommended by the World Health Organization (WHO. Standard Acupuncture Nomenclature, 2nd ed. Manila: WHO Regional Office for the Western Pacific; 1993).

Chinese herbs should be named according to both the Pinyin and the Latin name.

AJACM reserves the right to correct Chinese herb names to conform with the Pharmacopoeia of China (Pharmacopoeia Commission. Pharmacopoeia of the People's Republic of China 2000. English ed. Beijing: Chemical Industry Press; 2000).

The terminology of Chinese medicine, such as *Qi*, *Yin* and *Yang*, should be in Pinyin and may use common English translations where applicable.

It is recommended that each manuscript contain a glossary of Chinese medicine terms used.

Chinese characters should be in simplified form and will only be accepted as in-text characters.

Downloads for using in-text Chinese characters in Microsoft Word can be obtained from the Microsoft website, microsoft.com.

The language used in AJACM is standard Australian English as per the Macquarie Dictionary. Manuscripts will be amended accordingly.

Contact information

All correspondence should be addressed to the AJACM Editor-in-Chief.

E-mail: ajacm@acupuncture.org.au
Phone: +61 7 3457 1816
Fax: +61 7 3394 2399
Post: PO Box 1635
COORPAROO DC QLD 4151
AUSTRALIA

Advertise with AJACM

Display Advertising (per issue)

All quoted rates are in Australian dollars and include Australian Good and Services Tax

AD SPACES	1 ISSUE	2 ISSUES	AD SIZES
Outside back cover (full colour)	\$2200.00	\$1915.00 ea	297mm x 210mm (depth x width)
Inside front cover (full colour)	\$2000.00	\$1750.00 ea	297mm x 210mm (depth x width)
Inside back cover (full colour)	\$2000.00	\$1750.00 ea	297mm x 210mm (depth x width)
Full page (colour)	\$1700.00	\$1315.00 ea	288mm x 200mm (depth x width)
Half page horizontal (colour)	\$1200.00	\$825 ea	144mm x 200mm (depth x width)

Artwork must be in a PC compatible format (TIFF, JPEG or high resolution PDF). Please supply artwork via e-mail or CD-ROM, including all images and fonts.

Screen: 300 dpi

Binding: Saddle stitched

Printing: Offset printing

Conditions

Acceptance of any advertising and insertion material is at the sole discretion of AJACM.

The AJACM management committee reserves the right to refuse to publish any advertisement or accept any materials for insertions which it feels is in any way inappropriate to the journal.

Materials must be supplied in the required format and specification. AJACM will not be responsible for the quality or standard of materials supplied in an inaccurate and/ or incompatible format and reserves the right to reject any advertising or materials that do not comply with the specifications.

As AJACM is subject to certain restrictions on both size and weight, AJACM reserves the right to refuse to publish or disseminate any advertisement or advertising material which it feels will cause the journal to exceed these restrictions.

Contact for Advertising

For further information regarding advertising, please contact AACMA Communications Officer, Melinda Lyons on:

Phone: +61 7 3457 1816

Fax: +61 7 3394 2399

Email: communications@acupuncture.org.au





Aboriginal and Torres Strait
Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

The not-so-small print about keeping the public safe

There's lots of it... but it's important.

- ▶ Do you know there are things you can and can't do when **advertising health services**?
- ▶ Have you ever wondered if you should **report that practitioner** who might be putting the public at risk of harm?
- ▶ Are you meeting all your **obligations as a registered health practitioner**?

These are only three pieces.

Read the not-so-small print to complete the puzzle and keep the public safe.

Go to www.notsosmallprint.com/AJACM or call 1300 419 495 to find out more.