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RE: The National Institute for Health and Care Excellence (NICE) has updated its Guideline for Osteoarthritis in over 16s: diagnosis and management (NG226)

Joint statement by the British Acupuncture Council (BAcC), British Medical Acupuncture Society (BMAS) and Acupuncture Association of Chartered Physiotherapists (AACP).

The National Institute for Health and Care Excellence (NICE) has updated its Guideline for Osteoarthritis in over 16s: diagnosis and management (NG226). The new guideline does not recommend acupuncture. We believe that the decision not to include acupuncture is mistaken. It is a decision that limits access to treatment to millions of patients in England and Wales. The Guidelines could, and should, have taken a more pragmatic approach.

Acupuncture has been recommended for osteoarthritis of the knee in Germany, Scotland and America.[1-3]

The Guidelines did not include acupuncture principally because the committee considered the comparison with sham acupuncture* to show no clinically important difference. Other physical interventions were not compared to sham. Therefore, acupuncture was required to clear a hurdle that other interventions, such as exercise, were not required to jump. The 'hurdle' was to demonstrate a minimally important difference (MID) of 0.5 (SMD†) compared to sham/placebo.

The comparison against placebo was carried out for pharmacological options. An underlying assumption of sham/placebo-controlled trials is that the sham/placebo is inert. As the placebo effects are the same for both intervention and sham/placebo groups the difference measured is attributable to the intervention. Sham acupuncture is not inert.[4-7] Therefore, the hurdle acupuncture was required to clear was higher than pharmacological treatments. In short, acupuncture is required to show a difference of 0.5 (SMD) against an active treatment, sham acupuncture, whereas oral NSAIDs are compared to inactive placebos. Moreover, topical NSAID (Guidelines 1.4.3) and oral NSAIDs (Guidelines 1.4.4) are recommended even though the committee noted there was 'no clinically important difference for pain and physical function' for either (evidence review I, p219 & p244). In other words, the committee opted to lower the hurdle for NSAIDs.

* Sham acupuncture refers to different procedures that attempt to mimic acupuncture without providing any therapeutic benefit. The acupuncture equivalent of a placebo pill.

† SMD – standardised mean difference is the average difference between 2 groups in a controlled trial divided by the standard deviation of the difference. It is a way of estimating the size of the effect of an intervention.

There are problems with sham acupuncture and an arbitrary MID. Firstly, the degree to which sham acupuncture is 'active' is not known. A more 'active' sham will lead to a smaller SMD. It has been shown that sham acupuncture that penetrates the skin leads to smaller SMD.[8] Sham acupuncture is not a treatment given in practice, so it is not the appropriate comparison to assess whether acupuncture is 'clinically meaningful' to patients. The comparisons with, or in addition to, other therapies are more relevant.

We believe the main concerns for both patients and clinicians is to know a) whether the benefits of acupuncture are due to the placebo effect and b) how acupuncture compares to other options.

The sham acupuncture trials do control for the placebo effects. The best available evidence shows that the effects of acupuncture, for chronic pain and osteoarthritis, are not simply due to placebo. [8] This was confirmed in evidence review F.

In a network analysis of physical interventions for OA knee, sham acupuncture ranked more highly than exercise and weight loss.[7] Acupuncture has been shown to be better than sham, and sham acupuncture has been shown to be better than interventions included in the guidelines, exercise and weight loss.

As mentioned above, NSAIDs did not meet the 0.5 MID criterion for pain and physical function. Yet the committee concluded 'it is possible that the effect could be important in this population' (evidence review I, p219 & p224). Therefore, we believe, a similar, more pragmatic approach should have been taken regarding acupuncture. Acupuncture should not be excluded from the guidelines on the basis that it failed to demonstrate an SMD of 0.5 when compared to an intervention which has been shown to outperform physical therapies included in the guidelines, sham acupuncture.

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