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Research Article

Treating Pain in Pregnancy with Acupuncture: Observational Study Results from a Free Clinic in New Zealand

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Abstract

Introduction: Clinic-based acupuncturists, midwives, and physiotherapists have reported using acupuncture to treat lumbopelvic pain in pregnancy, a common condition that may affect functioning and quality of life. To contribute to the emerging evidence on treatment outcomes, we collected patient-reported pain reduction data from women treated during pregnancy in a no-pay, hospital-based acupuncture service in New Zealand.

Methods: Observational study of patient-reported symptom reduction. The main outcome measure was the MYMOP (Measure Your Medical Outcome Profile), a brief, validated self-report instrument. Open-ended questions on treatment experiences and adverse events were included.

Results: Of the 81 women on whom we had complete treatment data, the majority ($N = 72$, 89%) reported clinically meaningful symptom reduction. Patient-reported adverse events were infrequent and mild.

Discussion: Patient-reported and treatment-related lumbopelvic pain symptom reduction findings provide further evidence that acupuncture in pregnancy is safe and beneficial in a field setting. We discuss this study's unique contributions in providing guidance for clinicians who practice acupuncture in pregnancy, including midwives, physiotherapists, and physicians.

Abbreviations: LPP, lumbopelvic pain; AE, adverse events.

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Introduction

Pregnancy-related pain in the lower torso has been referred to as low back pain [1], pelvic girdle pain [2], or both [3]. Because precise diagnosis can be challenging [4] and because women frequently report symptoms as overlapping or difficult to distinguish [1–3], we use the familiar [3] and inclusive term “lumbopelvic pain” (LPP).

In global studies from Europe, the Americas, and Asia, 40–70% of pregnant women have reported LPP in pregnancy, [5–7] with half or more of those reporting impairments in daily functioning [6, 7] and others reporting related work loss [8, 9]. Pregnant women with LPP may more frequently request labor induction and caesarean, [10] which has risk and resource implications [11]. Symptoms may persist several years postpartum for up to 25% of women [12, 13].

Owing to concerns over risks of even other-the-counter pain medications for the developing fetus [14–16], lower risk treatment alternatives, including acupuncture, have an important place among available treatment options. In Europe, 4–13% of women reportedly obtained acupuncture in pregnancy or birth [17, 18]. Similar percentages have been identified in the United States, and women cited back pain as a chief concern in seeking complementary health care [19, 20]. Although thousands of women are likely seeking acupuncture for LPP in pregnancy, research on treatment outcomes is sparse [21]. The few published controlled trials generally support that auricular and body acupuncture result in reduced pain [22–25], as did the one observational study we found [26]. As well, this treatment appears to be generally safe for women, the developing fetus, and neonates [27–29].

As research on acupuncture in pregnancy advances, field-based observational studies are needed and are valuable contributions to this emerging area of research [21]. Testing the safety and efficacy of complementary health treatments in “real world” settings is essential to fully understand their effects because clinic-based treatment approaches may differ from those applied in randomized clinical trials (RCTs) [30, 31]. Also in the field, patients may experience treatments with RCT-based efficacy evidence as less effective because their health profiles are often more complex than those of patients included in RCTs [30, 32, 33]. A more robust evidence base can help guide professionals such as specialized acupuncturists, midwives, physicians, and physiotherapists [19–21, 34–37] who either specialize or integrate acupuncture into their care of pregnant women [33]. In recognition of the need to examine treatment effects in the field, national organizations such as the US Center for Complementary and Integrative Health [38] have made field studies a research priority.

In sum, a clear case exists for observational studies to help build the evidence base on using acupuncture to treat LPP in pregnancy. Therefore, we focused this report on the treatment outcomes and adverse events (AEs) that women reported after receiving acupuncture for LPP appropriate for pregnancy [39] in a no-pay, hospital-based clinic in New Zealand.

Overview of a New Zealand maternity acupuncture clinic

In New Zealand, community-based maternity care is publicly supported for eligible women (i.e., low risk) New Zealand citizens and their partners [40]. For women presenting with low-risk pregnancies, the majority of lead maternity carers are midwives, and in response to anecdotal reports of benefits from a number of midwives who used acupuncture with pregnant patients, the second author (DB) implemented a maternity acupuncture service within a hospital (Hutt Valley) outpatient department in June, 2008. The service was also responsive to interest from a national professional school in providing 4th year students a hospital-based clinical learning experience supervised by licensed professionals. The hospital unit offered free treatment for pregnancy- and postnatal-related conditions two afternoons a week over a 30-week academic year. To the authors’ knowledge, this is the first and only acupuncture clinic of this type in New Zealand.

Materials and methods

Participants

Women who attended the clinic during calendar year 2015–2016 were the focus of this report. Of the total 255 women who attended the clinic, 144 (56.5%) were treated for LPP as their self-identified primary or secondary concern. As is shown in the participant flow chart, 63 (43.8%) women could not be included in the analysis because they did not receive a baseline assessment ($N = 2$, 1.4%), they did not complete their baseline assessment ($N = 20$, 13.9%), or they had only a single visit and were not provided a posttreatment assessment on the expectation that they would do so at a scheduled follow-up ($N = 41$, 28.5%). Therefore, we had complete data for 81, or 56.3%, of the original LPP patients. General demographics, parity, gestational age at treatment, and referral source are presented in Table 1.

Measures

LPP symptom change: We used the MYMOP [41], a self-report measure in which patients describe their problems in their own words and then rate the severity on a 0 (“as good as it could be”) to 6 (“as bad as it could be”) scale. Patients may add associated symptoms, related functional impairments, and may rate general well-being. Patients included in our analysis reported LPP as their primary symptom on the MYMOP.

Profile (symptom change) scores were calculated by subtracting the final (posttreatment) from the initial (pre-treatment) scores. Because pain is subjective, the clinical relevance or magnitude of patient-reported/perceived change is considered a more valuable measure than statistical significance. In the MYMOP, a one point (or greater) reduction has been established as the indicator of clinically meaningful change from the patient’s perspective [41]. The MYMOP profile score has been shown to be relevant in

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