Letters to the Editor

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Acupuncture for Chronic Back Pain: What Level of Evidence?

Original Article: Acupuncture for Pain

Issue Date: September 1, 2009

Available at: http://www.aafp.org/afp/2009/0901/p481.html

TO THE EDITOR: In the article on acupuncture for treatment of pain, the author states: "A common finding has been that both sham and actual acupuncture improve pain, and the differences between the treatments do not reach statistical significance." A 2009 trial drew the same conclusion: "Collectively, these recent trials provide strong and consistent evidence that real acupuncture needling using the Chinese meridian system is no more effective for chronic back pain than various purported forms of sham acupuncture."[1]

Consistent evidence from randomized controlled trials has demonstrated that acupuncture is no better than the placebo sham acupuncture. Yet, the author asserts that the use of acupuncture for treatment of back pain is backed by level "A" evidence, defined as "consistent, good-quality patient-oriented evidence." In an online comment to an article in *BMJ,* Dr. Colquhoun stated: "Such is the delusional nature of much alternative medicine that when the test is failed, the conclusion isn't that the treatment doesn't work, but that the test doesn't work and must be replaced with one that is easier to pass (until such time as you get the answer you wanted in the first place)."[2]

In a desire to present information regarding treatments designated as complementary and alternative medicine (CAM), the editors of *American Family Physician* seem willing to suspend the usual criteria for evidence-based medicine, without explicitly stating that good scientific research somehow should not apply to CAM. Family physicians were among the first practitioners to embrace evidence-based medicine. We should not be the first to reject it when it gives the "wrong" answers, no matter how a therapy is labeled.

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Author disclosure: Nothing to disclose

REFERENCES

1. Cherkin DC, Sherman KJ, Avins AL, et al. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. *Arch Intern Med.* 2009;169(9):858-866.
2. Colquhoun D. (2009, September 2) If your treatments can't pass the test, the test must be wrong. Message posted to: http://www.bmj.com/cgi/eletters/339/sep01_2/b3335#219673.

IN REPLY: As I attempted to briefly summarize in the article, research on acupuncture is difficult. An excellent resource on acupuncture research is the book *Acupuncture Research: Strategies for Establishing an Evidence Base.*[1] Most research protocols standardize acupuncture therapy in a way that does not mirror the usual practice of acupuncture, which is individualized based on many factors (e.g., Chinese rather than Western medicine diagnosis; acupuncturists' training and experience). For many pain problems, it is not unusual for nontraditional modern acupuncture techniques such as percutaneous nerve stimulation and intramuscular stimulation (sometimes referred to as "dry needling") to be combined with, or used instead of, traditional "Qi-moving" acupuncture treatment. Sham acupuncture usually involves skin puncture with acupuncture needles at locations different from standard acupuncture. Because the mechanisms of acupuncture are not well understood, sham treatments that include skin puncture may be more active than intended by the investigators. Examples of improved methods of sham acupuncture that do not involve skin puncture exist,[2] but have not been widely used. Therefore, it is not surprising that many studies find that both sham and standard acupuncture benefit patients. In most of these studies, standard acupuncture effects are greater than sham ▶

acupuncture effects, but the difference between standard and sham acupuncture may not reach statistical significance. Given these and other limitations of research methods, it is difficult to interpret single studies, and therefore I emphasized reviewing meta-analyses and systematic reviews of multiple studies.

Level A evidence can come from one or more randomized controlled trials or from meta-analyses or systematic reviews of available RCTs and other studies. In the case of acupuncture for low back pain, I believed that the meta-analysis[3] and Cochrane review[4] that I cited in the article met this standard. In the meta-analysis, for the primary outcome of short-term relief of chronic pain, acupuncture was found to be significantly more effective than sham treatment, standardized mean difference, 0.54 (95% confidence interval [CI], 0.35 to 0.73; seven trials), and no additional treatment, standardized mean difference, 0.69 (CI, 0.40 to 0.98; eight trials). The plain language summary of the Cochrane review states: "For chronic low-back pain, results show that acupuncture is more effective for pain relief than no treatment or sham treatment, in measurements taken up to three months."[4]

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REFERENCES

1. MacPherson H, Hammerschlag R, Lewith G, Schnyer R, eds. *Acupuncture Research: Strategies for Establishing an Evidence Base.* Edinburgh: Churchill Livingstone/Elsevier; 2007:261.
2. Martin DP, Sletten CD, Williams BA, Berger IH. Improvement in fibromyalgia symptoms with acupuncture: results of a randomized controlled trial. *Mayo Clin Proc.* 2006;81(6):749-757.
3. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain [published correction appears in *Ann Intern Med.* 2005;142(11):950-951]. *Ann Intern Med.* 2005;142(8):651-663.
4. Furlan AD, van Tulder MW, Cherkin DC, et al. Acupuncture and dry needling for low back pain. *Cochrane Database Syst Rev.* 2005;(1):CD001351.

EDITOR'S NOTE: According to a survey conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics, nearly one half of adults have used CAM during their lifetime.[1] The intent of *American Family Physician*'s CAM series is not to further endorse the clearly prevalent use of CAM therapies and modalities, but rather to inform physicians about the therapies their patients may be using and the evidence behind them. We hold CAM reviews to the same standard of evidence labeling as other reviews. In Dr. Kelly's article, references 9 through 15, which supported the use of acupuncture in back pain, included several RCTs, systematic reviews, and a meta-analysis, which would warrant an evidence level A for any review article. Although Dr. Kelly discusses the controversy over sham acupuncture in his article, including a footnote in the Strength of Recommendation Taxonomy (SORT) table about the insufficient difference between traditional and sham therapies would have been a key clarification. Regardless, if a patient asks me if acupuncture provides pain relief for back pain, my answer will still be "yes."

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REFERENCE

1. Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary and alternative medicine use among adults: United States, 2002. *Adv Data.* 2004;343:1-19.

HIV Testing: Removing Barriers Can Lead to Earlier Detection and Reduced Transmission

Original Article: Applying HIV Testing Guidelines in Clinical Practice

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TO THE EDITOR: I was pleased to see the article by Dr. Mahoney and colleagues regarding the application of the Centers for Disease Control and Prevention (CDC) human immunodeficiency virus (HIV) testing guidelines in clinical practice, which were first released in September 2006. Routine opt-out HIV testing was recommended after repeated studies showed that risk-based screening failed to identify a significant number of adults with HIV infection (20 to 25 percent), and that patients continue to present in advanced stages of disease despite the availability of multiple effective HIV therapies.[1]

Unlike the American Congress of Obstetricians and Gynecologists and the American College of Physicians, the American Academy of Family Physicians (AAFP) has yet to endorse the CDC guidelines. The AAFP cites level C evidence based on the U. S. Preventive Services Task Force (USPSTF) 2005 statement on HIV screening, which states that the USPSTF makes no recommendation for or against routine screening in patients who are not at increased risk of infection.[2] Physicians who provide care to a large number of patients with HIV infection are constantly reminded of the many missed opportunities to diagnose patients at an early stage of this disease because their clinician did not perceive them to be "at risk." My hope is that the AAFP and the USPSTF will reevaluate newer evidence regarding HIV screening in adults and ultimately endorse routine opt-out testing as the standard of care. ▶

Historically, written informed consent has been a major barrier to HIV testing. This is slowly changing, and there are now only five states that require this before testing is performed.[3] Dr. Mahoney and colleagues also cite a lack of reimbursement as a barrier to testing. Fortunately, since their article was published, the Centers for Medicare and Medicaid Services has approved coverage for HIV screening, noting that they will cover screening tests for "persons who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors."[4]

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REFERENCES

1. Gostin LO. HIV screening in health care settings: public health and civil liberties in conflict? *JAMA.* 2006;296(16):2023-2025.
2. U.S. Preventive Services Task Force. Screening for HIV. Rockville, Md.: Agency for Healthcare Research and Quality; July 2005. http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm. Accessed April 12, 2010.
3. National HIV/AIDS Clinicians' Consultation Center. State HIV Testing Laws: Compendium of 2010 State Testing Laws. http://www.nccc.ucsf.edu/consultation_library/state_hiv_testing_laws/. Accessed June 29, 2010.
4. Jacques LB, Syrek Jensen T, Salive ME, Larson W, Schott L. Coverage decision memorandum for screening for the human immunodeficiency virus (HIV) infection. December 8, 2009. http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=229. Accessed April 12, 2010.

IN REPLY: The differences between the AAFP/USPSTF recommendations for risk-based HIV screening and the CDC recommendations for routine (universal) HIV screening are described in several previous family medicine articles.[1-3] Our article tried to emphasize that increased testing to identify patients who are unaware of their HIV status is essential, regardless of which recommendations are followed.

As Dr. Kirchner points out in his letter, the barrier of requiring written informed consent for HIV testing has diminished substantially. Currently, only five states (Massachusetts, Michigan, Nebraska, New York, and Pennsylvania) require written informed consent per the Compendium of 2010 State HIV Testing Laws. Some of these states, however, have large numbers of persons with HIV infection and, presumably, large numbers of persons with undiagnosed HIV infection.

Inconsistent reimbursement for HIV screening by public and private insurers continues to be a major barrier. The Centers for Medicare and Medicaid Services memorandum mentioned by Dr. Kirchner included the approval of reimbursement for HIV tests performed in patients who request the test, but do not declare risk factors.[4] This, however, is still considered risk-based (not routine) testing. Routine testing is designed to screen even those who do not identify themselves as being at risk of HIV infection. Even so, this benefit only applies to Medicare patients. A higher percentage of patients at risk of HIV infection are Medicaid patients. Although federal law permits, but does not require, state Medicaid programs to cover routine HIV screening, it is ultimately the prerogative of states to provide that coverage, and many state Medicaid programs have not opted to do so.[5] Mandating coverage of routine screening would require Congress to change Medicaid law, or states to pass legislation, requiring all insurers to cover routine HIV testing, as California did in 2008.[6]

The reasons persons do not get tested for HIV are complex. Recognizing the central role of primary care, the CDC has launched a new initiative, called *HIV Screening. Standard Care.* (http://www.cdc.gov/hiv/testing/HIVStandardCare/), aimed at internists and family physicians. The common goal of this program, as well as the various differing recommendations, is to encourage primary care physicians to implement broader HIV testing, engage newly identified patients in potentially lifesaving care, and prevent further HIV transmission.

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REFERENCES

1. Campos-Outcalt D. Time to revise your HIV testing routine. *J Fam Pract.* 2007;56(4)283-284.
2. Rodnick JE. The CDC and USPSTF recommendations for HIV testing. *Am Fam Physician.* 2007;76(10):1456, 1459.
3. Kirchner JT. It's time to normalize testing for HIV [letter]. *Am Fam Physician.* 2007;76(10):1459, 1462.
4. Jacques LB, Syrek Jensen T, Salive ME, Larson W, Schott L. Coverage decision memorandum for screening for the human immunodeficiency virus (HIV) infection. December 8, 2009. http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=229. Accessed April 12, 2010.
5. Centers for Medicare & Medicaid Services. Dear State Health Official [letter]. June 24, 2009. http://www.cms.gov/SMDL/downloads/SHO062409.pdf. Accessed June 29, 2010.
6. California Legislature—2007-08 Regular Session. AB 1894 (Ca 2008). http://www.chbrp.org/docs/index.php?action=read&bill_id=45&doc_type=1. Accessed June 29, 2010. ■