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PERSPECTIVE

Pragmatic Use of Acupuncture in a Neurology Practice: Experience in an Outpatient Veterans Administration Neurology Clinic

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ABSTRACT

Introduction: There is a need for nonopioid alternatives for treating pain. Acupuncture is one such modality. However, institutional resistance to the use of acupuncture is common in the Veterans Administration.
Objective: The goal of this article is to lay out the reasoning for integrating acupuncture within the VA as well as in general practice so as to be able to relieve patients' pain quickly.
Conclusions: Among the medical specialties, neurology is particularly suited to lead the way in incorporating acupuncture into daily practice. Aggressive training of physicians of at least basic acupuncture skills should be encouraged. The use of acupuncture as part of pain-control planning should be considered with more of a sense of urgency.

Keywords: neurology, Battlefield Acupuncture, pain management, peripheral neuropathy

INTRODUCTION

There are more than 3000 years of experience with using acupuncture for pain control.[1] In this article, the 28-month experience of a neurologist treating patients in an outpatient Department of Veterans Affairs (VA) clinic is shared. The United States is dealing with an opioid-use crisis that dovetails with a crisis of access to health care. Aggressive training of physicians in at least basic acupuncture skills should be encouraged. This would increase availability of a nonopiate pain treatment option. In 2017, from the Durham VA Medical System alone, there were 2946 referrals to community providers for acupuncture among 2135 patients at an estimated cost of $1,712,974.55.* All medical providers should be trained in simple acupuncture techniques. The use of acupuncture as part of pain-control planning should be considered with more of a sense of urgency. Among the medical specialties, neurology is particularly suited to be a leader in incorporating acupuncture into daily practice. To paraphrase the teachings of the Rebbe Menachem Mendel Schneerson, ''anything worth doing is worth doing now.''[2]

*Corporate data warehouse, data extracted from the VA computerized patient record system.

EXPERIENCE

Following completion of a 300-hour training course in medical acupuncture in September 2015, the first author presented his credentials to his facility's professional standards board, and 3 months later received privileges to include acupuncture treatments in the practice. Since then he has completed nearly 2000 treatments (often, more than 1 treatment is provided during a single visit). From his own neurology practice, the first author treats patients whom he believes would benefit from acupuncture therapy. These are patients he knows and for whom he believes he has an understanding of the mechanisms of their injuries and causes

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of their pain. After neurologic consultations, he also treats patients from referring physicians who wish to find a nonpharmaceutical option for relief of their patients' pain.

Treatments often include a combination of auricular treatments, alone or in conjunction with local body treatments, Chinese Scalp Acupuncture, periosteal stimulation, or other acupuncture techniques. The LPN assigned to the first author's neurology clinic remains in the room with him when a patient has described active pain during the nurse intake interview. While the author takes the patient's history and performs a neurologic examination, the LPN pulls up, from the electronic medical record, an acupuncture procedure consent. The author finishes his consultation, discusses a plan with the patient, and, when appropriate, offers an acupuncture treatment. In addition to a neurologic consultation, he enters an acupuncture procedure note into the medical record on a previously prepared template. If more extensive treatment or repeated treatments are warranted, the patient is booked to return to the author's clinic for that purpose.

Over the course of a 30-year career in neurology, the first author had lost enthusiasm for treating patients in pain, as he had little to offer other than yet another manipulation of the medication *du jour*. Now, it is more common than uncommon for a patient he sees who might be in the throes of a headache—even a migraine with nausea, vomiting, and photo and phono phobia—to leave a visit smiling and free of the headache. Patients receiving Botox® (botulinum toxin) for chronic migraine every 12 weeks often experience a recurrence of migraines a few weeks before the next Botox treatment is due. Yet, acupuncture during this same time period—including Battlefield Acupuncture (BFA)—is most often effective for providing headache relief. Cervicogenic- and temporomandibular joint–related headaches are particularly responsive to acupuncture with cervical percutaneous electrical nerve stimulation treatment and local treatment that involves piquiring GB 2, GB 7, GB 14,*Tai Yang*, GV 24, and GV 24.5. It has been fascinating to watch patients with phantom-limb pain describe the perception of a distorted, mangled, painful phantom extremity shrink in size over minutes, simultaneously with a resolution of the associated intense discomfort using an inverse–contralateral treatment.

With great success, KB-2[†] treatment reduces the intensity of painful peripheral neuropathy-related pain for many patients for days and weeks at a time. Countless patients with chronic neck or low-back pain present anticipating referral for yet another therapy program that involves weeks of waiting for an appointment in yet another clinic staffed by providers who do not know these patients, to whom they will, once again, have to explain their histories and describe their pain. It is gratifying to have those same patients leave the neurology clinic appointment with markedly reduced pain, all for the price of relatively little effort on the first author's part.

DISCUSSION

In a 2016 editorial, Niemtzow et al.[3] stated that ''new 'integrative medicine' techniques must be chosen and implemented wisely and well. Effective modalities will gain increased acceptance if the underlying mechanisms can be conveyed and understood.'' Research into the mechanisms of action of acupuncture should continue and be supported. However, the widespread use of acupuncture as an adjunctive option for pain control should not be contingent on a consensus of how acupuncture works. Acute and chronic pain—including from migraine and other headache syndromes, and spine and extremity conditions—can often be relieved within minutes through appropriate use of acupuncture. Institutional resistance to the use of acupuncture is common in the VA, often because of concerns about sanctioning the use of a treatment that many people assume works through a placebo effect. Because the mechanism of a placebo effect might not be understood does not mean that there is not a neurochemical explanation for the occurrence of the phenomenon. There is evidence that some acupuncture techniques might be effective for pain control because the treatment stimulates endorphin release.[4] Perhaps characterizing acupuncture therapy for pain as an ''endorphin release treatment'' might make its use more palatable to skeptics.

Increasing the availability of acupuncture should be approached aggressively. The BFA protocol is taught in a 4-hour course. A more comprehensive 8-hour auricular acupuncture curriculum has been developed.[‡] Unfortunately, the experience of many if not most acupuncture-trained providers in the VA system is that it takes months between the time training has been completed before the credentialing and privileging process is completed. Until then, the newly trained providers might not use the skills they have learned—and the enthusiasm to do so dwindles rapidly. A program called Acupuncture Training Across Clinical Settings (ATACS) was established in April 2013 to promote the use of acupuncture in the VA and the Department of Defense (DoD).[§] A Joint Initiative Fund (JIF) between the VA and DoD was established to fund the ATACS. The first author had the good fortune to be trained through

[†]KB-2 is a treatment during which the tip of a long acupuncture needle is inserted into the interosseous membrane between the tibia and fibula; the exposed end of the needle is activated manually by rapidly flicking it, creating a vibration in the membrane; a good response on part of the patient is a pleasant feeling of warmth spreading from the needle tip to encompass the foot.

[‡]Helms JM. ACUS foundation, personal communication 2017.

[§]Samueli Institute, Alexandria, VA. ATACS: Results and Evaluations. October 2016.

this program in 2015 in a 300-hour medical acupuncture course. Most states allow physicians to practice medical acupuncture under the scope of a medical license with appropriate training (usually 300 hours split between didactic and hands-on skills training). Approximately 80 VA physicians received similar training through the JIF.**

When there is a reasonable likelihood that a patient's pain might be reduced—or even relieved altogether—in an ideal setting, treatment options should be offered immediately. One voiced criticism is that paying the salary of a neurologist or other physician to perform acupuncture treatments is a misuse of funds and an inappropriate use of time when a clinic staffed by licensed acupuncturists could perform the same treatment at a lower cost. That is possibly a viewpoint to consider regarding ongoing care, but there is no justification to make a patient wait perhaps a few more weeks to be established with another clinic and another provider in order to begin experiencing life with less pain. The current nationwide situation regarding pain control should be addressed with the same sense of urgency when working in an emergency room or in a battlefield setting. It is distressing to hear repeated platitudes for physicians to band together to fight the opioid crisis and to use nonopioid alternatives for pain control when acupuncture options that each physician should be equipped to provide are gathering dust on the shelf. The opioid crisis will only end by offering nonpharmaceutical treatment of pain aggressively by every provider at every visit.

CONCLUSIONS

Easily and quickly learned and delivered, simple, safe, inexpensive, and effective acupuncture techniques may be used as nonopiate pain treatments. Taking only a few minutes to perform, an auricular acupuncture treatment such as BFA may be offered and provided at the time of initial patient presentation. Several pain conditions commonly seen in a general neurology practice are particularly responsive to acupuncture. Patient and provider satisfaction are powerful motivating factors to promote auricular acupuncture training (4 or 8 hours) aggressively to all medical providers. Neurology training programs should include the full scope of medical acupuncture training. Acupuncture skills should be a core competency required of all neurologists in a general practice.

AUTHOR DISCLOSURE STATEMENT

No competing financial interests exist.

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