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Acupuncture for acute hordeolum

Ke Cheng[1], **Andrew Law**[2], **Menghu Guo**[1], **L. Susan Wieland**[3], **Xueyong Shen**[4], and **Lixing Lao**[5]

[1]School of Acupuncture-Moxibustion and Tuina, Shanghai University of Traditional Chinese Medicine, Shanghai, China

[2]Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA

[3]Center for Integrative Medicine, University of Maryland School of Medicine, Baltimore, Maryland, USA

[4]School of Acupuncture-Moxibustion and Tuina, Shanghai University of Traditional Chinese Medicine, Shanghai Research Center of Acupuncture & Meridians, Shanghai Key Laboratory of acupuncture mechanism and acupoint function, Shanghai, China

[5]School of Chinese Medicine, The University of Hong Kong, Hong Kong, China

Abstract

Background—Hordeolum is an acute, purulent inflammation of the eyelid margin usually caused by obstructed orifices of the sebaceous glands of the eyelid. The condition, which affects sebaceous glands internally or externally, is common. When the meibomian gland in the tarsal plate is affected, internal hordeolum occurs, while when the glands of Zeis or Moll associated with eyelash follicles are affected, external hordeolum, or stye occurs. The onset of hordeolum is usually self limited, and may resolve in about a week with spontaneous drainage of the abscess. When the condition is severe, it can spread to adjacent glands and tissues. Recurrences are very

Contact address: Xueyong Shen, School of Acupuncture-Moxibustion and Tuina, Shanghai University of Traditional Chinese Medicine, Shanghai Research Center of Acupuncture & Meridians, Shanghai Key Laboratory of acupuncture mechanism and acupoint function, 1200, Cailun RD, Shanghai, 201203, China. snowysh@hotmail.com.

CONTRIBUTIONS OF AUTHORS

KC and XS conceived and designed the topic; KC, AL, and MG contribut ed to the writing of the review; all of the authors commented on drafts of the protocol and assisted in preparing responses to the Cochrane Eyes and Vision editorial base and peer review comments.

KC and MG screened titles and abstracts and full-text reports and extracted and entered data.

KC and AL prepared the 'Summary of findings' tables and applied the GRADE approach.

XS and LL assessed the adequacy of the acupuncture administered.

DECLARATIONS OF INTEREST

KC: teaches and do research on acupuncture at a traditional Chinese medicine institution.

AL: none known.

MG: teaches and practices acupuncture at a traditional Chinese medicine institution.

LSW: none known.

XS: teaches and practices acupuncture at a traditional Chinese medicine institution.

LL: teaches and practices acupuncture at a traditional Chinese medicine institution.

DIFFERENCES BETWEEN PROTOCOL AND REVIEW

Instead of "We will assess studies for which the randomization methods are not clearly described and for which author contact details could not be located, or for which the authors did not respond to interview requests as 'Studies awaiting classification"' as set forth in the protocol, we assigned these studies to 'excluded studies.'

common. As long as an internal hordeolum remains unresolved, it can develop into a chalazion or generalized eyelid cellulitis. Acupuncture is a traditional Chinese medical therapy aimed to treat disease by using fine needles to stimulate specific points on the body. However, it is unclear if acupuncture is an effective and safe treatment for acute hordeolum.

Objectives—The objective of this review was to investigate the effectiveness and safety of acupuncture to treat acute hordeolum compared with no treatment, sham acupuncture, or other active treatment. We also compared the effectiveness and safety of acupuncture plus another treatment with that treatment alone.

Search methods—We searched CENTRAL, Ovid MEDLINE, Ovid MEDLINE In-Process and Other Non-Indexed Citations, Ovid MEDLINE Daily, Ovid OLDMEDLINE, Embase, PubMed, Latin American and Caribbean Health Sciences Literature Database (LILACS), three major Chinese databases, as well as clinical trial registers all through 7 June 2016. We reviewed the reference lists from potentially eligible studies to identify additional randomised clinical trials (RCTs).

Selection criteria—We included RCTs of people diagnosed with acute internal or external hordeola. We included RCTs comparing acupuncture with sham acupuncture or no treatment, other active treatments, or comparing acupuncture plus another treatment versus another treatment alone.

Data collection and analysis—We used standard methodological procedures used by Cochrane.

Main results—We included 6 RCTs with a total of 531 participants from China. The mean age of the participants ranged from 18 to 28 years. Four RCTs included participants diagnosed with initial acute hordeolum with a duration of less than seven days; one RCT included participants diagnosed with initial acute hordeolum without specifying the duration; and one RCT included participants with recurrent acute hordeolum with a mean duration of 24 days. About 55% (291/531) of participants were women. Three RCTs included participants with either external or internal hordeolum; one RCT included participants with only external hordeolum; and two RCTs did not specify the type of hordeolum. Follow-up was no more than seven days after treatment in all included RCTs; no data were available for long-term outcomes. Overall, the certainty of the evidence for all outcomes was low to very low, and we judged all RCTs to be at high or unclear risk of bias.

Three RCTs compared acupuncture with conventional treatments. We did not pool the data from these RCTs because the conventional treatments were not similar among trials. Two trials showed that resolution of acute hordeolum was more likely in the acupuncture group when compared with topical antibiotics (1 RCT; 32 participants; risk ratio (RR) 3.60; 95% confidence interval (CI) 1.34 to 9.70; low-certainty of evidence) or oral antibiotics plus warm compresses (1 RCT; 120 participants; RR 1.45; 95% CI 1.18 to 1.78; low-certainty of evidence). In the third trial, little or no difference in resolution of hordeolum was observed when acupuncture was compared with topical antibiotics plus warm compresses (1 RCT; 109 participants; RR 1.00; 95% CI 0.96 to 1.04; low-certainty of evidence). One RCT mentioned adverse outcomes, stating that there was no adverse event associated with acupuncture.

Three RCTs compared acupuncture plus conventional treatments (two RCTs used topical antibiotics and warm compresses, one RCT used topical antibiotics only) versus the conventional treatments alone. One of the three RCTs, with very low-certainty evidence, did not report the resolution of acute hordeolum; however, it reported that acute hordeolum relief might be higher when acupuncture was combined with conventional treatments than with conventional treatments alone group (60 participants; RR 1.80; 95% CI 1.00 to 3.23). Pooled analysis of the remaining two RCTs, with low-certainty evidence, estimated resolution of acute hordeolum was slightly higher in the combined treatment group compared with the conventional treatment alone group at 7-day follow-up (210 participants; RR 1.12; 95% CI 1.03 to 1.23; $I^2 = 0\%$). None of the three RCTs reported adverse outcomes. Among the included RCTs, four participants, two from the acupuncture plus conventional treatments group and two from the conventional treatments alone group, withdrew due to exacerbation of symptoms.

Authors' conclusions—Low-certainty evidence suggests that acupuncture with or without conventional treatments may provide short-term benefits for treating acute hordeolum when compared with conventional treatments alone. The certainty of the evidence was low to very low mainly due to small sample sizes, inadequate allocation concealment, lack of masking of the outcome assessors, inadequate or unclear randomization method, and a high or unreported number of dropouts. All RCTs were conducted in China, which may limit their generalizability to non-Chinese populations.

Because no RCTs included a valid sham acupuncture control, we cannot rule out a potential expectation/placebo effect associated with acupuncture. As resolution is based on clinical observation, the outcome could be influenced by the observer's knowledge of the assigned treatment. Adverse effects of acupuncture were reported sparsely in the included RCTs, and, when reported, were rare. RCTs with better methodology, longer follow-up, and which are conducted among other populations are warranted to provide more general evidence regarding the benefit of acupuncture to treat acute hordeolum.

PLAIN LANGUAGE SUMMARY

Acupuncture for acute hordeolum (stye)

What is the aim of this review?—The aim of this Cochrane review was to compare the benefits and harms of acupuncture versus conventional treatments used for treating acute hordeolum (stye).

Key messages—Acupuncture, either alone or alongside conventional treatments, may increase the chance of hordeolum getting better (low-certainty evidence). There is a lack of information on adverse effects. Studies that have a longer follow-up and a more diverse study population are needed to tell if acupuncture really is a beneficial treatment.

What was studied in this review?—Hordeolum the medical name for a stye. It is a small painful lump, or abscess, on the inside or outside of the eyelid. Typically, hordeolum goes away on its own within a week or so. However, serious cases of hordeolum can infect nearby tissues and glands. This infection can result in serious eyelid conditions.

Common treatments for hordeolum include warm compresses applied at home, available over-the-counter topical medications and lid scrubs, antibiotics or steroids, lid massages, and other treatments. In East Asian countries, acupuncture is used to treat hordeolum, either alone or alongside these conventional treatments. According to the philosophy of traditional Chinese acupuncture, energy circulates in 'meridians' (or channels) through the body. When the meridian energy circulation is blocked by pathogenic factors, pain or ill health occurs. The way to restore health is to use fine needles to stimulate the appropriate acupuncture points in the body. The purpose of this review was to compare acupuncture with no treatment, sham acupuncture, or conventional treatment to determine which treatment works best for acute hordeolum.

What are the main results of the review?—We found six studies from China, including a total of 531 people. The follow-up was no more than seven days after treatment. Three studies compared acupuncture with different conventional treatments and three studies compared acupuncture plus conventional treatments versus conventional treatments alone.

The review showed that:

- Acupuncture may increase the chance of the hordeolum getting better compared with using antibiotics and/or warm compresses (low-certainty evidence).
- Acupuncture combined with antibiotics and/or warm compresses compared with antibiotics and/or warm compresses may slightly increase the chance of the hordeolum getting better (low-certainty evidence).
- It is uncertain whether there are any harmful effects of acupuncture for hordeolum.

How up-to-date is this review?—Cochrane researchers searched for studies that had been published up to 7 June 2016.

SUMMARY OF FINDINGS FOR THE MAIN COMPARISON *[Explanation]*

Acupuncture compared with topical antibiotics for acute hordeolum

Patient or population: people with acute hordeolum
Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist
Intervention: acupuncture
Comparison: topical antibiotics

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Assumed risk	Corresponding risk				
	Conventional treatment (topical antibiotics)	Acupuncture				
Resolution of hordeolum at short term Follow-up: 4 days	250 per 1,000	**900 per 1,000** (335 to 1,000)	**RR 3.60** (1.34 to 9.70)	32 (1 study)	⊕⊕◯◯ **low**[1,2]	

Acupuncture compared with topical antibiotics for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture** **Comparison: topical antibiotics**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (topical antibiotics)	**Acupuncture**				
Resolution of hordeolum between 8 and 30 days after diagnosis, or that closest to 14 days after diagnosis	Not reported					
Participants who required surgical incision and drainage after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the occurrence of a chalazion after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the recurrence of a hordeolum within six months and one year	Not reported					
Participants with a secondary hordeolum during or after the treatment period and seven days after diagnosis	Not reported					
Adverse effects Follow-up: 4 days	Not reported					

*The basis for the **assumed risk** is the control group risk. The **corresponding risk** (and its 95% CI) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; **RR:** risk ratio

GRADE Working Group grades of evidence
High-certainty: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate-certainty: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low-certainty: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low-certainty: We are very uncertain about the estimate.

[1] Downgraded one level for risk of bias, as the study was at unclear risk of selection bias due to unclear description of the random sequence generation and allocation assignment, and also was at unclear risk of performance, reporting and other biases.

[2] Downgraded one level for imprecision (wide confidence interval).

BACKGROUND

Description of the condition

A hordeolum is a common disorder of the eyelid (Ehrenhaus 2012; Skorin 2002). It is an acute, red, painful, and localized inflammation with abscess formation, usually caused by obstructed orifices of the sebaceous glands of the eyelid. The infected sebaceous glands can be the meibomian gland in the tarsal plate (internal hordeolum) or the glands of Zeis or Moll associated with eyelash follicles (external hordeolum, or stye) (Barza 1983; Chern 2011; Gerstenblith 2012; Grant 2013; Mueller 2008; Peralejo 2008; Tasman 2013). An episode is usually self limited and may resolve in about a week with spontaneous drainage of the abscess (Chern 2011; Deibel 2013; Lederman 1999; Peralejo 2008; Skorin 2002; Wald 2007). When the condition is severe, it may be accompanied by fever or chills (Garrity 2007), and the inflammation can spread to adjacent glands and tissue (Skorin 2002). Recurrences are also common (Garrity 2007; Skorin 2002). An untreated internal hordeolum may develop into a chalazion or generalized eyelid cellulitis (Bessette 2012; Chern 2011; Deibel 2013; Ehrenhaus 2012; Gerstenblith 2012; Lederman 1999).

Hordeola are among the most common eyelid lesions seen in clinical practice, but no data are available on the precise incidence and prevalence (Ehrenhaus 2012). Hordeola are more common in adults than in children, but are not limited to any age, gender, or racial group (Ehrenhaus 2012; Lindsley 2013). The usual cause of an acute hordeolum is the *Staphylococcus aureus* bacterium (Bessette 2012; Chern 2011; Ehrenhaus 2012; Gerstenblith 2012; Mueller 2008; Peralejo 2008; Tasman 2013; Wald 2007). Recent studies have reported that about 90% of hordeola are associated with *S aureus* (Bharathi 2010), and that 24% of methicillin-resistant *S aureus* ocular infections are eyelid disorders including hordeola (Hsiao 2012). Individuals with poor eyelid hygiene, inflammatory diseases of the eyelid (e.g. blepharitis, meibomitis, or rosacea), and stress, or who are experiencing hormonal changes are at greater risk of developing a hordeolum than the general population (Bessette 2012; Grant 2013).

Conservative treatment measures include warm compresses several times a day, which may help drainage. Topical antibiotics also may be prescribed by the ophthalmologist. If these fail, incision and drainage may be performed, and systemic antibiotics are indicated (Chern 2011; Gerstenblith 2012; Lindsley 2013; Mueller 2008; Peralejo 2008; Tasman 2013).

Description of the intervention

According to the philosophy of traditional acupuncture, energy (i.e. *qi* and blood in Traditional Chinese Medicine (TCM)) circulates in 'meridians' located throughout the body. When the meridian energy circulation is blocked by certain pathogenic factors, pain or ill health will result. The way to restore energy circulation, health, and balance is to stimulate the appropriate combination of the estimated 400 traditional meridian acupuncture points in the body by acupuncture (WHO 1991). Acupuncture is effective for many kinds of eye diseases, according to TCM literature and clinical practice (Cheng 2010; Shen 2007). The authors of a recent systematic review found some limited evidence for the effectiveness of acupuncture in the treatment of dry eye syndrome (Lee 2011). Authors of systematic reviews have drawn no conclusions regarding the benefits of acupuncture for other eye disorders, such as glaucoma and myopia, mainly due to sparse data (Law 2013; Wei 2011). In a broader sense, acupuncture includes several techniques (e.g. traditional body needling, electroacupuncture, moxibustion, etc.) (WHO 2003). According to TCM principles, redness, swelling, and pain of the eyelid are caused by pathogenic "wind heat" causing *qi* and blood stagnation at the eyelid (Shen 2007). Hence, the acupoints with the action of clearing heat are usually used in treatment (i.e. stimulated by either needle insertion, acupressure, or bloodletting). Bloodletting with a three-edged needle is used more often than other acupuncture techniques to clear "heat" and remove *qi*/blood stagnation, and is thus the most common technique used in treating an acute hordeolum. Bloodletting for the treatment of an acute hordeolum involves the withdrawal of a very small quantity of blood; the most commonly used points are Erjian (EX-HN6) at the ear apex and Taiyang (EX-HN5) in the temporal region (Shen 2007).

How the intervention might work

As of yet, few studies have explored the mechanism of acupuncture treatment for acute hordeola. The mechanism of acupuncture treatment that has been studied most widely is for analgesia. Different mechanisms of action have been proposed for the biological basis of acupuncture analgesia. For example, animal studies have provided evidence that acupuncture stimulates the release of neurochemicals (usually endogenous opioids or serotonin) (Han 1980; Han 2003). 'Gate theory' is another proposed mechanism for acupuncture analgesia (i.e. stimulation by the acupuncture needles may suppress the nervous system pathway of nociceptive pain signals) (Man 1972). Some studies have found that acupuncture may affect the autonomic nervous system, which regulates involuntary body functions such as immune reactions and the processes that govern blood pressure, blood flow, and body temperature (Moffet 2006). Basic science studies among animals also show that acupuncture suppresses inflammation (Li 2008), the main symptom of an acute hordeolum.

Why it is important to do this review

The most current Cochrane review of interventions for acute internal hordeola found no randomised controlled trials (RCTs) evaluating the use of conventional treatments, including heated compresses and antibiotics or steroids, or the use of surgical interventions, such as incision and curettage (Lindsley 2013). However, during the literature search for the Lindsley 2013 review, a number of RCTs on acupuncture for acute hordeola were identified,

but were excluded as they were outside the scope of that review. This review addressed acupuncture for this condition. Acupuncture has been demonstrated to be a safe treatment with a very low risk of serious side effects (Cherkin 2003; Xu 2013). Four large, prospective surveys of acupuncture practitioners confirmed that serious adverse events are uncommon after acupuncture (MacPherson 2001; Melchart 2004; White 2001; Witt 2009). Acupuncture for the treatment of an acute hordeolum is relatively convenient, usually administered in three or fewer sessions, with each session lasting for a few minutes only, which supports its use as an outpatient procedure.

Given the existing evidence, a systematic review of the effectiveness and safety of acupuncture for the treatment of acute hordeola is highly desirable to inform policy and practice.

OBJECTIVES

The objective of this review was to investigate the effectiveness and safety of acupuncture for the treatment of acute hordeolum compared with no treatment, sham acupuncture, or other active treatment. We also compared the effectiveness and safety of acupuncture plus another treatment with that treatment alone.

METHODS

Criteria for considering studies for this review

Types of studies—We included RCTs, as specified in the published protocol for this review (Cheng 2014).

Authors of a study reported in 2009 indicated that most of the reports of RCTs in Chinese journals lacked an adequate description of randomization, and that more than 90% of them did not adhere to accepted methodology for randomization (Wu 2009). Based on a more recent study, only 1 of 14 Chinese language studies labeled as RCTs could be confirmed to be a controlled trial (Adams 2012). We thus contacted the authors of RCTs published in Chinese journals that claimed to have randomised participants but did not report details about the randomization methods in order to determine whether they used appropriate methods for random sequence generation. The interview questions were administered over the telephone or email and adapted from the survey developed by Wu 2009. We also contacted the authors of non-Chinese language reports of studies labeled as RCTs whenever their reports did not include details about randomization methods.

Types of participants—We included RCTs that had enrolled participants with acute hordeola, including acute internal hordeola and acute external hordeola (styes). We excluded RCTs of people with chronic hordeola or chalazia.

Types of interventions—We included RCTs evaluating acupuncture, a key component of TCM. Acupuncture methods used for treating acute hordeola include but are not limited to body needle insertion on acupoints; bloodletting at Erjian (EX-HN6) at the ear apex or at Taiyang (EX-HN5) at the temporal region; pricking or bloodletting at Arshi points (i.e.

reflection spots that are small, pink pustules or papules) at the regions of the thoracic vertebra between the scapulae; acupressure; and electroacupuncture. We excluded RCTs of laser acupuncture and noninvasive electrostimulation, as these interventions do not involve the mechanical stimulation of acupoints. We excluded RCTs of injection acupuncture, which involves the injection of a herb, drug, or vitamin at the acupuncture point, because the effect may result from the herb, drug, or vitamin rather than the mechanical stimulation of acupuncture. However, as acupuncture is often accompanied by moxibustion (a TCM therapy that consists of warming specific points on the body by burning dried mugwort (moxa)), we included RCTs using moxibustion as a co-intervention with acupuncture.

We included RCTs that compared acupuncture with no treatment (observation), sham acupuncture, or an active conventional treatment (e.g. hot or warm compresses, lid scrubs, antibiotics, or steroids). We also included RCTs that compared acupuncture plus another treatment versus that treatment alone. The adjuvant treatments could be either those used in Western medicine (e.g. antibiotics) or TCM (e.g. intake of traditional Chinese herbal medicine), as long as the adjuvant treatment was given to both the acupuncture and control groups.

Types of outcome measures

Primary outcomes: The primary outcome for this review was the proportion of participants with complete resolution of an acute hordeolum no more than seven days after diagnosis. In this review, when we refer to early resolution of acute hordeolum, we mean resolution of acute hordeolum within seven days after diagnosis. The resolution of an acute hordeolum refers to the complete resolution of the redness, swelling, and pain at the eyelid, or drainage of the abscess with complete healing of the sore. We chose the time closest to seven days after diagnosis, or as defined by each individual RCT, since most cases of hordeola resolve on their own after seven days (between one and two weeks). If an RCT reported complete early resolution of a hordeolum at multiple time points, we chose the outcome measured at the time point closest to seven days after diagnosis.

Secondary outcomes

- Proportion of participants with complete late resolution of the hordeolum. When we refer to late resolution of hordeolum, we mean the resolution of hordeolum between 8 and 30 days after diagnosis, or that closest to 14 days after diagnosis.
- Proportion of participants who required surgical incision and drainage after the treatment period or seven days after diagnosis.
- Proportion of participants experiencing the occurrence of a chalazion after the treatment period or seven days after diagnosis.
- Proportion of participants experiencing the recurrence of a hordeolum within six months and one year (we defined a recurrence as any hordeolum that occurs after one month from the resolution of the initial hordeolum and at any location on the same eyelid, or as defined by the included RCT).

- Proportion of participants with a secondary hordeolum during or after the treatment period and seven days after diagnosis (we defined a secondary hordeolum as a hordeolum that occurs within one month of the initial hordeolum and at a different location than the initial hordeolum, or as defined by the included RCT).

Adverse outcomes: We documented all adverse effects of treatments such as conjunctivitis, eye irritation, discoloration of the eyelid, conjunctiva, or lens damage, corneal damage, and others reported by the included RCTs. We were unable to assess adverse outcomes at longer-term follow-up, as none of the included RCTs reported adverse events between 8 and 30 days after diagnosis.

Economic outcomes: None of the included RCTs reported economic outcomes. If more RCTs are added in future updates of this review, we plan to include economic outcome data, such as cost of acupuncture, as reported in the included RCTs at longer-term follow-up (i.e. 8 to 30 days and closest to 14 days after diagnosis).

Search methods for identification of studies

Electronic searches—We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (which contains the Cochrane Eyes and Vision Trials Register 2016, Issue 6), Ovid MEDLINE, Ovid MEDLINE In-Process and Other Non-Indexed Citations, Ovid MEDLINE Daily, Ovid OLDMEDLINE (January 1946 to June 2016), Embase (January 1980 to June 2016), Latin American and Caribbean Health Sciences Literature Database (LILACS) (1982 to June 2016), PubMed (1948 to June 2016), the *meta*Register of Controlled Trials (*m*RCT) (www.controlled-trials.com) (last searched May 2014), ClinicalTrials.gov (www.clinicaltrials.gov), and the World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP) (www.who.int/ictrp/search/en). We also searched the Chinese databases SinoMed (previously called the Chinese Biomedical Database, www.sinomed.ac.cn/), Chinese National Knowledge Infrastructure (www.cnki.net/), and VIP Database for Chinese Technical Periodicals (lib.cqvip.com/). We did not use any date or language restrictions in the electronic searches for trials. We last searched the electronic databases on 7 June 2016.

See: Appendices for details of search strategies for CENTRAL (Appendix 1), MEDLINE (Appendix 2), Embase (Appendix 3), LILACS (Appendix 4), PubMed (Appendix 5), Chinese CNKI Database (Appendix 6), SinoMed Database (Appendix 7), Chinese VIP Database (Appendix 8), *m*RCT (Appendix 9), Clinical-Trials.gov (Appendix 10), and the ICTRP (Appendix 11).

Searching other resources—We reviewed the reference lists from potentially eligible studies to identify additional RCTs. We sought to obtain information about any ongoing study by contacting the study investigators.

Data collection and analysis

Selection of studies—Two review authors independently screened all records identified by the electronic and other searches. According to the inclusion criteria, each review author assessed titles and abstracts as 'definitely relevant,' 'possibly relevant,' or 'definitely not relevant.' We resolved any discrepancies by discussion and then obtained the full-text reports assessed by each author as 'definitely relevant' or 'possibly relevant.' Two review authors independently labeled each study as 'include,' 'awaiting classification,' or 'exclude.' For studies classified as 'awaiting classification,' we requested additional information from study investigators to make the judgement. We resolved any disagreements by discussion and documented the reasons for exclusion of studies in the Characteristics of excluded studies table. We gave study investigators two weeks to respond to our requests and documented any communication we had with them. If we did not hear back from the study investigators within two weeks, we used the available information to make our judgement.

Data extraction and management—Two review authors independently extracted data using the data extraction forms created by Cochrane Eyes and Vision. We pilot-tested the extraction forms on a sample of included RCTs prior to the full extraction in order to ensure a similar extraction approach across review team members. For each included RCT, we extracted data on study design, participant characteristics, interventions, outcomes, and other relevant information. One review author entered the data into Review Manager 5 (RevMan 2014), and a second review author verified the data entry. Discrepancies between review authors were resolved by discussion.

When reported data were incomplete or ambiguous, we emailed or called the study author to request additional information or clarification. Whenever we did not receive a response in two weeks, we included the data as available in the study report.

Adequacy of treatment: Two experienced content experts in acupuncture independently assessed the adequacy of the acupuncture administered in the RCTs (XS and LL). Both content experts teach and practice acupuncture at a Traditional Chinese Medicine institution (Declarations of interest). They assessed six aspects of the acupuncture intervention for adequacy:

1. choice of acupuncture points;
2. total number of sessions;
3. treatment duration;
4. treatment frequency;
5. acupuncture technique; and
6. acupuncturist's experience (Manheimer 2010).

If a sham intervention was implemented, the likelihood of the sham intervention having physiological activity was assessed using an open-ended question on the data abstraction form, such as "what are your opinions or comments about the sham or placebo intervention?". The control groups were also assessed for: 1) appropriateness of sham/

placebo intervention; and 2) adequate number of sessions/dose (for the active treatments used in control group). The acupuncturists were provided with the section of each publication that described the acupuncture and control procedures, so that their assessments would not be influenced by the results of the RCTs. To assess the masking of the acupuncturist to the study publication and results, we asked the assessors to guess the identity of each RCT being assessed. The acupuncturists assessed adequacy independently and reached consensus by discussion.

Assessment of risk of bias in included studies—Two review authors independently assessed the risk of bias in the included RCTs based on the methods provided in Chapter 8 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011a). We used the following seven separate criteria:

- sequence generation;
- allocation concealment before randomization;
- masking of participants and study personnel;
- masking of outcome assessors;
- incomplete outcome data and percentage of missing data among treatment groups;
- selective outcome reporting; and
- other potential sources of bias.

For ’other potential sources of bias,’ we assessed the following items:

- groups similar at baseline with regard to the most important prognostic indicators;
- co-interventions avoided or similar between intervention groups;
- timing of the outcome assessment similar in all intervention groups;
- funding sources and conflicts of interest; and
- acceptable compliance with standards of all interventions.

We judged compliance to be acceptable when participants in the acupuncture group had received at least one session of acupuncture, as our two acupuncture adequacy assessors judged one session of acupuncture treatment to be enough for acute hordeolum. Our two acupuncture adequacy assessors judged that if the participants in the conventional group had used antibiotic or warm compresses daily for three days, this would be acceptable compliance, as they considered three days of conventional treatment to be common and enough for acute hordeolum.

We assessed the risk of bias for different outcomes based on whether masking of outcome assessors was performed and whether complete outcome data were consistently reported. For each RCT included in the review, we judged each criterion to have ’low,’ ’unclear,’ or ’high’ risk of bias. When the information available in the published RCT reports was

inadequate to assess risk of bias, we contacted the study investigators for clarification. If they did not respond within two weeks, we classified the RCT on the basis of the available information. We resolved discrepancies through discussion and by consulting a third review author when necessary.

Measures of treatment effect—Data analyses followed guidelines set forth in Chapter 9 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Deeks 2011). We presented dichotomous data as risk ratios with 95% confidence intervals. We reported outcomes based on the follow-up times in each RCT. Planned dichotomous outcome measures included the proportion of participants with the following outcomes: complete early and late resolution of a hordeolum; requirement for surgical incision and drainage after treatment; development of a chalazion after treatment; development of recurrent hordeola or secondary hordeola. When the RCT investigators reported improvement of acute hordeolum on an ordinal scale, such as 'resolved,' 'improved,' or 'ineffective,' we categorized the 'improved' and 'ineffective' groups as 'unresolved,' thus creating a dichotomous measure, 'resolved' and 'unresolved.' Planned continuous outcome measures included economic outcomes when data were available.

Unit of analysis issues—The unit of analysis for this review was the individual participant. The principle of acupuncture treatment for an acute hordeolum is to clear pathogenic "wind heat" in the body, which is a systemic effect and usually not limited to a specific eye (Cheng 2010; Shen 2007). We excluded any RCT in which participants had one eye randomised to acupuncture and the other eye to control.

Dealing with missing data—We conducted analyses by including RCTs with missing data according to the guidelines in Chapter 16 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2011b). We conducted the primary analysis based on the data as reported. Whenever information was missing or unclear in the report, we contacted the primary study investigators. If they did not respond within two weeks, we used the data available in the study reports and described the limitations of this method when applicable. We did not impute data in primary analysis.

We imputed data in sensitivity analysis to assess how sensitive results were to reasonable changes in the assumptions being made (see Sensitivity analysis).

Assessment of heterogeneity—We evaluated clinical and methodological homogeneity based on similarity of study characteristics, participant inclusion/exclusion criteria, and primary and secondary outcomes. We assessed statistical heterogeneity using the I^2 statistic and considered an I^2 statistic of 50% or more as indicating substantial statistical heterogeneity. We also examined the Chi^2 statistic for heterogeneity and the degree of overlap in confidence intervals of included studies. Poor overlap suggests the presence of heterogeneity.

Assessment of reporting biases—We did not generate a funnel plot to assess the potential for publication bias, since we included fewer than 10 RCTs in the meta-analysis.

We assessed the possibility of selective outcome reporting for each study as part of the 'Risk of bias' assessment.

Data synthesis—When there was no important clinical or methodological heterogeneity among studies, we summarized the results of the studies in meta-analyses. We used a random-effects model in each analysis because of the expected heterogeneity among the studies' acupuncture protocols and settings. When there were data from fewer than three RCTs, we used the fixed-effect model. We did not summarize results with meta-analysis when substantial statistical heterogeneity (I^2 greater than 50%) was present, instead reporting individual RCT results only.

Subgroup analysis and investigation of heterogeneity—The type of hordeolum was the only prespecified characteristic for subgroup analysis. We did not conduct subgroup analysis due to lack of data. For the comparisons of acupuncture versus conventional treatments, each comparison included only one RCT, and none of the RCTs reported the outcomes separately by the type of hordeolum (Li 2006a; Xu 2004; Zhang 1991). For the comparison of acupuncture plus conventional treatments versus conventional treatments alone, one RCT reported the outcomes for internal hordeolum (Qi 2013), and two RCTs did not report the outcomes separately for each type of hordeolum (Pang 2009; Yang 2014).

Sensitivity analysis—If possible in future updates, we plan to conduct sensitivity analyses for meta-analysis with greater than 10% of participants in the meta-analysis had missing primary outcome data. We plan to impute data for the proportion of participants with complete resolution for the missing participants.

1. impute data using the proportion of participants with complete resolution observed in the control group;
2. impute data using the proportion of participants with complete resolution among completers in the separate groups (i.e. the acupuncture group and the control group, respectively); and
3. assume that all randomised participants with missing outcomes achieved a complete resolution (Higgins 2011b).

However, imputation does not reduce the risk of attrition bias, but we hope to assess if our meta-analysis results might change using the above three methods of imputation. For our assessment of risk of attrition bias, please see Incomplete outcome data (attrition bias).

Also, due to the small number of included studies, we did not conduct planned sensitivity analyses to evaluate whether any meta-analysis result that was statistically significant remained statistically significant when meta-analysis was restricted only to RCTs judged to be at low risk of bias for the following domains: allocation concealment before randomization; masking of participants (for sham- versus non-sham-controlled trials); masking of outcome assessors; and completeness of outcome data. We planned to conduct sensitivity analyses to determine the impact of studies assessed as having inadequate treatment compliance by excluding RCTs judged as 'inadequate' and 'unclear' on each of the six aspects of adequacy of treatment.

Summary of findings—We have presented a 'Summary of findings' table of relative and absolute risks based on the risks across intervention groups from the included studies. Two review authors independently graded the overall certainty of the evidence for each outcome using the GRADE classification (www.gradeworkinggroup.org).

We assessed the certainty of evidence for each outcome as "high," "moderate," "low," or "very low" according to the following criteria as described in Chapter 12 of the *Cochrane Handbook for Systematic Reviews of Interventions* (Schünemann 2011).

1. High risk of bias among included studies.
2. Indirectness of evidence.
3. Unexplained heterogeneity or inconsistency of results.
4. Imprecision of results (i.e. wide confidence intervals).
5. High probability of publication bias.

RESULTS

Description of studies

Results of the search—We identified 1418 titles and abstracts through electronic database searches as of 7 June 2016 (Figure 1). After removing duplicate records, 830 titles and abstracts remained. We excluded 763 records and assessed 64 studies (from 67 full-text reports) for eligibility. We excluded 58 studies (60 reports) and documented reasons for exclusion (see Characteristics of excluded studies). We included 6 RCTs (7 reports), with a total of 531 participants (Li 2006a; Pang 2009; Qi 2013; Xu 2004; Yang 2014; Zhang 1991). We found no clinical trial protocol for any of the included trials; one RCT was linked to a clinical trial registry record (Qi 2013). We have documented 364 studies from Chinese literature databases that we excluded after reviewing the titles and abstracts in Appendix 12.

Included studies—We included 6 RCTs (531 participants) identified through the electronic searches and judged by the review authors to meet eligibility criteria (see Characteristics of included studies). We contacted the investigators of five of the included RCTs to obtain relevant information about randomization, allocation concealment, masking of outcome assessment, dropouts, and funding source for their studies (Li 2006a; Pang 2009; Qi 2013; Yang 2014; Zhang 1991). We could not reach the investigator of the remaining included RCT to obtain further information (Xu 2004).

Settings and participants: Table 1 includes an overview description of RCT characteristics. All RCTs included primarily young participants, with mean ages ranging from 18 to 28 years; a majority (55%) were women. Three RCTs included participants with either external or internal hordeolum (Li 2006a; Yang 2014; Zhang 1991), one RCT included participants with only external hordeolum (Qi 2013), and two RCTs did not specify the type of hordeolum (Pang 2009; Xu 2004). Four RCTs included participants with initial acute hordeolum with a duration of no more than 3 to 6 days (Li 2006a; Qi 2013; Xu 2004; Zhang 1991), 1 RCT included participants with recurrent acute hordeolum with a mean duration of

24 days from its first onset (Yang 2014), and 1 RCT did not specify the duration of the hordeolum (Pang 2009).

Interventions and comparisons: Three RCTs compared acupuncture with other conventional treatments: oral antibiotics plus warm compresses in Li 2006a, topical antibiotics plus warm compresses in Xu 2004, and topical antibiotics only in Zhang 1991. Three RCTs compared acupuncture plus conventional treatments versus the conventional treatments alone: topical antibiotics only in Pang 2009 and topical antibiotics plus warm compresses in Qi 2013 and Yang 2014.

Acupuncture intervention: All RCTs used a fixed formula for point selection. Four RCTs used bloodletting methods at the ear apex, that is ipsilateral or bilateral Erjian (EX-HN6) (Pang 2009; Qi 2013; Xu 2004; Yang 2014). Two RCTs used needling acupuncture at other body points such as points at upper back (i.e. Du 13 and Du 12) or at upper arm (i.e. ipsilateral LI 14) (Li 2006a; Zhang 1991).

Outcomes

Primary outcome: All included RCTs except one, Pang 2009, reported the proportion of participants with complete early resolution of a hordeolum within seven days of diagnosis. Pang 2009 reported the proportion of participants with relief of hordeolum within seven days. For all the included RCTs, the day of diagnosis was also the day of the initial treatment.

Secondary outcomes: None of the RCTs reported the proportion of participants with complete late resolution of the hordeolum or other secondary outcomes specified for this review.

Adverse effects: Only one RCT mentioned adverse effects as an outcome (Qi 2013).

Excluded studies—The Characteristics of excluded studies table lists the 58 studies we excluded after full-text review, including reasons for exclusion. The interventions used in 11 studies did not meet our inclusion criteria for type of intervention. Thirteen studies were controlled trials, and randomization was not mentioned. Thirteen studies claimed to have randomised participants, however improper methods for random sequence generation were used. Another 21 studies were reported to be RCTs, but did not report the randomization methods used, and the study investigator could not be reached or did not respond to our request for additional information.

Risk of bias in included studies

'Risk of bias' assessments for individual RCTs are described in detail in the Characteristics of included studies tables and are summarized in Figure 2.

Allocation—Overall, we judged all RCTs except Li 2006a and Zhang 1991 to be at high risk of selection bias. When the RCT was judged to be at high risk of bias due to either

inappropriate random sequence generation or allocation concealment, the overall risk of selection bias was high.

For random sequence generation, while all included RCTs reported either using a random number table or statistical software to generate the random sequence of assignments, we suspect one of the RCTs (Xu 2004) might have used inappropriate methods; this is because the number of participants randomised to each arm was very different (67 vs. 42). We judged the other RCT (Zhang 1991) to be as unclear risk on random sequence generation, because the investigator stated the participants were randomly allocated at a ratio of 2:1, but the power and sample size calculations was not provided, and the actual allocation ratio was not equal to 2:1 (20 vs 12). Also, the Zhang 1991 RCT did not describe in detail how the random sequence allocated the intervention. The remaining four RCTs were judged to be at low risk of bias.

Consequently, we judged four RCTs to be at high risk of selection bias due to inadequate allocation concealment (Pang 2009; Qi 2013; Xu 2004; Yang 2014;). . Allocation concealment may have been breached as the number of participants in each group was very different for one RCTs (Xu 2004). Pang 2009 did not use any method to conceal allocations. Yang 2014 used a random allocation table, but the table was kept unsealed. For Qi 2013, the outpatient nurse had prepared and distributed the sequentially numbered envelops containing the treatment assignment, therefore may be aware of the allocation sequence. We judged the risk of selection bias for the remaining two RCTs as unclear (Li 2006a; Zhang 1991). Li 2006a used numbered, opaque, sealed envelopes, but the investigator was unable to recall whether the envelopes had been opened sequentially. Zhang 1991 RCT stated to have used sequentially numbered, opaque, sealed envelopes, which were opened sequentially, however, allocation concealment may have been breached because the actual allocation ratio was not equal to 2:1 as originally set, and the investigator also did not describe in detail how the random sequence were allocated the intervention.

Masking (performance bias and detection bias)—Three RCTs compared acupuncture alone with other conventional treatments (Li 2006a; Xu 2004; Zhang 1991); the other three RCTs evaluated acupuncture plus active conventional treatments versus conventional treatments alone (Pang 2009; Qi 2013; Yang 2014). Masking of participants was not possible in any of the six RCTs, however, we are not sure whether the resolution of a hordeolum could be influenced by knowing the treatment group assignment, therefore we judged them all to be at unclear risk of performance bias. In addition, we judged two RCTs in which masking of outcome assessors was not employed to be at high risk of detection bias (Li 2006a; Yang 2014). We judged the three RCTs in which outcome assessors had been masked to treatment at low risk of detection bias (Pang 2009; Qi 2013; Zhang 1991). We judged Xu 2004 to have an unclear risk of detection bias, as the investigators did not describe outcome assessment sufficiently to judge masking.

Incomplete outcome data—We judged four RCTs to be at low risk of attrition bias (Qi 2013; Xu 2004; Yang 2014; Zhang 1991). We assessed Li 2006a to be at unclear risk of attrition bias, and Pang 2009 to be at high risk of attrition bias. Due to the short duration of the treatment and follow-up, there were very few dropouts for all RCTs except Pang 2009,

which reported more than 20% dropouts in each group. Three RCTs reported no dropouts (Xu 2004; Yang 2014; Zhang 1991), and Qi 2013 reported two dropouts. Li 2006a reported a very small number of dropouts, however the exact number was not noted.

Selective reporting—Study protocols or trial registry records were not available for any of the six included RCTs. Even thought data for all outcomes specified in the methods sections of the RCT reports were included in the results sections, we judged all RCTs to be at unclear risk of reporting bias. Also, none of the included studies reported power or sample size calculations for their primary outcome.

Other potential sources of bias—Poor reporting limited our ability to identify other potential sources of bias. While all included RCTs reported similar baseline characteristics of intervention groups compared, study investigators did not report whether the participants were permitted to use or had used other treatments while enrolled in the RCT or whether the study investigators discouraged participants from using other treatments while in the study. No investigator reported information regarding compliance of the participants to the treatment regimens; it is unclear whether all participants completed the assigned study intervention. All RCTs assessed our primary outcome at the same time point for each group. The range of the follow-up time points was from 1 to 7 days. Four RCTs were reported to be unfunded (Li 2006a; Qi 2013; Yang 2014; Zhang 1991), while the other two RCTs did not mention funding (Pang 2009; Xu 2004). In none of the included RCTs did the investigators declare potential conflicts of interest; however, five RCTs (Li 2006a; Pang 2009; Xu 2004; Yang 2014; Zhang 1991) were conducted at institutes or departments of traditional Chinese medicine, where there may be an interest in showing acupuncture works and, therefore, may be considered a potential source of bias. Overall, we judged all RCTs to be at unclear risk of other biases.

Effects of interventions

See: **Summary of findings for the main comparison** Acupuncture compared with topical antibiotics for acute hordeolum; **Summary of findings 2** Acupuncture compared with topical antibiotics plus warm compresses for acute hordeolum; **Summary of findings 3** Acupuncture compared with oral antibiotics plus warm compresses for acute hordeolum; **Summary of findings 4** Acupuncture plus conventional treatments compared with conventional treatments alone for acute hordeolum

We judged all six included RCTs to have used appropriate ’choice of acupuncture points,’ ’treatment duration,’ ’total number of sessions,’ ’treatment frequency,’ and ’needling technique.’ We judged acupuncturists in five RCTs to have adequate ’training and experience’; Xu 2004 did not report the relevant information. We judged the number of sessions and dose of active treatment used in all control groups as adequate, except for one RCT (Pang 2009). See Table 2.

Acupuncture versus conventional treatments—Three RCTs with a total of 261 participants compared acupuncture with different conventional treatments (e.g. topical or oral antibiotics plus warm compresses) (Li 2006a; Xu 2004; Zhang 1991). As the

conventional treatments were dissimilar and the outcomes were heterogeneous across trials, we have reported the data from these three RCTs individually. Two RCTs were conducted in traditional Chinese medicine hospital (Xu 2004; Zhang 1991), while one RCT was conducted in the outpatient clinic of the acupuncture department (Li 2006a).

Complete early resolution of hordeolum: One RCT compared acupuncture with topical antibiotics only (Zhang 1991). Low-certainty evidence may show that early resolution of acute hordeolum was higher in the acupuncture group as compared with the conventional treatment group. Eighteen out of 20 participants (90%) in the acupuncture group experienced early resolution compared with 3 out of 12 participants (25%) in the conventional treatment group (32 participants; risk ratio (RR) 3.60 (95% confidence interval (CI) 1.34 to 9.70). We downgraded the evidence to low for imprecision because the confidence interval was wide and very small sample size (downgraded one level) and for risk of bias as the study was at high risk of selection bias, and unclear risk of performance, reporting and other biases (downgraded one level) (see Summary of findings for the main comparison).

One RCT compared acupuncture with topical antibiotics plus warm compresses (109 participants) (Xu 2004). The low-certainty evidence showed all 67/67 (100%) participants in the acupuncture group resolved within seven days, compared with all 42/42 (100%) participants in the conventional treatment group (RR 1.00 (95% CI 0.96 to 1.04). We downgraded the evidence to low for high risk of selection bias and unclear risk of performance, detection, attrition, reporting and other biases (downgraded two levels) (see Summary of findings 2).

The third RCT compared acupuncture with oral antibiotics plus warm compresses (Li 2006a). The low-certainty evidence showed that early resolution of acute hordeolum was higher in the acupuncture group than in the conventional treatment group: 55 out of 60 participants (92%) in the acupuncture group compared with 38 out of 60 participants (63%) in the conventional treatment group (120 participants; RR 1.45 (95% CI 1.18 to 1.78)). We downgraded the evidence to low for detection bias due to lack of masking outcome assessors, and unclear risk of detection, performance, attrition, reporting and other biases (downgraded two levels)(see Summary of findings 3).

Adverse outcomes: None of the three RCTs comparing acupuncture alone with conventional treatments reported on adverse outcomes.

Sensitivity analysis: We were unable to perform sensitivity analysis for Li 2006a because the exact number of dropouts was not provided. However, as the number was reported to be very small, and the effect size of the primary outcome was large, we assumed the impact of missing data was likely to be minimal.

Acupuncture plus conventional treatments versus conventional treatments alone—Three RCTs (270 participants) compared acupuncture plus conventional treatments versus conventional treatments alone (topical antibiotics, topical antibiotics and warm compresses, etc.). The conventional treatments were not acupuncture. Pang 2009 compared

acupuncture plus topical antibiotics with topical antibiotics alone. Qi 2013 and Yang 2014 compared acupuncture (blood-letting at ear apex) plus topical antibiotics and warm compresses with topical antibiotics and warm compresses alone. Two of the three RCTs were based in teaching units for Traditional Chinese Medicine where there might be an interested in showing acupuncture works (Pang 2009; Yang 2014).

Complete early resolution of hordeolum: Only two RCTs reported the proportion of participants with complete resolution of hordeolum (Qi 2013; Yang 2014). The pooled analyses of the two RCTs showed that resolution of acute hordeolum was higher in the acupuncture plus conventional treatments group compared with conventional treatment alone group (210 participants; RR 1.12 (95% CI 1.03 to 1.23); I^2 = 0%; see Figure 3; Analysis 2.1). However, we downgraded the evidence to low due to high risk of selection bias and detection biases, and unclear bias of performance, reporting and other biases (downgraded two levels) (see Summary of findings 4).

There was very low-quality evidence from the other RCT (60 participants) that the proportion of participants with relief of hordeolum symptoms was higher in the acupuncture plus conventional treatments group than in the conventional treatments group (60 participants; RR 1.80 (95% CI 1.00 to 3.23);) (Pang 2009). We could not pool the results from Pang 2009 with the other two RCTs (Qi 2013; Yang 2014), because Pang 2009 reported on a different outcome: reduced redness, swelling, and pain with relief of either itching or conjunctival congestion. We downgraded the evidence to very low because of indirectness of evidence, as the study reported relief of hordeolum symptoms compared with complete resolution (downgraded one level); and high risk of selection biases, and unclear risk of performance, reporting and other biases (downgraded two levels).

Adverse outcomes: Only one RCT reported on adverse outcomes (Qi 2013). Qi 2013 only collected information about adverse outcomes associated with acupuncture, such as hematoma and infection at the acupuncture site(s); no adverse events associated with acupuncture were reported to have been observed. Two participants, one in each group, withdrew from the study due to exacerbation of symptoms (enlarged area of redness and abscess).

Sensitivity analysis: Due to the very small numbers of participants with missing outcome data (less than 1% if 212 participants), we did not carry out any sensitivity analysis.

ADDITIONAL SUMMARY OF FINDINGS *[Explanation]*

Acupuncture compared with topical antibiotics plus warm compresses for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture** **Comparison: topical antibiotics plus warm com presses**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (topical antibiotics plus warm compresses)	**Acupuncture**				
Resolution of hordeolum at short term Follow-up: 7 days	1,000 per 1,000	**1,000 per 1,000** (960 to 1,000)	**RR 1.00** (0.96 to 1.04)	109 (1 study)	⊕⊕◯◯ **low**[1]	
Resolution of hordeolum between 8 and 30 days after diagnosis, or that closest to 14 days after diagnosis	Not reported					
Participants who required surgical incision and drainage after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the occurrence of a chalazion after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the recurrence of a hordeolum within six months and one year	Not reported					
Participants with a secondary hordeolum during or after the treatment period and	Not reported					

Acupuncture compared with topical antibiotics plus warm compresses for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture** **Comparison: topical antibiotics plus warm com presses**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (topical antibiotics plus warm compresses)	**Acupuncture**				
seven days after diagnosis						
Adverse effects Follow-up: 3 days	Not reported					

*The basis for the **assumed risk** is the control group risk. The **corresponding risk** (and its 95% CI) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; **RR:** risk ratio

GRADE Working Group grades of evidence
High-certainty: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate-certainty: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low-certainty: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low-certainty: We are very uncertain about the estimate.

[1]Downgraded two levels for risk of bias, as the study was at high risk of selection bias as randomization may have not been executed properly, and unclear risk of performance bias, detection bias, attrition bias, reporting bias and other biases.

Acupuncture compared with oral antibiotics plus warm compresses for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture** **Comparison: topical antibiotics plus warm com presses**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (oral antibiotics plus warm compresses)	**Acupuncture**				
Resolution of hordeolum at short term Follow-up: 3 days	633 per 1,000	**918 per 1,000** (747 to 1,000)	**RR 1.45** (1.18 to 1.78)	120 (1 study)	⊕⊕◯◯ **low** [1]	

Acupuncture compared with oral antibiotics plus warm compresses for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture** **Comparison: topical antibiotics plus warm com presses**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (oral antibiotics plus warm compresses)	**Acupuncture**				
Resolution of hordeolum between 8 and 30 days after diagnosis, or that closest to 14 days after diagnosis	Not reported					
Participants who required surgical incision and drainage after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the occurrence of a chalazion after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the recurrence of a hordeolum within six months and one year	Not reported					
Participants with a secondary hordeolum during or after the treatment period and seven days after diagnosis	Not reported					
Adverse effects Follow-up: 3 days	Not reported					

*The basis for the **assumed risk** is the control group risk. The **corresponding risk** (and its 95% CI) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; **RR:** risk ratio

GRADE Working Group grades of evidence
High-certainty: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate-certainty: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low-certainty: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low-certainty: We are very uncertain about the estimate.

[1] Downgraded two levels for risk of bias, as the study was at high risk of detection bias due to lack of masking of outcome assessors, and unclear risk of selection, performance, attrition, reporting, and other biases.

Acupuncture plus conventional treatments compared with conventional treatments alone for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture plus conventional treatment** **Comparison: conventional treatment alone**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (topical antibiotics and warm compresses)	**Acupuncture plus conventional treatment**				
Resolution of hordeolum at short term Follow-up: 6 ~ 7 days	**848 per 1000**	**950 per 1000** (882 to 1000)	**RR 1.12** (1.03 to 1.23)	210 (2 studies)	⊕⊕◯◯ **low**[1]	
Resolution of hordeolum between 8 and 30 days after diagnosis, or that closest to 14 days after diagnosis	Not reported					
Participants who required surgical incision and drainage after the treatment period or seven days after diagnosis	Not reported					
Participants experiencing the occurrence of a chalazion after the treatment period or seven days after diagnosis	Not reported					

Acupuncture plus conventional treatments compared with conventional treatments alone for acute hordeolum						
Patient or population: people with acute hordeolum **Settings: acupuncture clinics or ophthalmology clinics with acupuncture specialist** **Intervention: acupuncture plus conventional treatment** **Comparison: conventional treatment alone**						
Outcomes	**Illustrative comparative risks* (95% CI)**		**Relative effect (95% CI)**	**No of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Assumed risk	**Corresponding risk**				
	Conventional treatment (topical antibiotics and warm compresses)	**Acupuncture plus conventional treatment**				
Participants experiencing the recurrence of a hordeolum within six months and one year	Not reported					
Participants with a secondary hordeolum during or after the treatment period and seven days after diagnosis	Not reported					
Adverse effects Follow-up: 7 days	Only 1 randomised controlled trial reported adverse effects, finding no adverse events in acupuncture group. Local adverse events such as red, swollen, inflammation, or abscess at the area where the acupuncture was applied were absent in acupuncture group. 2 participants, 1 from each group, withdrew from the study due to exacerbation of symptoms (e.g. enlarged area of redness and abscess)					

*The basis for the **assumed risk** is the control group risk. The **corresponding risk** (and its 95% CI) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; **RR:** risk ratio

GRADE Working Group grades of evidence
High-certainty: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate-certainty: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low-certainty: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low-certainty: We are very uncertain about the estimate.

[1]Downgraded two levels for risk of bias, as both randomised controlled trials were at high risk of selection bias due to inadequate allocation concealment. One RCT (Yang 2014) was at high risk of detection bias due to inadequate masking of outcome assessor, Both RCTs were at unclear risk of performance, reporting, and other biases.

DISCUSSION

Summary of main results

Two RCTs suggest that acupuncture may be associated with greater benefit on resolution of acute hordeolum compared with topical antibiotics, in Zhang 1991, or oral antibiotics plus

warm compresses, in Li 2006a, within seven days after treatment, while a third RCT showed little or no difference in the resolution of acute hordeolum when acupuncture was compared with topical antibiotics plus warm compresses (Xu 2004). Three RCTs found that acupuncture plus conventional treatments may be associated with greater benefit of resolution or relief of acute hordeolum compared with conventional treatments alone at an early stage (no more than seven days after treatment). The inconsistency in the estimated effects from comparisons of acupuncture with conventional treatments might be due to slight differences in acupuncture methods or conventional treatments used. Reporting of adverse effects was infrequent and poor, as study investigators did not specify which adverse effects were collected.

Overall completeness and applicability of evidence

Overall, the evidence is limited, with only six RCTs of different active comparisons, small sample sizes, that are at high risk of bias, especially on the criteria of allocation concealment. Further more, except for one RCT, all the other RCTs were conducted at traditional Chinese medicine institute, which might be a conflict of interest. Also, all six RCTs were conducted in China, presumably among Chinese participants. This population characteristic may limit the general applicability of our results; although most people who seek acupuncture treatment may live in China or be of Chinese or East Asian descent. Although the available RCTs suggest there are benefits associated with acupuncture relative to conventional treatments or with acupuncture plus conventional treatments compared with conventional treatments alone, we could not preclude a potential expectation/placebo effect of acupuncture because we identified no RCT evaluating acupuncture compared with a valid sham control. However, the potential placebo effect is probably minor, because the resolution of an acute hordeolum, which is based on clinical observation, is unlikely to be influenced by participants' knowledge of the treatment received. However, failure to mask outcome assessors could have influenced conclusions regarding resolution.

We judged the six included RCTs to have used an adequate acupuncture treatment protocol, with bloodletting or body needling acupuncture for one to three sessions over no more than three days. Additionally, in the two RCTs comparing acupuncture plus conventional treatments versus conventional treatments alone, the bloodletting methods were applied by experienced ophthalmology technicians or nurses, but not specialized acupuncturists. Thus, due to the short duration of treatment and the simple method of bloodletting at the ear apex, this treatment seems to be applicable in current practice. However, as all RCTs were from China, the applicability of these methods to other countries is unknown.

Certainty of the evidence

We judged the overall quality of the evidence to be low to very low (Summary of findings for the main comparison; Summary of findings 2; Summary of findings 3; Summary of findings 4). The major reasons for downgrading the evidence included the risk of bias for the included RCTs (mainly risk of selection bias due to inadequate allocation concealment and randomization, risk of detection bias due to lack of masking of outcome assessors, and risk of attrition bias due to high or unreported numbers of dropouts, etc.) and small number of participants and events, which resulted in imprecise estimates of intervention effects.

Potential biases in the review process

Introduction of potential biases in the review process is unlikely due to the application of standard review methods, which included comprehensive searching, dual and independent data extraction, and masking of the acupuncture treatment adequacy assessors to the identities of the RCTs and interventionists. In addition, since all potentially eligible trials were published in Chinese language journals, we contacted the corresponding authors of all trials labeled as “randomised” to determine whether the investigators had actually used proper methods for random sequence generation.

Agreements and disagreements with other studies or reviews

This review complements the 2013 Cochrane review of interventions for acute internal hordeolum (Lindsley 2013), which investigated conventional non-surgical interventions (e.g. warm compresses, lid scrubs, antibiotics, or steroids) for acute internal hordeolum. The Lindsley 2013 review identified no RCTs evaluating the effectiveness of non-surgical interventions for the treatment of acute internal hordeolum; therefore, the authors “did not find any evidence for or against the effectiveness of non-surgical interventions for the treatment of hordeolum” (Lindsley 2013). Our systematic review includes six RCTs and provides low- to very low-certainty evidence, almost certainly due to bias, that acupuncture plus conventional treatments may be more effective than conventional treatments alone. Low-certainty evidence also shows acupuncture may be more effective than topical antibiotics. Whether acupuncture results in little or no difference in early resolution of acute hordeolum compared with topical antibiotics plus warm compresses is uncertain. During the review process, we had difficulty in identifying evidence, assessing and summarizing certainty, and addressing potentially rare serious adverse events. Our experiences were similar to those published elsewhere (Shekelle 2005).

AUTHORS’ CONCLUSIONS

Implications for practice

Patients should be informed that the currently available evidence does not provide any evidence as to whether acupuncture has specific benefits for treating acute hordeolum, due to the small size of the randomised controlled trials (RCTs) and the absence of sham-controlled RCTs. Low-certainty evidence suggest that acupuncture seems to have an additional benefit when used along with conventional treatments such as warm compresses and topical antibiotics. Our results are limited by the type of acupuncture used in the included trials; all trials supporting our results used blood-letting at the ear apex. In general, serious adverse events are rare after acupuncture (MacPherson 2001; Melchart 2004; White 2001; Witt 2009); however, as the reporting on adverse events was inadequate in the included RCTs, the safety of acupuncture in treating acute hordeolum is uncertain. Generally, acupuncture, especially the bloodletting method, should be used cautiously by people on anticoagulant therapy or who have a coagulation disorder. Patients would also need to consider costs, because acupuncture treatment often must be paid for out of pocket.

Implications for research

Randomized controlled trials with better methodology, standardized outcomes, and appropriate control groups are needed. Authors of future trials should assess the resolution of the hordeolum, using a physician as the outcome assessor who should be masked to the participant's treatment group. Additionally, the appropriate control group would include a valid sham acupuncture control (e.g. non-penetrating Streitberger sham needles placed far away from the true acupuncture points) (Streitberger 1998). Future RCTs should evaluate long-term outcomes such as the complete resolution of the hordeolum at 8 to 30 days and recurrence of hordeola at 6 months and 1 year. Future RCTs should also collect and report adverse events, especially adverse events related to acupuncture, which might be better detected by using a standard checklist or questionnaire (Chung 2015). In addition, since for most of the included RCTs reporting of details of trial methods (e.g. randomization, concealment, masking, and co-intervention) and other important information (e.g. registration, protocol, and funding) is lacking, the reporting of future RCTs should be improved by complying with the CONSORT (Schulz 2010), and Standards for Reporting Interventions in Controlled Trials of Acupuncture (STRICTA) statement (MacPherson 2010). Finally, if possible, the researchers should stratify results by different type of the hordeolum.

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APPENDICES

Appendix 1. CENTRAL search strategy

#1	MeSH descriptor: [Hordeolum] explode all trees
#2	(Hordeol* or stye or styes)
#3	MeSH descriptor: [Eye] explode all trees
#4	sty
#5	#3 and #4
#6	MeSH descriptor: [Meibomian Glands] explode all trees
#7	(Meibomian* adj3 (gland* or cyst* or infection* or inflammat*))
#8	(tarsal adj3 (gland* or cyst* or infection* or inflammat*))
#9	(palpebral adj3 (gland* or cyst* or infection* or inflammat*))
#10	(conjunctiv* adj3 (gland* or cyst*))
#11	(gland* adj5 (zeis* or Moll*))
#12	(lid* or eyelid* or “eye margin”) adj3 inflammat*
#13	(lid* or eyelid* or “eye margin”) adj3 infection*
#14	#1 or #2 or #4 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13
#15	MeSH descriptor: [Acupuncture] explode all trees
#16	MeSH descriptor: [Acupuncture Therapy] explode all trees
#17	MeSH descriptor: [Medicine, Chinese Traditional] explode all trees
#18	MeSH descriptor: [Bloodletting] explode all trees
#19	acupunctur*
#20	(meridian* or moxi*)
#21	(electrostimulat* or electroacupunctur*)
#22	(electro* next/1 (stimulat* or acupunctur*))
#23	acupoint*
#24	(erjian or taiyang or EX-HN6 or EX-HN5)

#25	body needl*
#26	(bloodletting or blood-letting)
#27	(Ear-apex or temporal region)
#28	qi
#29	((chinese near/3 medicin*) or TCM)
#30	#15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29
#31	#14 and #30

Appendix 2. MEDLINE Ovid search strategy

1.	Randomized Controlled Trial.pt.
2.	Controlled Clinical Trial.pt.
3.	(randomized or randomised).ab,ti.
4.	placebo.ab,ti.
5.	drug therapy.fs.
6.	randomly.ab,ti.
7.	trial.ab,ti.
8.	groups.ab,ti.
9.	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8
10.	exp animals/not humans.sh.
11.	9 not 10
12.	exp hordeolum/
13.	(Hordeol* or stye or styes).tw.
14.	sty.tw.
15.	exp eyes/
16.	14 and 15
17.	exp meibomian glands/
18.	(Meibomian* adj3 (gland* or cyst* or inflammat* or infection*)).tw.
19.	(tarsal adj3 (gland* or cyst* or inflammat* or infection*)).tw.
20.	(palpebral adj3 (gland* or cyst* or inflammat* or infection*)).tw.
21.	(conjunctiv* adj3 (gland* or cyst*)).tw.
22.	(gland* adj5 (zeis* or Moll*)).tw.

23. ((lid* or eyelid* or eye margin) adj3 inflammat*).tw.

24. ((lid* or eyelid* or eye margin) adj3 infection*).tw.

25. 12 or 13 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24

26. 11 and 25

27. exp Acupuncture/

28. exp Acupuncture Therapy/

29. exp Medicine, Chinese Traditional/

30. acupunctur*.tw.

31. (meridian* or moxi*).tw.

32. (electrostimulat* or electroacupunctur*).tw.

33. (electro* adj1 (stimulat* or acupunctur*)).tw.

34. acupoint*.tw.

35. exp Bloodletting/

36. (erjian or taiyang or EX-HN6 or EX-HN5).tw.

37. body needl*.tw.

38. (bloodletting or blood-letting).tw.

39. (Ear-apex or temporal region).tw.

40. qi.tw.

41. ((chinese adj3 medicin*) or TCM).tw.

42. or/27–41

43. 26 and 42

The search filter for trials at the beginning of the MEDLINE strategy is from the published paper by Glanville 2006.

Appendix 3. Embase.com search strategy

#1 'randomized controlled trial'/exp

#2 'randomization'/exp

#3 'double blind procedure'/exp

#4 'single blind procedure'/exp

#5 random*:ab,ti

#6 #1 OR #2 OR #3 OR #4 OR #5

#7 'animal'/exp OR 'animal experiment'/exp

#8	’human’/exp
#9	#7 AND #8
#10	#7 NOT #9
#11	#6 NOT #10
#12	’clinical trial’/exp
#13	(clin* NEAR/3 trial*):ab,ti
#14	((singl* OR doubl* OR trebl* OR tripl*) NEAR/3 (blind* OR mask*)):ab,ti
#15	’placebo’/exp
#16	placebo*:ab,ti
#17	random*:ab,ti
#18	’experimental design’/exp
#19	’crossover procedure’/exp
#20	’control group’/exp
#21	’latin square design’/exp
#22	#12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21
#23	#22 NOT #10
#24	#23 NOT #11
#25	’comparative study’/exp
#26	’evaluation’/exp
#27	’prospective study’/exp
#28	control*:ab,ti OR prospectiv*:ab,ti OR volunteer*:ab,ti
#29	#25 OR #26 OR #27 OR #28
#30	#29 NOT #10
#31	#30 NOT (#11 OR #23)
#32	#11 OR #24 OR #31
#33	’hordeolum’/exp
#34	hordeol*:ab,ti OR stye:ab,ti OR styes:ab,ti
#35	sty:ab,ti
#36	’eye’/exp
#37	#35 AND #36
#38	’meibomian gland’/exp
#39	(meibomian* NEAR/3 (gland* OR cyst* OR inflammat* OR infection*)):ab,ti

#40 (tarsal NEAR/3 (gland* OR cyst* OR inflammat* OR infection*)):ab,ti

#41 (palpebral NEAR/3 (gland* OR cyst* OR inflammat* OR infection*)):ab,ti

#42 (conjunctiv* NEAR/3 (gland* OR cyst*)):ab,ti

#43 (gland* NEAR/5 (zeis* OR moll*)):ab,ti

#44 ((lid* OR eyelid* OR 'eye margin') NEAR/3 inflammat*):ab,ti

#45 ((lid* OR eyelid* OR 'eye margin') NEAR/3 infection*):ab,ti

#46 #33 OR #34 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45

#47 'acupuncture'/exp

#48 'acupuncture needle'/exp

#49 'chinese medicine'/exp

#50 acupunctur*:ab,ti

#51 (electro* NEAR/1 (stimulat* OR acupunctur*)):ab,ti

#52 electrostimulat*:ab,ti OR electroacupunctur*:ab,ti

#53 acupoint*:ab,ti

#53 erjian:ab,ti OR taiyang:ab,ti OR EX-HN6:ab,ti OR EX-HN5:ab,ti

#55 'ear apex':ab,ti OR 'temporal region':ab,ti

#56 bloodletting:ab,ti OR 'blood letting':ab,ti

#57 (body NEXT/1 needl*):ab,ti

#58 meridian*:ab,ti OR moxi*:ab,ti

#59 qi:ab,ti

#60 (chinese NEAR/3 medicin*):ab,ti OR tcm:ab,ti

#61 #32 AND #46 AND #61

Appendix 4. LILACS search strategy

(Hordeol$ OR Orzuelo OR Terçol OR Stye$ OR MH:C01.252.354.400$ OR MH:C01.539.375.354.400$ OR MH: C11.294.354.400$ OR MH:C11.338.648$ OR Meibomian OR Tarsal OR Palpebral OR Conjunctiv$ OR Zeis$ OR Moll$ OR "Glándulas Tarsales" OR "Glândulas Tarsais" OR MH:A09.371.337.614$ OR MH:A10.336.827.600$) AND (Acupunctur$ OR MH:H02.004$ OR MH:HP3.018.069$ OR MH:E02.190.044$ OR Chinese Traditional Medicine OR TCM OR "Medicina China Tradicional" OR "Medicina Tradicional Chinesa" OR "Zhong Yi Xue" OR "Chung I Hsueh" OR MH:E02.190.488.585.520$ OR MH:I01.076.201.450.654.558.520$ OR Bloodletting OR Venodisección OR Sangria OR MH:E02.800.558.500$ OR Meridian$ OR moxi$ OR electrostimulat$ OR electroacupunctur$ OR electro-stimulat$ OR electro-acupunctur$ OR

acupoint$ OR erjian OR taiyang OR EX-HN6 OR EX-HN5 OR “body needling” OR bloodletting OR blood-letting OR Ear-apex OR “temporal region” OR qi)

Appendix 5. PubMed search strategy

#1 ((randomized controlled trial[pt]) OR (controlled clinical trial[pt]) OR (randomised[tiab] OR randomized[tiab]) OR (placebo[tiab]) OR (drug therapy[sh]) OR (randomly[tiab]) OR (trial[tiab]) OR (groups[tiab])) NOT (animals[mh] NOT humans[mh])

#2 (Meibomian*[tiab] AND (gland*[tiab] OR cyst*[tiab] OR inflammat*[tiab] OR infection*[tiab])) NOT Medlines[sb]

#3 (tarsal[tiab] AND (gland*[tiab] OR cyst*[tiab] OR inflammat*[tiab] OR infection*[tiab])) NOT Medline[sb]

#4 (palpebral[tiab] AND (gland*[tiab] OR cyst*[tiab] OR inflammat*[tiab] OR infection*[tiab])) NOT Medline[sb]

#5 (conjunctiv*[tiab] AND (gland*[tiab] OR cyst*[tiab])) NOT Medline[sb]

#6 (gland*[tiab] AND (zeis*[tiab] OR Moll*[tiab])) NOT Medline[sb]

#7 ((lid*[tiab] OR eyelid*[tiab] OR eye margin[tiab]) AND inflammat*[tiab]) NOT Medline[sb]

#8 ((lid*[tiab] OR eyelid*[tiab] OR eye margin[tiab]) AND infection*[tiab]) NOT Medline[sb]

#9 #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8

#10 acupunctur*[tiab] NOT Medline[sb]

#11 (meridian*[tiab] OR moxi*[tiab]) NOT Medline[sb]

#12 (electrostimulat*[tiab] OR electroacupunctur*[tiab] OR electro-stimulat*[tiab] OR electro-acupunctur*[tiab]) NOT Medline[sb]

#13 acupoint*[tiab] NOT Medline[sb]

#14 (erjian[tiab] OR taiyang[tiab] OR EX-HN6[tiab] OR EX-HN5[tiab]) NOT Medline[sb]

#15 body needl*[tiab] NOT Medline[sb]

#16 (bloodletting[tiab] OR blood-letting[tiab]) NOT Medline[sb]

#17 (Ear-apex[tiab] OR temporal region[tiab]) NOT Medline[sb]

#18 Qi[tiab] NOT Medline[sb]

#19 ((Chinese[tiab] AND medicin*[tiab]) OR TCM[tiab]) NOT Medline[sb]

#20 #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19

#21 #1 AND #9 AND #20

Appendix 6. Chinese CNKI Database search strategy

Strategy in Chinese phonetic alphabet (i.e., Pinyin):

(SU='Mai li zhong' or SU='Jian xian yan' or SU='Zhen yan') and (SU='Zhen ci' or SU='Zhen jiu' or SU='Fang xue' or SU='Ci luo' or SU='Er zhen' or SU='Ci xue' or SU='Tiao ci' or SU='Dian ci' or SU='Er ya' or SU='Er xue')

SU =subject, includes title, abstract and key words; FT=full text.

(SU= '麦粒肿' or SU= '睑腺炎' or SU= '针眼') and (SU= '针刺' or SU= '针灸' or SU= '放血' or SU= '刺络' or SU= '耳针' or SU= '刺血' or SU= '挑刺' or SU= '点刺' or SU= '耳压' or SU= '耳穴')

SU =subject 主题

Appendix 7. SinoMed Database search strategy

Strategy in Chinese phonetic alphabet (i.e., Pinyin):

(Mai li zhong OR Jian xian yan OR Zhen yan) AND (Zhen ci OR Zhen jiu OR Fang xue OR Ci luo OR Er zhen OR Ci xue OR Tiaoci OR Dian ci OR Er ya OR Er xue)

--- search in Que sheng (Que sheng includes title, MeSH, keywords, abstract, journal name)

(麦粒肿 or 睑腺炎 or 针眼) and (针刺 or 针灸 or 放血 or 刺络 or 耳针 or 刺血 or 挑刺 or 点刺 or 耳压 or 耳穴) 在缺省里检索

Appendix 8. Chinese VIP Database search strategy

Strategy in Chinese phonetic alphabet (i.e., Pinyin):

(U=(Mai li zhong+Jian xian yan+Zhen yan))*(U=(Zhen ci+Zhen jiu+Fang xue+Ci luo+Er zhen+Ci xue+Tiao ci+Dian ci+Er ya+Er xue))

U means all text.

(U= (麦粒肿+睑腺炎+针眼))*(U= (针刺+针灸+放血+刺络+耳针+刺血+挑刺+点刺+耳压+耳穴))

Appendix 9. metaRegister of Controlled Trials search strategy

Hordeolum OR stye

Appendix 10. ClinicalTrials.gov search strategy

Hordeolum OR stye

Appendix 11. WHO ICTRP search strategy

Hordeolum OR stye

Appendix 12. Excluded studies from Chinese literature databases

No.	References	Reason for exclusion
1	He XG. Effect observation on pricking Quchi (LI11) and ear apex to bleed in treating 100 cases of stye. Acta Acupuncture and Moxibustion (now: Journal of Clinical Acupuncture and Moxibustion). 1990;6(3):16	Full-text or abstract was not found on the Internet, in Chinese databases, or in the library at Shanghai University of Traditional Chinese Medicine
2	He XG. Effect observation on pricking Quchi (LI11) and ear apex to bleed in treating stye. Jiaozuo Medical & Pharmaceutical Journal. 1988; (1):76–8	Full-text or abstract was not found on the Internet, in Chinese databases, or in the library at Shanghai University of Traditional Chinese Medicine
3	Su Y, Liu DM. Pricking to bleed with three-edged needle in treating 119 cases of stye. Shandong Journal of Traditional Chinese Medicine. 1996;15(S):26–7	Full-text or abstract was not found on the Internet, in Chinese databases, or in the library at Shanghai University of Traditional Chinese Medicine
4	Xu ZB, Wu J. Report of auricular acupuncture therapy in treating 400 cases of stye. Chinese New Medicine. 2003;4(1) :23	Full-text or abstract was not found on the Internet, in Chinese databases, or in the library at Shanghai University of Traditional Chinese Medicine
5	Zhang XH. Experience on bloodletting therapy in treating 76 acute stye. Chinese Journal of Combined Medicine. 2003;16 (15/16):60	Full-text or abstract was not found on the Internet, in Chinese databases, or in the library at Shanghai University of Traditional Chinese Medicine
6	Liu CL, Bi YF. Recent development of acupuncture treatment for acute hordeolum. Shaanxi Journal of Traditional Chinese Medicine. 1990;11(2):90–1	Review
7	Wu QF. Advance on acupuncture in treating acute hordeolum. Journal of Clinical Acupuncture and Moxibustion. 1995;11 (3):47–9	Review
8	Hou ZH, Jia HL. Overview of the clinical research on acupuncture in treating hordeolum. Journal of Shandong University of Traditional Chinese Medicine. 2016(02):198–200	Review
9	Dong HC. Research advance of the Chinese and Western medicine in treating hordeolum. Public Medical Forum Magazine. 2015;19(27): 3809–11	Review
10	Chen Y. Recent advance of external therapy of Traditional Chinese Medicine for hordeolum. Jiangxi Journal of Traditional Chinese Medicine. 2015(7):74–5	Review
11	Liu YY, Chen GX. Literature analysis of Chinese medicine in treating hordeolum. Journal of Jiangxi University of Traditional Chinese Medicine. 2014(02):19–20	Review
12	Guo Y. The great effect of bloodletting at ear lobe in treating acute hordeolum. Journal of Clinical Acupuncture and Moxibustion. 1993;(1): 47	Introduction or experience on acupuncture in treating acute hordeolum
13	Hong YL. Acupuncture on tear point to treat acute hordeolum. Fujian Journal of Traditional Chinese Medicine. 1991;(5):50	Introduction or experience on acupuncture in treating acute hordeolum
14	Li JF. Acupuncture method in treating acute hordeolum. Journal of Sichuan of Traditional Medicine. 1997;15(1):55	Introduction or experience on acupuncture in treating acute hordeolum
15	Li K. Bloodletting at ear apex to treat acute hordeolum. Yi Yao Yang Sheng Bao Jian Bao (newspaper). 8 January 2007:6	Introduction or experience on acupuncture in treating acute hordeolum
16	Li MQ. Wrist-ankle acupuncture to treat acute hordeolum. Jiangsu Journal of Traditional Chinese Medicine. 1983;(1):41	Introduction or experience on acupuncture in treating acute hordeolum

No.	References	Reason for exclusion
17	Li XN. Bloodletting at ear apex plus plaster to treat acute hordeolum. China News of Traditional Chinese Medicine (newspaper). 24 February 2010:5	Introduction or experience on acupuncture in treating acute hordeolum
18	Li YY, Cai YM. Bloodletting at Taiyang (EX-HN5) to treat acute hordeolum. Chinese Primary Health Care. 1989;(1):37	Introduction or experience on acupuncture in treating acute hordeolum
19	Liang WB. Acupuncture at ear concavity to treat acute hordeolum. Shanghai Journal of Traditional Chinese Medicine. 1966;(2):44	Introduction or experience on acupuncture in treating acute hordeolum
20	Liu TY. Analysis of acupuncture at Binao (LI14) to treat acute hordeolum. Journal of Tianjin College of Traditional Chinese Medicine (Journal of Tianjin University of Traditional Chinese Medicine). 2001;20(1):47	Introduction or experience on acupuncture in treating acute hordeolum
21	Mao BX. Acupuncture at ear apex to treat acute hordeolum. Nongcun Baishitong (Rural Life Know All). 2001;(9):45	Introduction or experience on acupuncture in treating acute hordeolum
22	Tang QY. Bloodletting at ear apex to treat hordeolum. Health Times (newspaper). 27 July 2006:8	Introduction or experience on acupuncture in treating acute hordeolum
23	Wang XY, Xing JY. Bloodletting and cupping to treat acute hordeolum. China's Naturopathy. 2003;(10):14	Introduction or experience on acupuncture in treating acute hordeolum
24	Wang YE, Dai LL. Acupuncture at ear apex to treat acute hordeolum. China's Naturopathy. 2000;(10):14	Introduction or experience on acupuncture in treating acute hordeolum
25	Xie LJ. Bloodletting at ear apex to treat acute hordeolum. Da Zhong Wei Sheng (Public Health) (newspaper). 18 February 2004	Introduction or experience on acupuncture in treating acute hordeolum
26	Xie LJ. Bloodletting at ear apex to treat acute hordeolum. Zhong Guo Yi Yao Bao (newspaper). 6 August 2000:2	Introduction or experience on acupuncture in treating acute hordeolum
27	Xie LJ. Bloodletting at ear apex to treat acute hordeolum. Jia Ting Ke Ji (Family Technology). 1999;(6):24	Introduction or experience on acupuncture in treating acute hordeolum
28	Zhang L, Wang B. Acupuncture can treat acute hordeolum rapidly. Chinese Journal of Nursing. 1989;24(4):219	Introduction or experience on acupuncture in treating acute hordeolum
29	Zheng XL. Acupuncture to treat acute hordeolum. Henan Traditional Chinese Medicine. 1983;(2):39	Introduction or experience on acupuncture in treating acute hordeolum
30	Wang SX. Acupuncture at ear apex to treat acute hordeolum. Journal of Gannan Medical University. 1998;18(01):29	Introduction or experience on acupuncture in treating acute hordeolum
31	Zeng YH, Zhou WY, Liao WJ, Xu SW, Zhang YP. Clinical observation on injection acupuncture at ear points in treating hordeolum. Chinese Journal of Integrative Medicine. 1998;18 (3):184	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
32	Leng YX, Li QB, Liu XY. Injection acupuncture with composite salvia in treating hordeolum. Chinese Journal of Optometry & Ophthalmology. 2001;(1):37	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
33	Leng YX, Liu BY, Sheng LX. Injection acupuncture with composite salvia in treating hordeolum. Journal of Chinese Practical Medicine. 2001;3(1):94	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
34	Liu QL. Injection acupuncture with medicine at ear points in treating 210 cases of hordeolum. 1996;12(5/6):91	The trial used injection acupuncture, which does not meet

No.	References	Reason for exclusion
		our inclusion criteria for type of intervention
35	Ruan ZZ, Zhou YY. Clinical observation on Injection acupuncture in treating hordeolum. Journal of Clinical Acupuncture and Moxibustion. 1997;(4,5):53	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
36	Shen JS, Luo XZ. Injection acupuncture with vitamin B_{12} at ear point "eye" in treating 86 cases of early hordeolum. Jiangxi Journal of Traditional Chinese Medicine. 2000;31(2):43	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
37	Xu GQ. Injection acupuncture with vitamin B_{12} at ear point in treating 86 cases of early hordeolum. Chinese Journal of Integrated Traditional and Western Medicine. 1994;12(01): 53	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
38	Zheng ZF, Xu YP. Injection acupuncture at SJ20 in treating 176 cases of hordeolum. Journal of External Therapy of Traditional Chinese Medicine. 1996;5(5):15	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
39	Jiang H. Acupoint injection to treat acute hordelum. Journal of Jinggangshan Medical College. 2004;11(5):95	The trial used injection acupuncture, which does not meet our inclusion criteria for type of intervention
40	An ZL. Special needling to treat acute hordeolum. Gansu Journal of Traditional Chinese Medicine. 1994;7(6):38	Case report
41	He YY, Li JP. Bloodletting to treat acute hordeolum. China's Naturopathy. 2001;9(3):14	Case report
42	Hou ZW. Bloodletting at Quchi (LI11) to treat acute hordeolum. China News of Traditional Chinese Medicine (newspaper). 20 February 2014:5	Case report
43	Lian WZ. Bloodletting at Lidui (ST43) to treat acute hordeolum. Zhejiang Journal of Traditional Chinese Medicine. 1989;24(5):225	Case report
44	Lian WZ. Bloodletting at Lidui (ST43) to treat acute hordeolum. Anthology of Medicine. 1991;(2):32	Case report
45	Lv MZ. Bloodletting treatment in treating acute hordeolum. China's Naturopathy. 2002;10(9):20	Case report
46	Shen ZX, Wan ZM. Bloodletting and cupping combined with Chinese herbal medicine in treating one case of acute hordeolum. Clinical Journal of Chinese Medicine. 2012;(22):34	Case report
47	Sun JH, Qin SY. Bloodletting at Dadun (SP1) in treating acute hordeolum. Nei Mongol Journal of Traditional Chinese Medicine. 1996; (3):28	Case report
48	Tang WH. Moxibustion at Erjian (LI2) in treating acute hordeolum. Journal of Sichuan of Traditional Medicine. 1988;(9): 60	Case report
49	Wang JZ. Acupuncture at Houxi (SI3) in treating one case of acute hordeolum. Shanghai Journal of Acupuncture and Moxibustion. 1995;14(2):95	Case report
50	Yang Q. Acupuncture combined with bloodletting at ear apex to treat acute hordeolum. Shandong Journal of Traditional Chinese Medicine. 2011;(1):34	Case report
51	Zhang Y, Yang BL. Bloodletting combined with needling acupuncture to treat acute hordeolum. Hubei Journal of Traditional Chinese Medicine. 1994;(3):55	Case report
52	Zou J, Qi CW. Bloodletting at ear lobe to treat acute hordeolum. Journal of Clinical Acupuncture and Moxibustion. 1994;(3):55	Case report
53	Chen ZN. Three bloodletting methods to treat acute hordeolum. Fujian Journal of Traditional Chinese Medicine. 1991; (4):9	Case report

No.	References	Reason for exclusion
54	Hong F, Hong Y. Bloodletting at ear to treat acute hordeolum. China's Naturopathy. 2005;(12):22–3	Case report
55	Jiang QH. Bloodletting at ear apex to treat early acute hordeolum-204 cases. Recent Advances in Ophthalmology. 1988; (2):37–8	Case report
56	Tao SX. Acupuncture at Houxi (SI3) to treat acute hordeolum. Jiangxi Journal of Traditional Chinese Medicine. 1997;(3):45	Case report
57	Unknown. Effect observation on bloodletting with three-edged needle in treating 22 cases of stye. Selected paper of 1987 Annual meeting of Tai'an area Association of Chinese Medicine. 1989;4:95–6	Case series
58	An JX, Li GZ. Bloodletting at ear apex to treat acute hordeolum. Chinese Journal of the Practical Chinese With Modern Medicine. 2005;18(2):197	Case series
59	Bi Z. Bloodletting at Neiting (ST43) in treating 40 cases of acute hordeolum. Heilongjiang Journal of Traditional Chinese Medicine. 1998; (1):46	Case series
60	Bian YX, Chen W. Acupuncture and acupressure at Ear point in treating 50 cases of hordeolum. Journal of Chinese Modern Traditional Chinese Medicine. 2005;1(2):118	Case series
61	Bu L. Bloodletting to treat acute hordeolum. Journal of China Traditional Chinese Medicine Information. 2011;3(10):320	Case series
62	Cai SH. Bloodletting at sensitive points on ear helix to treat 85 cases of acute hordeolum. People's Military Surgeon. 1994; (7):76	Case series
63	Zeng GW. Bloodletting method to treat acute hordeolum. Jiangxi Journal of Traditional Chinese Medicine. 1996;(S2): 139	Case series
64	Chang MZ. Bloodletting at ear apex to treat 20 cases of acute hordeolum. Journal of External Therapy of Traditional Chinese Medicine. 2008;(2): 47	Case series
65	Chang ZL, Yin ZC. Ear acupressure combined with medicine to treat stye. Shanxi Nursing Journal. 1996;10(6):256	Case series
66	Chang ZL, Yin ZC. Ear acupressure combined with medicine to treat acute hordeolum. Chinese Community Doctors. 1996;12(9):29–30	Case series
67	Chen B, Cai LH. Bloodletting at auricular point to treat stye. Harbin Medical Journal. 2001;(02):71	Case series
68	Chen HM, Yang HL, Dong HQ. Thread embedding at auricular point in treating 174 cases of stye. Journal of Integrated Traditional Chinese and Western Medicine. 1987;(06):373	Case series
69	Chen JH. Thread binding at 1st, 2nd and 5th finger combined with bloodletting and cupping in treating stye. Chinese Acupuncture & Moxibustion. 2009;(07):560	Case series
70	Chen JG, Tang YL. Acupuncture bloodletting at Taiyang (EX-HN5) to treat 68 cases of early acute hordeolum. China's Naturopathy. 2006;14(2):17–8	Case series
71	Chen JG, Zhu YL, Shao JX. Bloodletting at diseased side locally plus penetrating acupuncture at healthy side to treat acute hordeolum. 2011;27(09):40–1	Case series
72	Chen J, Yuan L. Bloodletting at ear apex combined with auricular point acupressure to treat stye. Shandong Journal of Traditional Chinese Medicine. 1997;16(10):476	Case series
73	Chen LY. Bloodletting to treat 30 cases of acute hordeolum. Fujian Journal of Traditional Chinese Medicine. 1986;(6):45	Case series
74	Chen L, Zou ZY. Moxibustion to treating acute hordeolum. Chinese Journal of Chinese Ophthalmology. 1999;9(4):220	Case series
75	Chen M. Bloodletting at auricular veins to treat 34 cases of acute stye. Journal of Jinggangshan Normal College. 2001;22 (05):53–7	Case series

No.	References	Reason for exclusion
76	Cheng SM, Li PL, Wang GY. Health care earring in treating 30 cases of acute hordeolum. Chinese Acupuncture & Moxibustion. 1996;(8):16	Case series
77	Cheng XY. Bloodletting at ear apex to treat 90 cases of acute hordeolum. China's Naturopathy. 1997;(02):18	Case series
78	Chu XY, Lin JH. Bloodletting at ear apex in treating 47 cases of early stye. China's Naturopathy. 2002;10(12):9	Case series
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253	Wang M. Experience on bloodletting at ear apex in treating 130 cases of stye. Anthology of Medicine. 1995;16(03):231–2	Case series
254	Wang PZ. Auricular acupressure to treat 26 cases of stye. China's Naturopathy. 1995;(01):44	Case series
255	Wang QH. Bloodletting at ear apex in treating 70 cases of early stye. Shanghai Journal of Acupuncture and Moxibustion. 2004;23(5):27	Case series
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257	Wang RY, Chen GF. Bloodletting at auricular point in treating 60 cases of stye. China's Naturopathy. 1999;7(11):37–8	Case series
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266	Wang YY, Zhang HZ. Clinical observation on pricking to bleed at ear apex in treating 91 cases of stye. Shandong Medical Journal. 2000;(06): 48	Case series
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270	Wang ZH. Bloodletting at auricular point in treating 58 cases of stye. Shanghai Journal of Acupuncture and Moxibustion. 2005;24(03):15	Case series
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No.	References	Reason for exclusion
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275	Wang ZL. Bloodletting at Zhongchong (PC9) in treating stye. China's Naturopathy. 2001;9(12):25	Case series
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286	Xiao P, Huang XQ. Pricking acupoint combined with Chinese herbal medicine to treat 28 cases of stye. Journal of Clinical Acupuncture and Moxibustion. 1999;15(3):26	Case series
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No.	References	Reason for exclusion
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296	Xue ZQ, Zhang ZL. Clinical observation on auricular acupuncture in treating 62 cases of stye. Xinjiang Journal of Traditional Chinese Medicine. 1994;(03):23–4	Case series
297	Xue ZY. Acupuncture at ear apex to treat stye. Clinical Journal of Anhui Traditional Chinese Medicine. 1997;9(04):224	Case series
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347	Zheng HM. Bloodletting to treat stye. Journal of Ningbo University (Natural Science and Engineering Edition). 1997;(02) :119–20	Case series
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351	Zhou W, Wang LY. Observation on bloodletting at Zhongchong (PC9) in treating 160 cases of stye. Journal of Practical Traditional Chinese Medicine. 1998;14(05):19	Case series
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355	Zong YX. Clinical observation on bloodletting at ear apex in treating 200 cases of external acute inflammation. Journal of Guiyang College of Traditional Chinese Medicine. 1991;(03) :36	Case series
356	Zou YJ. Pricking ear apex in treating 75 cases of stye. Journal of Medical Theory and Practice. 1993;(06):48	Case series
357	Zou ZG. Bloodletting at ear apex in treating 156 cases of stye. China's Naturopathy. 1996;(01):19	Case series
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363	Feng ZX. Bloodletting at ear apex in treating 31 cases of early hordeolum. China's Naturopathy. 2014;(09):13	Case series
364	Xu Y, Wang Y, Zhang JX, Yu W, Duan HJ. Clinical observation of integrative Chinese and Western medicine in treating early hordeolum in children. Journal of Qiqihar University of Medicine. 2014;35(07):1007	Case series

CHARACTERISTICS OF STUDIES

Characteristics of included studies *[ordered by study ID]*

Li 2006a	
Methods	**Study design:** parallel randomised controlled trial **Number randomised:** total 120 participants; acupuncture group: 60 participants; conventional treatment group: 60 participants **Exclusions after randomization:** 0 **Number analyzed:** total: 120 participants; acupuncture group: 60 participants; conventional treatment group: 60 participants **Unit of analysis:** individual **Losses to follow-up:** a very small number of dropouts, but the author could not recall the exact number (information provided by correspondence with the study investigator) Study investigator did not report how they handled missing outcome data **Reported power calculation:** no
Participants	**Country:** China **Setting**: outpatient clinic of the acupuncture department of Gongyi People's Hospital **Age (mean ± SD)**: 18 ± 8.42 in total; 18 ± 8.15 in acupuncture group; 18 ± 8.82 in oral erythromycin plus warm compresses group **Age range**: 3 to 41 years in total; 3 to 41 years in acupuncture group; 4 to 38 years in oral erythromycin plus warm compresses group **Duration**: equal to or less than 3 days **Gender:** total: men and boys: 64/120 (53%); women and girls: 56/120 (47%); acupuncture group: men and boys: 33 (55%); women and girls: 27 (45%); oral erythromycin plus warm compresses group: men and boys: 31 (52%); women and girls: 29 (48%) **Inclusion criteria:** diagnosed as hordeolum (both external and internal), patients presented with symptoms for no more than 3 days, no abscess at eyelid border, no other treatments (traditional Chinese or Western medicine) **Exclusion criteria:** not reported **Equivalence of baseline characteristics:** yes; "the two groups were equivalent at baseline in terms of gender, age, length of disease, location of hordeolum (P > 0.05)."
Interventions	**Intervention 1:** acupuncture Point selection: fixed formula Points stimulated: Du 13 and Du 12 Total length of treatment period: 3 days Number of sessions target (mean): 3 sessions Times per day: 1 Number of points used: 2 Insertion depth: not reported Was De qi reportedly sought?: not reported Duration (minutes): 30 Method of stimulation: penetration needling from Du 13 to Du 12, insert needle obliquely (15°) into Du 13, then insert horizontally subcutaneously to Du 12. Manipulate the needle manually every 10 min with reduce method **Intervention 2:** oral erythromycin plus warm compresses **Dosage:** 0.25 g oral erythromycin 3 times/day plus warm compresses, reduced prescription for children **Length of follow-up:** Planned: 3 days after diagnosis Actual: 3 days after diagnosis

Outcomes	**Primary outcome, as defined in study reports:** the proportion of participants with complete early resolution of a hordeolum (3 days after diagnosis) **Secondary outcomes, as defined in study reports:** not reported **Adverse events reported:** not reported **Intervals at which outcomes assessed:** 3 days	
Notes	**Trial registry record:** not reported **Type of study:** published **Funding sources:** The study investigators reported that they did not receive any funding (information provided by correspondence with the study investigator) **Disclosures of interest:** not reported **Study period:** January 2003 to January 2006 **Reported subgroup analyses:** no KC contacted the study investigator Li Y by telephone for further information on 13 February 2015	
Risk of bias		
Bias	**Authors' judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	A random number table was used to generate sequence (information provided during phone conversation with the study investigator)
Allocation concealment (selection bias)	Unclear risk	Numbered, opaque, sealed envelopes were used, but the author could not recall whether the envelopes were sequentially numbered and were opened sequentially (information provided during phone conversation with the study investigator)
Masking of participants and personel (performance bias)	Unclear risk	Acupuncture vs oral erythromycin plus warm compresses was assessed in this study Due to the nature of the treatments, participants and personnel could not be masked. We are not sure weather the resolution of a hordeolum could be influenced by knowing the treatment group assignment
Masking of outcome assessment (detection bias)	High risk	The outcome assessor was not masked (information provided in correspondence with the study investigator); outcomes based on clinical observation could be influenced by lack of masking
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	A very small number of dropouts, but number was not reported for each group (information provided during phone conversation with the study investigator)
Selective reporting (reporting bias)	Unclear risk	Although study protocol is not available, the primary outcome (i.e. proportion of participants with complete early resolution of a hordeolum at follow-up) was reported and was the only outcome prespecified in the methods section
Other bias	Unclear risk	• Important prognostic indicators at baseline (low risk). "The two groups were comparable at baseline in terms of gender, age, duration and location of sty (P > 0. 05)." • Co-interventions (unclear risk). Study investigators did not report if the participants used other treatments while enrolled in the RCT or if the study investigators discouraged the participants from using other treatments while enrolled in the study. • Treatment compliance (unclear risk). Not reported. • Timing of the outcome assessment across groups (low risk). Both groups were evaluated at 3 days after diagnosis. • Funding sources and conflicts of interest (unclear risk). Authors did not receive funding (information provided in correspondence with the study investigator), and did not declare their conflicts of interest. • Trial conducted in an acupuncture department, where there may be an interest in showing acupuncture works and, therefore, may be considered a potential source of bias.
Pang 2009		
Methods	**Study design:** parallel randomised controlled trial	

	Number randomised: 77 participants in total; 40 in acupuncture group plus conventional treatment group; 37 in conventional treatment group **Exclusions after randomization:** 0 **Number analyzed:** 30 in acupuncture group plus conventional treatment group; 30 in conventional treatment group **Unit of analysis:** individual **Losses to follow-up:** 17 participants in total; 10 participants in acupuncture plus conventional treatment group; 7 participants in conventional treatment group Study investigator did not report how they handled missing outcome data. The study investigator continued to recruit participants to ensure that at least 30 participants were in each group (information provided in email with the study investigator) **Reported power calculation:** none	
Participants	**Country:** China, outpatient clinic of ophthalmology in the first hospital affiliated to Guangzhou University of Traditional Chinese Medicine **Age (mean ± SD):** 27.6 ± 11 in total; 27.6 ± 11 in acupuncture plus conventional treatment group; 26 ± 12 (or 28.5 ± 13) in conventional treatment group (the study investigators reported the age of conventional treatment group differently from the published report) **Age range:** 7 to 45 years in total; 7 to 39 years in acupuncture plus conventional treatment group; 9 to 45 years in conventional treatment group **Duration**: not reported **Gender:** total: men and boys: 32/60 (53%); women and girls: 28/60 (47%); acupuncture plus conventional treatment group: men/boys: 17 (57%); women/girls: 13 (43%); conventional treatment group: men/boys: 15 (50%); women/girls: 15 (50%) **Inclusion criteria:** diagnosed as stye according to the national Chinese medical school: 1) local itch, swelling and pain of eyelid; 2) subcutaneous induration can be felt under pressing, painful under pressing **Exclusion criteria:** people with incomplete demographic data; people who had used medicines; people with history of purulence; people who do not comply with the treatment or follow-up; people with blood disorder or severe damage of heart, liver, or kidney; people in poor health or with mental disorder; women pregnant or lactating; infants or children who could not co-operate with doctor **Equivalence of baseline characteristics:** yes; “the two groups were comparable at baseline in terms of gender, age and treatment duration (P > 0.05).”	
Interventions	**Intervention 1:** acupuncture plus conventional treatment (topical antibiotics: ofloxacin eyedrops) N allocated to acupuncture: 30 Point selection: fixed formula Points stimulated: bloodletting at ipsilateral Erjian (EX-HN6) at the ear apex Total length of treatment period: 1 day Number of sessions target (mean): 1 Times per day: 1 Number of points used: 2, bilateral Erjian (EX-HN6) Insertion depth: 1 ~ 2 mm Was De qi reportedly sought?: not applicable Duration (minutes): not reported Method of stimulation: bloodletting with 3-edged needle and withdrawal of 5 ~ 10 drops of blood **Intervention 2:** conventional treatment alone (topical antibiotics: ofloxacin eyedrops) N allocated to conventional treatment group B: 30 Total length of treatment period: 1 day **Dosage**: not reported **Length of follow-up:** Planned: 1 day after diagnosis Actual: 1 day after diagnosis **Acupuncturists’ experience:** The author Pang Y, who was a graduate student majoring in acupuncture and Chinese massage, performed the treatment	
Outcomes	**Primary outcome, as defined in study reports:** proportion of participants with relief of symptoms (i.e. relief of swelling and pain with relief of either itching or conjunctival congestion) at 1 day after diagnosis. Proportion of participants with complete resolution of a hordeolum was not reported **Adverse events reported:** not reported	
Notes	**Trial registry record:** not reported **Type of study:** published **Funding sources:** not reported **Disclosures of interest:** not reported **Study period:** March 2007 to April 2009 **Reported subgroup analyses:** no KC contacted the study investigator Pang Y by email for further information on 6 September 2014	
Risk of bias		
Bias	**Authors’ judgement**	**Support for judgement**
Random sequence	Low risk	The author referred to a random number table to generate the allocation sequence (information provided in email with the study investigator)

generation (selection bias)		
Allocation concealment (selection bias)	High risk	The author used no method to conceal the allocation (information provided in email with the study investigator)
Masking of participants and personel (performance bias)	Unclear risk	Acupuncture plus conventional treatment vs conventional treatment alone was assessed in this study Due to the nature of the treatments, participants and personnel could not be masked for this study. We are not sure weather the resolution of a hordeolum could be influenced by knowing the treatment group assignment
Masking of outcome assessment (detection bias)	Low risk	The author Pang Y performed the treatment. Her mentor, who was not aware of the treatment or the allocation, evaluated the results (information provided in email with the study investigator)
Incomplete outcome data (attrition bias) All outcomes	High risk	Study investigators excluded data from participants for whom outcome data were missing. 10 participants dropped out in acupuncture plus conventional treatment group, 7 participants dropped out in conventional treatment group. The author continued to recruit participants to ensure 30 participants in each group. The data for dropout were not considered in the results (information provided in email with the study investigator)
Selective reporting (reporting bias)	Unclear risk	Study protocol is not available, however the investigators reported all outcomes listed in the methods section of the RCT, including relief of a hordeolum, relief of swollen and redness, pain, itching, and conjunctival congestion at 1 day after diagnosis
Other bias	Unclear risk	• Important prognostic indicators at baseline (low risk). The two groups were similar at baseline in terms of gender, age, and duration ($P > 0.05$). • Co-interventions (unclear risk). Study investigators did not report if the participants used other treatments while enrolled in the RCT or if the study investigators discouraged the participants from using other treatments while enrolled in the study. • Compliance (unclear risk). Not reported. • Timing of the outcome assessment across groups (low risk). Both groups were evaluated at 1 day after diagnosis. • Funding sources and conflicts of interest (unclear risk). Source of funding for the RCT was not reported, and authors did not declare potential conflicts of interest. • Trial conducted at a university of Traditional Chinese Medicine, where there may be an interest in showing acupuncture works and, therefore, may be considered a potential source of bias.
Qi 2013		
Methods	**Study design:** parallel randomised controlled trial **Number randomised:** total 104 participants, acupuncture plus conventional treatment group: 52; conventional treatment alone group: 52 **Exclusions after randomization:** 0 **Number analyzed:** 102, conventional treatment alone group: 51; acupuncture plus conventional treatment group: 51 **Unit of analysis:** individual **Losses to follow-up:** 2 participants **Missing data handling:** 2 participants dropped out after randomization and were therefore excluded from the analysis. Another 4 participants changed to other treatment due to adverse events, and were included in per-protocol analysis **Reported power calculation:** 90% power; effect size (proportion of participants with complete resolution of acute hordeolum) was 97% for acupuncture plus conventional treatment group, 75.5% for conventional treatment group; sample size was calculated as 104 participants (information obtained from study investigator's master thesis) **Unusual study design**: four participants stopped their initial treatment and started other treatments; two participants in topical antibiotic group used acupuncture at the 3^{rd} and 4^{th} day respectively; two patients in acupuncture plus topical antibiotic group used systematic antibiotics at the 3^{rd} day; the four participants were analyzed as they were randomised.	
Participants	**Country:** China	

	Setting: ophthalmology department (outpatient clinic), the first affiliated hospital to Xinjiang Medical University; not a Traditional Chinese Medicine institution **Age (mean ± SD):** 28 ± 9.5 in total; 29 ± 10 in acupuncture plus conventional treatment group; 27 ± 9 in conventional treatment alone group **Age range:** not reported; the authors stated that participants age 6 to 65 years were included **Duration**: 0.5 to 3 days **Gender:** total: men 32/102 (31%), women 70/102 (69%); acupuncture plus conventional treatment group: men 17 (33.3%), women 34 (66.7%); conventional treatment alone group: men 15 (29.4%), women 36 (70.6%) **Inclusion criteria:** age 6 to 65 years; patients diagnosed with hordeolum early with duration with symptoms of redness and swelling of 0.5 to 3 days, no abscess present **Exclusion criteria:** people age under 6 or above 65; taking oral hormone, antibiotics, or immunosuppressant; people with coagulation disorders or abscess of ears; people with history of drug allergy (levofloxacin hydrochloride eyedrops or erythromycin eye ointment); pregnant women or planned to become pregnant during the trial **Equivalence of baseline characteristics:** yes
Interventions	**Intervention 1:** acupuncture (bloodletting) plus conventional treatment; topical antibiotics (ofloxacin eyedrops + erythromycin ointment) + warm compresses N allocated to acupuncture: 52 (51 were analyzed) Point selection: fixed formula Points stimulated: bloodletting at ipsilateral Erjian (EX-HN6) at the ear apex, and withdrew 5 ~ 6 drops of blood Total length of treatment period: 3 days Number of sessions target (mean): 3 sessions Times per day: 1 Number of points used: 1 Insertion depth: 2 ~ 3 mm using a syringe needle Was De qi reportedly sought?: NA Duration (minutes): not reported Method of stimulation: bloodletting **Intervention 2:** conventional treatment: topical antibiotics (ofloxacin eyedrops + erythromycin ointment) + warm compresses N allocated to conventional treatment group: 52 (51 were analyzed) Total length of treatment period: 3 days **Length of follow-up:** Planned: 7 days after diagnosis Actual: 7 days after diagnosis
Outcomes	**Primary outcome, as defined in study reports:** the proportion of participants with complete early resolution of a hordeolum (7 days after diagnosis) **Secondary outcomes, as defined in study reports:** not reported **Adverse events reported:** “no obvious adverse events occurred in acupuncture group. Local adverse events such as red, swollen, inflammation, or abscess at the treatment area were absent in acupuncture group, which indicated that bloodletting was as safe as conventional treatment for external hordeolum.” “Two participants withdrew in both groups due to exacerbation of symptom (e.g., enlarged area of redness and abscess)” **Intervals at which outcomes assessed:** 3, 5, 7 days
Notes	**Trial registry record:** The RCT was registered in Chinese Clinical Trial Registry (registration number: ChiCTR-TRC-12002201). (Information was obtained from study investigator’s master thesis.) **Type of study:** published **Funding sources:** This RCT was reported not funded (information was provided during phone communication with study investigator on 15 March 2015) **Disclosures of interest:** not reported **Study period:** April 2011 to October 2012 **Reported subgroup analyses:** no KC contacted the study investigator Chen XY by phone for further information on 15 March 2015

Risk of bias

Bias	**Authors’ judgement**	**Support for judgement**
Random sequence generation (selection bias)	Low risk	We assume the trial investigators had a column of participants ids (from 1 to 104). They then generated a second column of random numbers, order the columns by the generated random number, assigned the first half of participant ids to the acupuncture group, and the second half of the participants ids to the conventional treatment group. Finally, reorder the columns by the participant ids Translated from Chinese: “The sequence of 104 was generated by a statistician using software. The sequence was divided into 2 groups in terms of the size of number. The numbers of smaller size were allocated to A (bloodletting) group, the numbers of larger size were allocated to B (conventional treatment) group. 52 cases were allocated to each group.” pg149

Allocation concealment (selection bias)	High risk	One outpatient nurse prepared and distributed the envelops containing the treatment assignment, therefore may be aware of the allocation sequence The outpatient nurse prepared the sequentially numbered sealed opaque envelops. If the participant met the RCT inclusion/exclusion criteria, the outpatient nurse would distribute the number of the envelops to the participants (information was obtained from study investigator's master thesis and during a phone call with the study investigator on 15 March 2015)
Masking of participants and personel (performance bias)	Unclear risk	Acupuncture plus conventional treatment vs conventional treatment was assessed in this study Due to the nature of the treatments, participants and personnel could not be masked. We are not sure weather the resolution of a hordeolum could be influenced by knowing the treatment group assignment
Masking of outcome assessment (detection bias)	Low risk	The outpatient nurse who assessed the outcome was not the one who distribute the number and was masked to the group assignment. (Information was provided during phone communication with study investigator on 15 March 2015).
Incomplete outcome data (attrition bias) All outcomes	Low risk	Two participants dropped out after randomization due to exacerbation of symptoms. Another four participants used other treatment due to the poor effects and were included in per-protocol analysis. That is, two patients in topical antibiotic group used acupuncture at the 3rd and 4th day respectively; two patients in acupuncture plus topical antibiotic group used systematic antibiotic at the 3rd day. The four participants were included in per-protocol analysis The proportion was less than 10% in each group. The reason and number of dropouts were reported and balanced across groups
Selective reporting (reporting bias)	Unclear risk	Although study protocol is not available, the primary outcome (i.e. proportion of participants with complete early resolution of a hordeolum) and other outcomes (size of stye and VAS pain severity after the 1st treatment, 3, 5, and 7 days after diagnosis) prespecified in the methods section were reported in the results
Other bias	Unclear risk	• Important prognostic indicators at baseline (low risk). The 2 groups were comparable at baseline in terms of gender, age, size of stye, and VAS pain ($P > 0.05$) (see also Table 1 in the published article). • Co-interventions (unclear risk). Study investigators did not report if the participants used other treatments while enrolled in the RCT or if they discouraged participants from using other treatments while enrolled in the study. • Treatment compliance (unclear risk). Not reported. • Timing of the outcome assessment across groups (low risk). Both groups were evaluated at 7 days after diagnosis. • Funding sources and conflicts of interest (unclear risk). The authors did not receive funding (information provided in correspondence with the study investigator), and did not declare their conflicts of interest.
Xu 2004		
Methods	**Study design:** parallel randomised controlled trial **Number randomised:** total 109 participants; acupuncture group: 67 participants; conventional treatment group: 42 participants **Exclusions after randomization:** none **Number analyzed:** total 109 participants; acupuncture group: 67 participants; conventional treatment group: 42 participants **Unit of analysis:** individual **Losses to follow-up:** none As there was no loss to follow-up, study investigator did not report how missing outcome data would have been handled **Reported power calculation:** no	
Participants	**Country:** China **Setting**: School clinic of Hunan Traditional Chinese Medicine College **Age (mean ± SD):** not reported	

	Age range: 16 to 57 years in total; 16 to 56 years in acupuncture group; 17 to 57 years in conventional treatment group **Duration**: 1 to 4 days **Gender:** total: men 46/109 (42%), women 63/109 (58%); acupuncture group: men: 26 (38.8%), women: 41 (61.2%); conventional treatment group: men: 20 (47.6%), women: 22 (52.4%) **Inclusion criteria:** patients diagnosed with hordeolum in early stage, with symptoms of redness and swelling, pain, fever, enlarged lymph nodes **Exclusion criteria:** not reported **Equivalence of baseline characteristics:** yes
Interventions	**Intervention 1:** acupuncture group (bloodletting plus repeated shallow puncture) N allocated to acupuncture: 67 Point selection: fixed formula Points stimulated: bloodletting ipsilateral Erjian (EX-HN6) at the ear apex, and withdrew 4 ~ 6 drops of blood and repeated shallow puncture on stye Total length of treatment period: 1 ~ 3 days Number of sessions target (mean): 1 ~ 3 sessions Times per day: not reported Number of points used: 2 Insertion depth: NA Duration (minutes): not reported Method of stimulation: bloodletting ipsilateral Erjian (EX-HN6) at the ear apex plus repeated shallow puncture with 7 needles simultaneously for 7 times on stye **Intervention 2:** conventional treatment group (topical antibiotics (erythromycin ointment) + warm compresses) N allocated to conventional treatment group: 42 Total length of treatment period: 1 to 3 days **Dosage**: erythromycin ointment was applied at stye before bedtime; warm compresses were applied 3 times/day **Length of follow-up:** Planned: not reported Actual: 1, 2, and 3 days after diagnosis
Outcomes	**Primary outcome, as defined in study reports:** the proportion of participants with complete early resolution of a hordeolum (3 days after diagnosis) **Secondary outcomes, as defined in study reports:** not reported **Adverse events reported:** not reported **Intervals at which outcomes assessed:** 3 days
Notes	**Trial registry record:** not reported **Type of study:** published **Funding sources:** not reported **Disclosures of interest:** not reported **Study period:** not reported **Reported subgroup analyses:** not reported The study investigator could not be reached.

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	High risk	Randomization may have not been executed properly as there was a large difference in the number of participants in each arm; the acupuncture arm had 25/109 (40%) more participants than the control group A random number table was used to generate sequence. Odd numbers were allocated to treatment group, even numbers were allocated to control group
Allocation concealment (selection bias)	High risk	Not reported. Allocation concealment may have been breached with odd and even random number allocation as the number of participants in each group was so unequal
Masking of participants and personel (performance bias)	Unclear risk	Acupuncture vs topical antibiotics plus warm compresses was assessed in this study Due to the nature of the treatments, participants and personnel could not be masked. We are not sure weather the resolution of a hordeolum could be influenced by knowing the treatment group assignment
Masking of outcome assessment (detection bias)	Unclear risk	Not reported
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	No missing outcome data were reported for this study. We are unclear whether there is dropout during the RCT

Selective reporting (reporting bias)	Unclear risk	Although study protocol is not available, the primary outcome (i.e. proportion of participants with complete early resolution of a hordeolum) was reported at 3 time points, and it was the only outcome prespecified in the methods section
Other bias	Unclear risk	• Important prognostic indicators at baseline (low risk). The 2 groups were comparable at baseline in terms of general information (i.e. gender, age, and location of stye) (P > 0.05). • Co-interventions (unclear risk). Study investigators did not report if the participants used other treatments while enrolled in the RCT or if they discouraged participants from using other treatments while enrolled in the study. • Treatment compliance (unclear risk). Not reported. • Timing of the outcome assessment across groups (low risk). Both groups were evaluated at 3 days after diagnosis. • Funding sources and conflicts of interest (unclear risk). Source of funding for the RCT was not reported, and authors did not declare potential conflicts of interest. • Trial conducted at a college of Traditional Chinese Medicine, where there may be an interest in showing acupuncture works and, therefore, may be considered a potential source of bias.
Yang 2014		
Methods	**Study design:** parallel randomised controlled trial **Number randomised:** total 108 participants; acupuncture plus conventional treatment group: 54 participants; conventional treatment alone group: 54 participants **Exclusions after randomization:** none **Number analyzed:** total 108 participants; acupuncture plus conventional treatment group: 54 participants; conventional treatment alone group: 54 participants **Unit of analysis:** individual **Losses to follow-up:** none (information provided by the study investigator during follow-up communication) **Missing data handling:** As there was no loss to follow-up, study investigator did not report how missing data would have been handled **Reported power calculation:** no	
Participants	**Country:** China **Setting**: outpatient clinic of the ophthalmology department of the Chengdu Hospital of Integrated Traditional Chinese with Western Medicine **Age (mean ± SD):** 23.22 ± 1.16 in total; age (mean ± SD) was not reported for the individual groups **Age range**: 18 to 42 years in total; age range was not reported for the individual groups **Duration**: 13 to 24 days, mean ± SD: 24.07 ± 3.48 days. All participants are with recurrent hordeola, duration was counted from the onset day of the first hordeolum (information provided by the study investigator during follow-up communication) **Gender:** total: male: 60/108 (56%); female: 48/108 (44%); gender was not reported for the individual groups **Inclusion criteria:** patients identified with hordeolum (both external and internal) with symptoms of redness and swelling on the eyelid, pressure pain, and hard nodule (information provided by the study investigator during follow-up communication) **Exclusion criteria:** patients with presentation of abscess at the first onset, patients with coagulation disorders, patients under other treatment **Equivalence of baseline characteristics:** yes	
Interventions	**Intervention 1:** acupuncture (bloodletting) plus conventional treatment: topical antibiotics (tobramycin eyedrops + erythromycin ointment) + warm compresses N allocated to acupuncture: 54 Point selection: fixed formula Points stimulated: bloodletting at ipsilateral Erjian (EX-HN6) at the ear apex, and withdrew several drops (0.1 mL) of blood Total length of treatment period: 1 ~ 3 days Number of sessions target (mean): 1 ~ 3 sessions Times per day: 1 Number of points used: 1 Insertion depth: NA Was De qi reportedly sought?: NA Duration (minutes): not reported Method of stimulation: bloodletting using a syringe needle	

	Intervention 2: conventional treatment alone topical antibiotics (0.3% tobramycin eyedrops + 0.5% erythromycin ointment) + warm compresses N allocated to conventional treatment group: 54 Total length of treatment period: 1 ~ 6 days, applied until resolved (information provided by the study investigator during follow-up communication) **Dosage**: Tobramycin eyedrops (0.3%) and erythromycin ointment (0.5%) were applied after warm compresses morning and night daily (2 times/day) **Length of follow-up:** 6 days after the diagnosis Planned: not reported Actual: 1, 2, 3, and 6 days after diagnosis
Outcomes	**Primary outcome, as defined in study reports:** the proportion of participants with complete early resolution of a hordeolum (6 days after diagnosis) **Secondary outcomes, as defined in study reports:** none **Adverse events reported:** not reported **Intervals at which outcomes assessed:** 1, 2, 3, and 6 days after diagnosis
Notes	**Trial registry record:** not reported **Type of study:** published **Funding sources:** This study was reported to be unfunded (information provided by the study investigator during follow-up communication) **Disclosures of interest:** not reported **Study period:** January 2012 to May 2013 **Reported subgroup analyses:** no KC contacted the study investigator YR by phone for further information on 16 and 27 February 2015

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	A random number table was used to generate sequence (information provided by the study investigator during follow-up communication on 16 and 27 February 2015)
Allocation concealment (selection bias)	High risk	The random allocation table was held by nurse, but was kept unsealed (information provided by the study investigator during follow-up communication on 16 and 27 February 2015)
Masking of participants and personel (performance bias)	Unclear risk	Acupuncture plus conventional treatment vs conventional treatment was assessed in this study Due to the nature of the treatments, participants and personnel could not be masked. We are not sure weather the resolution of a hordeolum could be influenced by knowing the treatment group assignment.
Masking of outcome assessment (detection bias)	High risk	The first authors and another physician assessed the outcome. The author was aware of the assignment, but the other assessor was not aware of the assignment (information provided by the study investigator during follow-up communication on 16 and 27 February 2015)
Incomplete outcome data (attrition bias) All outcomes	Low risk	No dropout (information provided by the study investigator during follow-up communication on 16 and 27 February 2015) Outcome data were available for all participants.
Selective reporting (reporting bias)	Unclear risk	Although study protocol is not available, the primary outcome (i.e. proportion of participants with complete early resolution of a hordeolum) and other outcomes (feeling of scorching hot and swelling (VAS items) after the 1st day of treatment and days of resolution) prespecified in the methods section were reported in the results
Other bias	Unclear risk	• Important prognostic indicators at baseline (low risk). The 2 groups were comparable at baseline in terms of gender, age, and duration ($P > 0.05$). • Co-interventions (unclear risk). Study investigators did not report if the participants used other treatments while enrolled in the RCT or if they discouraged the participants from using other treatments while enrolled in the study. • Treatment compliance (unclear risk). Not reported. • Timing of the outcome assessment across groups (low risk). Both groups were evaluated at 6 days after diagnosis. • Funding sources and conflicts of interest (unclear risk). The authors did not receive any funding (information provided in

		correspondence with the study investigator), and did not declare conflicts of interest. • Trial conducted at a hospital department of Traditional Chinese Medicine, where there may be an interest in showing acupuncture works and, therefore, may be considered a potential source of bias.
Zhang 1991		
Methods	**Study design:** parallel randomised controlled trial **Number randomised:** total 32 participants; acupuncture group: 20 participants; topical antibiotic group: 12 participants **Exclusions after randomization:** none **Number analyzed:** total 32 participants; acupuncture group: 20 participants; topical antibiotic group: 12 participants **Unit of analysis:** individual **Losses to follow-up:** none As there are no losses to follow-up, study investigator did not report how missing data would have been handled **Reported power calculation:** none	
Participants	**Country:** China **Setting**: outpatient clinic of acupuncture department of Tianjian Traditional Chinese Medicine Hospital **Age (mean ± SD)**: not reported **Age range**: 10 to 41 years in total; 10 to 41 years in acupuncture group; 12 to 39 years in topical antibiotic group **Duration**: total: not reported; acupuncture group: 6 hours to 6 days; topical antibiotic group: 1 to 5 days **Gender:** total: men/boys: 6/32 (19%), women/girls: 26/32 (81%); acupuncture group: men/boys: 4 (25%), women/girls: 16 (75%); topical antibiotic group: men/boys: 2 (17%); women/girls: 10 (83%) **Inclusion criteria:** acute hordeolum (both external and internal) (information was provided during phone call with the study investigator on 3 September 2014) **Exclusion criteria:** not reported **Equivalence of baseline characteristics:** yes	
Interventions	**Intervention 1:** acupuncture N allocated to acupuncture: 20 Point selection: fixed formula Points stimulated: ipsilateral LI 14 Total length of treatment period: 3 days Number of sessions target (mean): less than or equal to 3 sessions Times per day: 1 Number of points used: 1 Insertion depth: not reported Was De qi reportedly sought?: not reported; slow lifting-quick thrusting reduce method was used. Duration (minutes): 15 Method of stimulation: manual **Intervention 2:** topical antibiotic (chloramphenicol (Chloromycetin) eyedrops plus erythromycin ointment) N allocated to conventional intervention group: 12 Total length of treatment period: 3 days Dosage: chloramphenicol eyedrops applied 4 ~ 6 times/day, erythromycin ointment was applied before bedtime **Length of follow-up:** Planned: not reported Actual: 4 days after diagnosis	
Outcomes	**Primary outcome, as defined in study reports:** the proportion of participants with complete early resolution of a hordeolum (4 days after diagnosis) **Secondary outcomes, as defined in study reports:** the proportion of participants with improved symptoms at 4 days after diagnosis **Adverse events reported:** not reported **Intervals at which outcomes assessed:** 4 days after diagnosis	
Notes	**Trial registry record:** not reported **Type of study (published/unpublished):** published **Funding sources:** This study was reported as not funded (information provided during phone call with the study investigator on 3 September 2014) **Disclosures of interest:** not reported	

	Study period: not reported **Reported subgroup analyses:** no KC contacted the study investigator Zhang ZL by phone for further information on 3 September 2014

Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	The investigator said in a phone call survey that sample size was calculated with the allocation ratio 2:1, but power and sample size calculations was not provided, and the actual allocation ratio was not equal to 2:1 (20 vs 12). The investigator did not describe in detail how the random sequence allocated the intervention, either A random number table was used to generate sequence (information provided during phone call with the study investigator on 3 September 2014)
Allocation concealment (selection bias)	Unclear risk	Although the investigator said sequentially numbered, opaque, sealed envelopes were used, and the envelopes were opened sequentially (information provided during phone call with the study investigator on 3 September 2014), allocation concealment may have been breached because the actual allocation ratio was not equal to 2:1 (20 vs. 12) as originally set. and the investigator also did not describe in detail how the random sequence allocated the intervention,
Masking of participants and personel (performance bias)	Unclear risk	Acupuncture vs topical antibiotics was assessed in this study Due to the nature of the treatments, participants and personnel could not be masked. We are not sure weather the resolution of a hordeolum could be influenced by knowing the treatment group assignment
Masking of outcome assessment (detection bias)	Low risk	The outcome assessors were blinded to the allocated interventions (information was obtained during a follow-up phone call to the study investigator on 3 September 2014)
Incomplete outcome data (attrition bias) All outcomes	Low risk	Outcome data were available for all participants.
Selective reporting (reporting bias)	Unclear risk	Although study protocol is not available, the primary outcome (i.e. proportion of participants with complete early resolution of a hordeolum) was reported and was the only outcome prespecified in the methods section
Other bias	Unclear risk	• Important prognostic indicators at baseline (low risk). The 2 groups were comparable at baseline ($P > 0.05$). • Co-interventions (unclear risk). Study investigators did not report if the participants used other treatments while enrolled in the RCT or if they discouraged the participants from using other treatments while enrolled in the study. • Treatment compliance (unclear risk). Not reported. • Timing of the outcome assessment across groups (low risk). Both groups were evaluated at 4 days after diagnosis. • Funding sources and conflicts of interest (unclear risk). The authors received no funding (information provided in correspondence with the study investigator), and did not declare their conflicts of interest. • Trial conducted at a hospital department of Traditional Chinese Medicine, where there may be an interest in showing acupuncture works and, therefore, may be considered a potential source of bias.

NA: not applicable

RCT: randomised controlled trial

SD: standard deviation

VAS: visual analogue scale

Characteristics of excluded studies *[ordered by study ID]*

Study	Reason for exclusion
Bai 2000	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Chen 2000	Claimed to have randomized participants, however participant allocation used in this trial was based on alternation, which indicates that this was a quasi-randomized trial. Its results favored acupuncture (bloodletting at ear apex) plus topical antibiotics over topical antibiotics alone. Telephone survey was on 1 September 2014
Ding 2014	The trial compared bloodletting at ear apex plus oral TCM medicine vs topical antibiotics, which does not meet inclusion criteria for type of intervention. Reported as an RCT
Dong 1996	Controlled trial, randomization was not mentioned. The trial compared two different types of acupuncture techniques (bloodletting versus body needling), which does not meet our inclusion criteria for type of intervention
Du 2011	The trial compared ultrashort wave plus bloodletting plus antibiotics versus bloodletting plus antibiotics; bloodletting was a co-intervention, which does not meet our inclusion criteria for type of intervention
Duan 2005	Controlled trial, randomization was not mentioned.
Duo 1988	Controlled trial, randomization was not mentioned.
Fan 1992	Claimed to have randomized participants, however participant allocation used was based on alternation, which indicates that this was a quasi-randomized trial. Its results favored acupuncture (bloodletting at toe or fingertips) over topical and oral antibiotics. Telephone survey was on 1 September 2014
Fan 1998	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Gao 2001	Claimed to have randomized participants; however, in a telephone survey on 1 September 2014, the author Gao Qiang said he used a random number table to generate random sequence, but only some of the participants were allocated randomly; others were allocated casually, not using any specific randomization method. The author also could not explain the large imbalance in sample size between the 2 groups
Gong 2008	Claimed to have randomized participants but did not include details about the randomization methods, and authors did not respond to interview requests
Han 1994	The trial compared 4 different types of acupuncture techniques (bloodletting at ear apex and Taiyang versus electrical stimulation on acupoints around eye versus auricular acupuncture versus combined therapy including the former 3 treatments), which does not meet our inclusion criteria for type of intervention
Han 2000	The trial compared 2 different types of acupuncture techniques (ear acupuncture versus body acupuncture), which does not meet our inclusion criteria for type of intervention
Hou 1992	Controlled trial, randomization was not mentioned.
Hu 2000	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Hua 2003	Claimed to have randomized participants but did not include details about the randomization methods, and authors did not respond to interview requests
Jiang 2002	Claimed to have randomized participants; however, in a telephone survey on 31 October 2014, the first author Jiang Rongtao said the participants were allocated casually, not using any specific randomization method
Jin 2015	Claimed to have randomized participants using coin tossing; however, in a telephone survey on 26 February 2015, the first author Jin Hong said only some of the participants were allocated using coin tossing; others were allocated casually, not using any specific randomization method
Li 1996	Controlled trial, randomization was not mentioned.
Li 1998	Claimed “random sampling,” however stated that “we selected the patients using antibiotics and warm compresses as control which is not considered an authentic randomization method,” which indicated that the allocation was not authentically randomized
Li 2006b	Claimed to have randomized participants but did not include details about the randomization methods, and authors did not respond to interview requests

Liao 2013	The trial compared Chinese herbal plaster versus pricking and cupping, which does not meet our inclusion criteria for type of intervention
Lin 2006	Claimed to have randomized participants, however in a telephone survey on 1 September 2014, the first author Lin Nan said participants were assigned according to their will
Liu 1998	Controlled trial, randomization was not mentioned.
Lv 2012	Claimed to have randomized participants, however participant allocation used was based on alternation, which indicates that this was a quasi-randomized trial. Its results favored acupuncture over topical antibiotics. Telephone survey was on 31 October 2014
Ma 1994	Controlled trial, randomization was not mentioned.
Pan 1994	Claimed “random sampling,” however stated that “In recent 10 years, we treat patients of hordeolum using blood-letting method, and found good effect. And we used medicine treatment as control and finally treated 156 cases totally. We used random sampling method to do statistical analysis…,” which indicated that the allocation was not authentically randomized
Peng 2002	Claimed to have randomized participants, however in a telephone survey on 2 September 2014, the first author Peng Xiwen said participants were assigned according to the severity of the disease: participants at the early stage were allocated to the acupuncture plus antibiotics and warm compresses group, and participants with abscess formations were allocated to the antibiotics and warm compresses group
Ren 1997	The trial compared 4 different types of acupuncture techniques (tapping to bleed at eyelid versus bloodletting at back acupoints versus bloodletting at ear apex versus combined therapy of the former 3 methods), which does not meet our inclusion criteria for type of intervention
Ren 2012	Controlled trial, randomization was not mentioned.
Shi 2009	Claimed to have randomized participants but did not include details about the randomization methods, and the author Shi Lai declined to be interviewed
Shi 2011	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Sun 1992	Controlled trial, randomization was not mentioned.
Sun 2004	The trial compared 2 different types of acupuncture techniques (bloodletting plus ear acupressure versus bloodletting), which does not meet our inclusion criteria for type of intervention
Tang 2000	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Tang 2013	Acupuncture plus Chinese herb fumigation used in 1 group, but the intervention used in the control group was not reported. Reported as an RCT
Teng 2014	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Wang 1995	Claimed “random,” however stated that “We randomly selected 96 cases of this disease as treatment group, and 50 cases as control group, then we did investigation and treatment,” which indicated the allocation was not authentically randomized
Wang 2014	The trial compared bloodletting at ear apex plus oral TCM medicine vs topical antibiotics plus warm compress, which does not meet our inclusion criteria for type of intervention. Reported as an RCT
Wang 2015	The trial compared bloodletting at ear apex plus Houttuynia eyedrops and topical antibiotics versus warm compress plus topical antibiotics, which does not meet our inclusion criteria for type of intervention. Reported as an RCT
Xia 1997	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Xu 1996	Controlled trial, randomization was not mentioned.
Xu 2007	Claimed to have randomized participants; however, in a telephone survey on 2 September 2014, the first author Xu Xiangdong said the participants were allocated casually, not using any specific randomization method
Xue 1994	Controlled trial, randomization was not mentioned.
Xue 1996	The trial compared needle-scraping plus topical antibiotics versus camphor-ginger ointment plus topical and systemic antibiotics plus tetracycline eye ointment, which does not meet our inclusion criteria for type of intervention

Yan 1999	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Yang 2010a	Controlled trial, randomization was not mentioned.
Yang 2010b	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located. (The authors did not report an outcome for resolution of a hordeolum or other prespecified outcomes in our review; reported only the rate of improvement of hordeolum.)
Yin 1998	Claimed to have randomized participants but did not include details about the randomization methods, and authors did not respond to interview requests
Yin 2003	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Zang 2013	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Zhang 1989	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Zhang 1997a	Controlled trial, randomization was not mentioned.
Zhang 1997b	Claimed to have randomized participants but did not include details about the randomization methods, and the author Zhang Shu Hua declined to be interviewed. (The authors did not report an outcome for resolution of a hordeolum or other prespecified outcomes in our review; reported only the rate of improvement of hordeolum.)
Zhang 1999	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Zhang 2004	Claimed to have randomized participants, however participant allocation used was based on alternation, which indicates that this was a quasi-randomized trial. Its results favored acupuncture (bloodletting at ear apex and back) over topical antibiotics. Telephone survey was on 3 September 2014
Zhao 1995	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located
Zhong 2012	Claimed to have randomized participants but did not include details about the randomization methods, and author contact details could not be located

RCT: randomized controlled trial

TCM: Traditional Chinese Medicine

DATA AND ANALYSES

Comparison 1

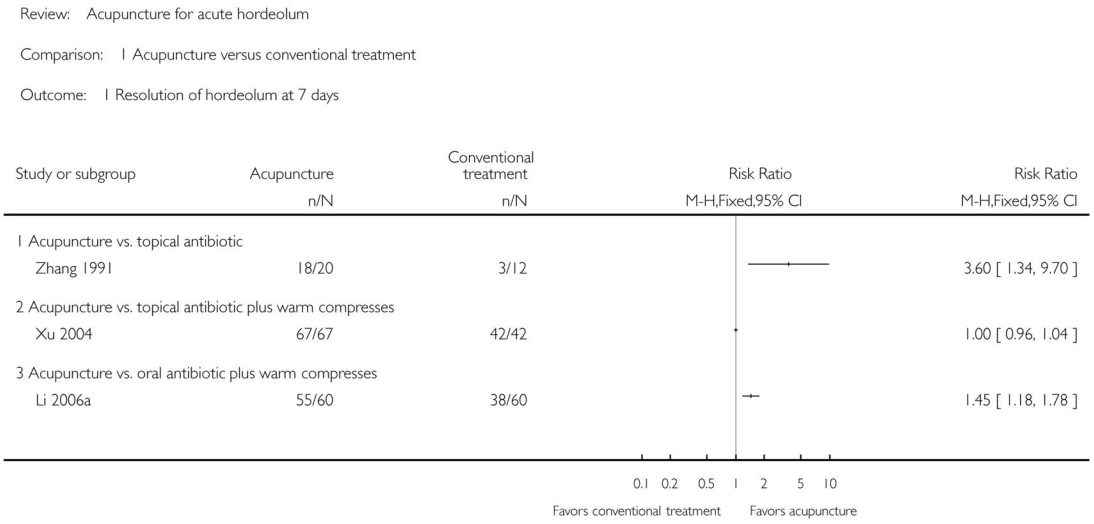
Acupuncture versus conventional treatment

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Resolution of hordeolum at 7 days	3		Risk Ratio (M-H, Fixed, 95% CI)	Totals not selected
1.1 Acupuncture vs. topical antibiotic	1		Risk Ratio (M-H, Fixed, 95% CI)	0.0 [0.0, 0.0]
1.2 Acupuncture vs. topical antibiotic plus warm compresses	1		Risk Ratio (M-H, Fixed, 95% CI)	0.0 [0.0, 0.0]
1.3 Acupuncture vs. oral antibiotic plus warm compresses	1		Risk Ratio (M-H, Fixed, 95% CI)	0.0 [0.0, 0.0]

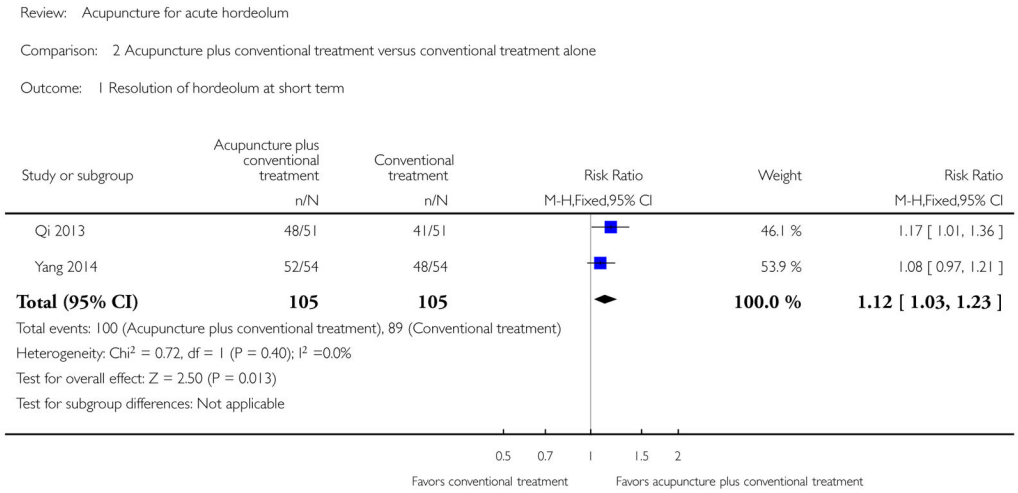
Comparison 2

Acupuncture plus conventional treatment versus conventional treatment alone

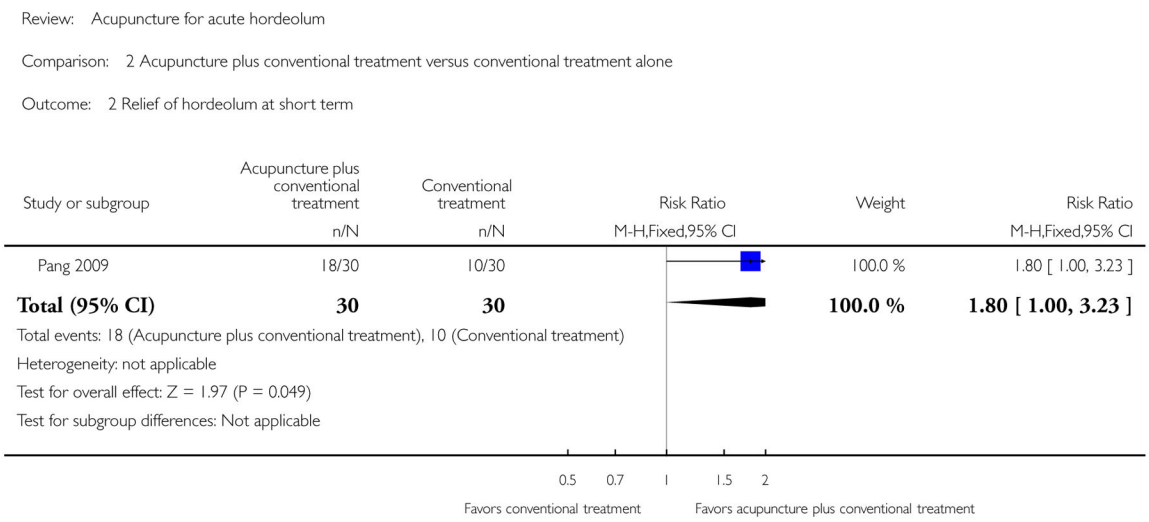
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Resolution of hordeolum at short term	2	210	Risk Ratio (M-H, Fixed, 95% CI)	1.12 [1.03, 1.23]
2 Relief of hordeolum at short term	1	60	Risk Ratio (M-H, Fixed, 95% CI)	1.8 [1.00, 3.23]



Analysis 1.1.
Comparison 1 Acupuncture versus conventional treatment, Outcome 1 Resolution of hordeolum at 7 days.



Analysis 2.1.
Comparison 2 Acupuncture plus conventional treatment versus conventional treatment alone, Outcome 1 Resolution of hordeolum at short term.



Analysis 2.2.
Comparison 2 Acupuncture plus conventional treatment versus conventional treatment alone, Outcome 2 Relief of hordeolum at short term.

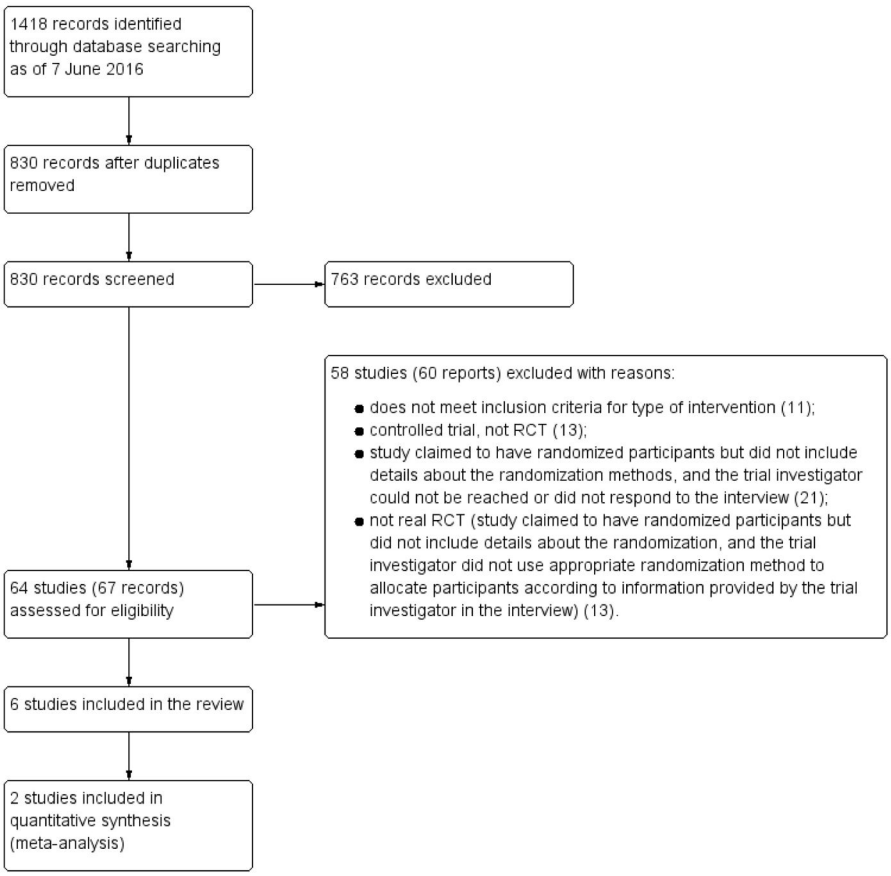


Figure 1.
Study flow diagram.

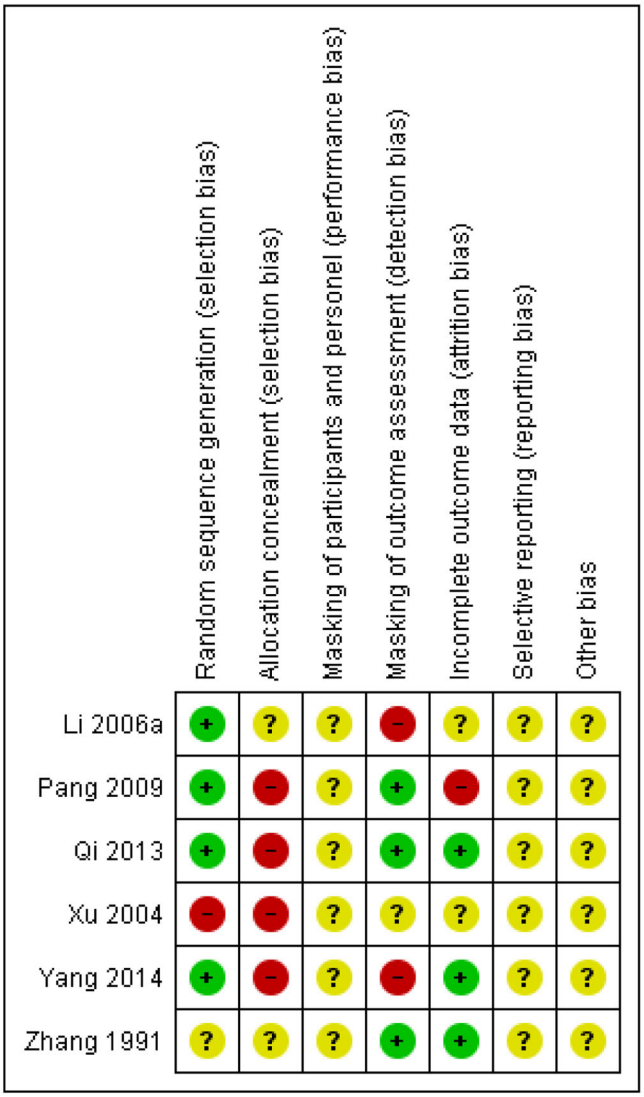


Figure 2.
Risk of bias summary: review authors' judgements about each risk of bias item for each included study.

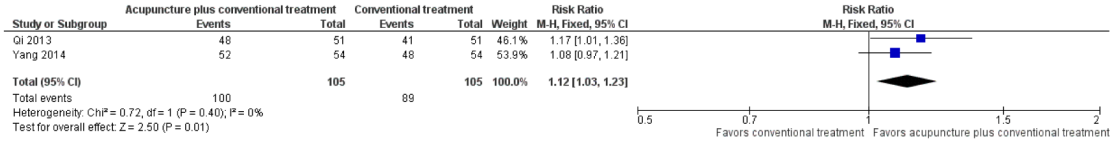


Figure 3.

Acupuncture plus conventional treatment versus conventional treatment alone: Resolution of hordeolum at short term.

Table 1

Characteristics of randomized controlled trials of acupuncture for acute hordeolum

Study	Country	Population[a]	Acupuncture treatment	Control treatment	Time point for assessment of complete resolution of a hordeolum[b]
Li 2006a	China	120 participants with acute external or internal hordeolum, mean age 18 years, duration of acute hordeolum no more than 3 days	**Acupuncture:** penetration needling from Du 13 to Du 12; 3 sessions over 3 days	Oral antibiotic (erythromycin) plus warm compresses over 3 days	3 days after diagnosis
Pang 2009	China	60 participants with acute hordeolum (internal or external hordeolum was not mentioned), mean age 28 years, duration of acute hordeolum not mentioned	**Acupuncture (bloodletting) plus conventional treatments**: bloodletting at bilateral Erjian (EX-HN6) at the ear apex plus conventional treatment; 1 session over 1 day	**Conventional treatments alone:** topical antibiotics (ofloxacin eyedrops) over 1 day	1 day after diagnosis
Qi 2013	China	102 participants with acute external hordeolum, mean age 28 years, duration of acute hordeolum no more than 4 days	**Acupuncture (bloodletting) plus conventional treatments**: bloodletting at ipsilateral Erjian (EX-HN6) at the ear apex plus conventional treatment; 3 sessions over 3 days	**Conventional treatments alone:** topical antibiotics (ofloxacin eyedrops + erythromycin ointment) plus warm compresses over 3 days	7 days after diagnosis
Xu 2004	China	109 participants with acute hordeolum (internal or external hordeolum was not mentioned), age range from 16 to 57 years, duration of acute hordeolum no more than 4 days	**Acupuncture:** bloodletting ipsilateral Erjian (EX-HN6) at the ear apex plus repeated shallow puncture on stye; 1 to 3 sessions over 1 to 3 days	Topical antibiotics (erythromycin ointment) plus warm compresses over 1 to 3 days	3 days after diagnosis
Yang 2014	China	108 participants with recurrent acute external or internal hordeolum, mean age 23 years, mean duration of acute hordeolum from its first onset 24 days	**Acupuncture (bloodletting) plus conventional treatments**: bloodletting at ipsilateral Erjian (EX-HN6) at the ear apex; 1 to 3 sessions over 1 to 3 days	**Conventional treatments alone:** topical antibiotics (tobramycin eyedrops + erythromycin ointment) plus warm compresses over 1 to 6 days	6 days after diagnosis
Zhang 1991	China	32 participants with acute external or internal hordeolum, age range from 10 to 41 years, duration of acute hordeolum no more than 6 days	**Acupuncture:** needling at ipsilateral LI 14; 1 to 3 sessions over 1 to 3 days	Topical antibiotic (chloramphenicol (Chloromycetin) eyedrops plus erythromycin ointment) over 3 days	4 days after diagnosis

[a]Number listed is the number of participants analyzed.

[b]For all the included RCTs, the day of diagnosis was also the day of the initial treatment.

Table 2

Acupuncture adequacy assessments of included studies

Study	Choice of acupuncture points	Total number of sessions	Treatment duration	Treatment frequency	Needling technique	Experience	Assessment of number of sessions/dose (for the active treatments used in control group)	Guess of study[f]
Li 2006a	Adequate[a]	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Don't know
Pang 2009	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Inadequate[b]	Don't know
Qi 2013	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate[c]	Adequate	Don't know
Xu 2004	Adequate	Adequate	Adequate	Adequate	Adequate	Unclear	Adequate	Don't know
Yang 2014	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate[d]	Adequate	Don't know
Zhang 1991	Adequate[e]	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Don't know

[a] Although the two points (DU 12 and DU 13) were not commonly used points for treating eye disorders, they might be effective to treat acute hordeolum due to their action of clearing heat.

[b] Application of topical antibiotic for only one day was not enough to treat acute hordeolum.

[c] The acupuncture treatment was administered by an ophthalmic technician with more than five years of professional experience and experience in bloodletting at ear apex for hordeolum.

[d] The acupuncture treatment was administered by a nurse with eight years of experience bloodletting at ear apex for hordeolum.

[e] Although LI 14 was not commonly used, the literature showed that LI 14 has specific effect on eye disorders and was used by some experienced acupuncturists (Bai 2011; Liu 2001).

[f] Assessors of acupuncture adequacy were masked to the study identity and were asked to guess the study identity. Their response was "don't know."