

Empiricism Revisited

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MANY PRACTITIONERS WOULD AGREE that randomized trials, suitable as they are for drug and device research, are inadequate and inappropriate for acupuncture and other interactional therapies. Yet, the debate continues. In the meantime, acupuncture organizations carry on paying lip service to trials that many members suspect are meaningless. In the past I have argued that the acupuncture community should let go of trying to meet inappropriate research requirements and move on.^{1,2} But what should be put in their place? And what might constitute convincing evidence for a front-line practitioner? One answer, curiously, might be found in reconnecting with how acupuncture developed in the first place. Perhaps it is time for a re-emergence of the time-honored tradition of empiricism.

Two years ago I coauthored an article with Stephen J. Burnett, MD, suggesting that venous thromboembolism (VTE) prophylaxis post joint replacement might be significantly improved in selected low-risk patients by paying attention to energetic principles in the postoperative period.³ The thrust of the article was that if, postoperatively, all obstacles to Qi flow were removed, then pain might be less of an issue, the risk of VTE might be reduced, and, concomitantly, recovery might be hastened. The most salient issue we explored was the virtually unquestioned use of opioid analgesics postoperatively, as these are drugs that are known to aggravate constipation and urinary retention. An acupuncture perspective would suggest that, because such drugs stagnate the flow of Qi in the Large Intestine and Bladder sectors, these agents would likely aggravate Qi/Blood Stagnation in a more general way too, which, in turn, would increase the risk of VTE. It seemed strange to me then, as it does now, that this possibility is not a forefront consideration. Instead, huge amounts of money are directed toward comparing the minute differences between various low-molecular weight heparin (LMWH) preparations, when, for most low-risk patients, (1) aspirin is perfectly acceptable,⁴ and (2) stopping energy-stagnating drugs might be a far more effective overall strategy.

For those patients who might recoil at the thought of overwhelming pain, we suggested using acupuncture, in par-

ticular, the battlefield ear-acupuncture protocol,⁵ as an alternative to opioids. The protocol has been proven to be effective, has no side-effects to speak of, is simple to administer and can be done by ward nurses with minimal instruction.

After my original hip replacement, not having thought things through too much and being reticent to rock the boat, I accepted the usual prescriptions, albeit at somewhat reduced dosages, and only instituted acupuncture after returning home on day 3. While in the hospital, I experienced typical bowel and bladder dysfunction. No doubt, the urinary retention was, in part, caused by the spinal anaesthetic, but the symptoms resolved quickly after I discontinued the opioids. Indeed, in retrospect, the opioids seemed to be more effective for inducing brain fog and dissociation than for eliminating pain.

It is not every day one has a chance to test a theory personally. But, given that hip arthritis is often a bilateral disease, it was only a matter of time before I found myself facing the same surgery on the other side of my body. This time, having gone to the trouble of exploring alternatives to postoperative management, it rather behooved me to follow through with these alternatives. After all, not to do so would have risked relegating the theory to the dustbin of a dubious armchair philosophy while simultaneously hoisting me on my own petard. Both of these prospects seemed unpalatable.

Therefore, for postoperative management, I arranged to have the battlefield acupuncture points inserted in my ear using press-tacks and semi-permanent ASP needles, supplemented by daily application of the GB Jing-well point on the fourth toe (Zuqiao, GB 44), a readily accessible point that did not interfere with local dressings and hospital protocols. I declined all medications except acetaminophen and rivaroxaban, the latter of which I switched to aspirin when I was discharged from the hospital on day 3. Fortunately, I had the support of my surgeon to do this, because the nursing staff seemed slightly incredulous and encouraged me repeatedly to change my mind.

The results exceeded my expectations. To summarize: The pain was no worse than the first time I had been operated on; my head remained clear; my sleep was no worse; my wound drainage was less—the wound was dry by day 4 (versus

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day 10 the first time); weight-bearing and initial walking proved easier, perhaps because my head was clear; my urinary retention resolved within 24 hours (versus 48 hours); and, finally, I had no constipation at all (versus 5 days the first time).

Never mind the enormous hassles of a double-blinded trial. My own experience is all the evidence I will ever need. Regardless of what the research pundits might say, I now know something about Qi Stagnation and drugs that, before, was largely theoretical. But what to do with the knowledge in a broader sense poses all kinds of difficulties, some of which were discussed in the original article. Certainly, I would encourage practitioners who are facing joint surgery to consider a similar strategy. But how to encourage patients to do the same, well, that's another story.

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