

The lively presentational style of the revamped Journal is welcome, and the new concise and accessible approach to research will certainly help time-pressed clinicians. However, there is an uncomfortable tension between the need to present data to busy practitioners in an easily digestible format and gross-oversimplification that risks the misinterpretation of data. The Editor seems to have fallen into this trap with Paterson et al's study on acupuncture with medically unexplained symptoms.¹

The study is riddled with bias in a number of key areas including participant selection and the unblinded intervention. The construction of the study lends itself to a positive result and there is little value in conducting acupuncture studies without adjusting for this bias by using some kind of sham treatment. The authors do discuss the 'black-box' effect of the intervention and this does raise the unfortunate, but in this case appropriate, image of a terrible crash that needs careful post-disaster investigation. Even given the obvious bias, the effect was small and the graphs presented in the full-length article,¹ sadly missing in the print version, made this abundantly clear.

The *BJGP* has done a disservice to the communication of science, and the uncritical message, propagated through the RCGP, of the effectiveness of acupuncture in this study simply doesn't stand up to any reasonable scrutiny. Thanks to the *BJGP* press release, the national print media picked up on the story and ran it uncritically in the true spirit of modern 'churnalism'.² Pragmatic studies need pragmatic interpretation and shouldn't develop into publicity campaigns that can be boiled down to 140 characters. Ironically, it is subsequently through Twitter and the blogosphere that the damage to the reputation of the *BJGP* has been done.³ I recognise the need to make research palatable but the headline front-cover conclusion printed by the *BJGP* is ill-judged and owes more to a tabloid approach to journalism than any sober consideration of the true nature of the findings in this study.

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DOI: 10.3399/bjgp11X588286

We have some serious concerns about the methodology and the conclusions of the studies by Paterson, Rugg and colleagues.^{1,2}

First of all, the results of these studies would have been more acceptable if five-element acupuncture would have been compared to placebo, that was not the case. Acupuncturists often argue that placebo control is not feasible with acupuncture. But in several studies investigators were able to compare acupuncture to placebo by using non-invasive acupuncture or superficial needling at non-acupuncture points.^{3,4}

It has been proven that simulated acupuncture procedures are a reasonable control treatment for acupuncture-naïve individuals in randomised controlled trials (subjects receiving acupuncture with real needles versus pokes with a toothpick in a guide-tube).³ In a placebo controlled study with patients suffering from chronic low back pain there were no significant differences between real acupuncture and minimal acupuncture at non-acupuncture points.⁴

Second, the studies by Paterson, Rugg and colleagues do not clearly describe how patients with medically unexplained physical symptoms (MUPS) were defined. Inclusion and exclusion criteria remain unclear. Being an inhomogeneous group, patients with MUPS undoubtedly present with different diagnoses, each needing a specific treatment. As the study groups consisted of frequent attenders with MUPS, we are concerned about a selection bias favouring 'medical shoppers'. These patients may feel better after any medical 'consultation' as such, enhancing the role of a placebo effect. In this study the patients knew whether they were in the treatment group or control

group. The cross-over design of the study does not surmount this issue, especially because all outcome measures are subjective evaluations of health status and wellbeing.

Third, improvement on the Measure Yourself Medical Outcome Profile score was only borderline significant ($P = 0.05$), while, except for wellbeing, there was no significant improvement for any of the other parameters. This confirms the fact that medical 'attention' may play a more important role than the treatment, for example, acupuncture itself.

Finally, the non-significant decrease in consultations with the GP should have been adjusted with the 12 sessions of acupuncture. In our opinion, the gain in number of consultations will be small, but there will be a shift in consultations from the GP to the acupuncturist.

In conclusion, we are not convinced of the benefit of acupuncture for patients with MUPS. There certainly is a further need for higher quality trials in this domain before treatment guidelines can recommend acupuncture for MUPS.

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DOI: 10.3399/bjgp11X588295