

2. Jones R. Editor's briefing. *Br J Gen Pract* 2011; **61(587)**: 372.

DOI: 10.3399/bjgp11X588349

Paterson *et al*¹ conclude from their randomised controlled trial (CACTUS study) that an addition of 12 sessions of five-element acupuncture to usual care resulted in improved health status and wellbeing. We were immediately attracted to their article by the clinical relevance of investigating treatment in patients with medically unexplained physical symptoms (MUPS). MUPS are an interesting and relevant problem in primary health care, because these patients are often 'frequent attenders' and this leads to high medical costs, frustrated doctors, and patients who feel misunderstood. The authors recommend in their study the use of five-element acupuncture for patients with MUPS as a safe and potentially effective intervention. However, we have some questions and comments about the outcome measures applied and the selection of patients in their study.

The conclusion of the study is only based on the outcomes of two questionnaires, that is to say, the Measure Yourself Medical Outcome Profile (MYMOP) and the Wellbeing Questionnaire (W-BQ12). At 26 weeks' follow-up, when adjusted for missing values and baseline scores, a significant difference in the between-group analysis is only seen on the W-BQ12. Moreover, the medical and clinical relevance of the outcome measures of these, for clinicians, relatively-unknown questionnaires are not described. Although acupuncture in people with MUPS may lead to improved wellbeing, there was no evidence that the GP consultation rate or medication use was decreased. The Patient Enablement Instrument was omitted because it did not perform well as a repeated measure. The authors state that many control group patients checked 'not applicable' because they thought the questions related only to the acupuncture treatment. What is this statement based on and how bad did it perform as a repeated measure?

Because patients were selected by their own GPs, selection bias is likely. Besides, inclusion criteria are not clear enough. Four inclusion criteria are stated in Box 1, however, the authors also report 'other inclusion criteria (from electronic record search).' What is meant with this? Is this an additional criterion or a new criterion

for inclusion? One of the inclusion criteria of this study was the existence of the symptom for at least 3 months, but the table of participant characteristics shows two patients with a duration of the complaint of 4 to 12 weeks. Why were these patients included in the study?

With these comments, it is hard for us to estimate the clinical relevance of this study.

Marjolein Meijer,

Medical Student, Department of General Practice, Erasmus MC, The Netherlands.

Annemieke Verwoerd,

GP Trainee and PhD Student, Department of General Practice, Erasmus MC, PO Box 2040, 3000 CA Rotterdam, The Netherlands. E-mail: j.verwoerd@erasmusmc.nl

REFERENCE

1. Paterson C, Taylor RS, Griffiths P, *et al*. Acupuncture for 'frequent attenders' with medically unexplained symptoms: a randomised controlled trial (CACTUS study). *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X572689.

DOI: 10.3399/bjgp11X588358

Editor's response

The *BJGP* Editorial Board considered this correspondence recently. The Board endorsed the Journal's peer review process and did not consider that there was a case for retraction of the paper or for releasing the peer reviews. The Board did, however, think that the results of the study were highlighted by the Journal in an overly-positive manner. However, many of the criticisms published above are addressed by the authors themselves in the full paper.

DOI: 10.3399/bjgp11X588367

Authors' response

Much of the response to our papers about acupuncture as a treatment for medically unexplained symptoms, some as letters to the Journal and some in other online fora, relates to the headline messages. In the papers we acknowledged the limitations of our work and explained our choice of methods. The trial and accompanying process evaluation was always intended to be a pragmatic real world trial, with all its

attendant potential biases, and we have attempted to report its results fully, warts and all. The pragmatic interpretation that Lawson asks for is as we reported: within the limits of the trial, five-element acupuncture is a safe and potentially effective intervention for patients with medically unexplained symptoms that may help some of them to take an active role in their treatment and make cognitive or behavioural lifestyle changes.

The design of the study was a standard waiting list controlled pragmatic trial, that was the best design to answer a pragmatic question. It was also best as a precursor to a cost effectiveness study, that would further inform NHS provision. The effect size was demonstrated on the basis of the preselected primary outcome measure, using standard statistical methods. It was conducted according to its registered protocol with the exception of the sample size that was revised downward because, in common with many trials, recruitment was slower than anticipated. This deviation from protocol was fully reported in the paper. We noted that the results were sensitive to missing data and that the study may have been underpowered.

Devroey and Van De Vijver complain that the sample was a heterogenous group with different diagnoses, but has missed the point that patients in this group all lacked diagnoses. As we explain in the paper, sham acupuncture controls are used to investigate the efficacy of a particular needling protocol, usually for a narrowly defined diagnosis, but are not appropriate for answering the pragmatic question of whether a referral for a series of acupuncture treatments is likely to be beneficial. The reason for doing the trial in the first place is that this group of patients are challenging for their doctors and occupy a considerable amount of their time.

We acknowledge in the paper that the 'study design precludes assigning the benefits of this complex intervention to any one component of the acupuncture consultations, such as the needling or the amount of time spent with a healthcare professional', but the suggestion that simply spending more time with physicians would achieve the same effect fails to address the issue, either for doctor or patients. The Measure Yourself Medical Outcome Profile instrument has been validated in settings other than complementary medicine.^{1,2} In terms of determining clinical significance, we can draw on work done with other seven-point scales, that concludes 'the smallest

difference that patients consider important is often approximately 0.5.³ Consequently, our finding of a 0.6 mean difference between the groups is likely to be clinically significant — especially as substantial numbers of patients in the trial will have perceived more benefit than this.

Adjustment of consultation rates for the extra acupuncture consultations would not change the inference on the within — and between-group inference on consultation rates. All the 41 control patients were offered acupuncture after a period of 6 months, and 35 took up the offer. Patients from both the intervention and the control groups were interviewed.

The rationale for offering acupuncture to this group of patients is that medicine seems to have little to offer them; this mixed methods study suggests an acceptable and potentially valuable way out of what is often an impasse for doctors and patients.

Charlotte Paterson,

Senior Research Fellow, Peninsula Medical School, University of Exeter, Institute of Health Service Research, Veysey Building, Salmon Pool Lane, Exeter, EX2 4SG.
E-mail: charlotte.paterson@pms.ac.uk

Rod Taylor,

Peninsula Medical School, University of Exeter, Institute of Health Service Research, Exeter.

Peter Griffiths,

University of Southampton, School of Health Sciences, Southampton.

Nicky Britten,

Peninsula Medical School, University of Exeter, Institute of Clinical Education, Exeter.

Sue Rugg,

Peninsula Medical School, University of Exeter, Institute of Health Service Research, Exeter.

Jackie Bridges,

School of Community and Health Sciences, City University London.

Bruce McCallum,

London Institute of Five-Element

Acupuncture, 73 New Bond Street, London.

Gerad Kite,

London Institute of Five-Element Acupuncture, 73 New Bond Street, London.

REFERENCES

1. Paterson C. Measuring outcome in primary care: a patient-generated measure, MYMOP, compared to the SF-36 health survey. *BMJ* 1996; **312**(7037): 1016–1020.
2. Paterson C, Langan CE, McKaig GA, *et al*. Assessing patient outcomes in acute exacerbations of chronic bronchitis: the measure yourself medical outcome profile (MYMOP), medical outcomes study 6-item general health survey (MOS-6) and EuroQol (EQ-5D). *Qual Life Res* 2000; **9**(5): 521–527.
3. Guyatt GH, Juniper EF, Walter S, *et al*. Interpreting treatment effects in randomised trials. *BMJ* 1998; **316**(7132): 690–693.

DOI: 10.3399/bjgp11X588376

Domestic violence, PTSD, and diagnostic enquiry

It was refreshing to read a paper¹ and editorial² that sought to identify causes of patients' anxiety in their life events, as patients complain that doctors often fail to ask why they are anxious or depressed.³

The reported research identified domestic violence and abuse (DVA) as a cause of anxiety using the HARK questions (four short questions relating to Humiliation, being Afraid, Raped, and Kicked).⁴

The paper also notes that the Generalised Anxiety Disorder Scale (GAD-7) can be used as a 'case-finder' for panic-disorder, social anxiety disorder, and post-traumatic stress disorder (PTSD), as well as generalised anxiety disorder (GAD). The questions of the GAD-7 overlap with the questions required to make the diagnoses above, that is why GAD-7 can act as a 'case-finder'.¹ However, I think it is a mistake to conclude from the paper that domestic violence causes GAD, as the editorial seems to. Sherina *et al* do not claim this. They did not pursue further analysis of the type of anxiety disorder patients were suffering from in their research. Diagnostic rigour helps the doctor and patient understand the consequences of DVA and thus find appropriate solutions. Sherina *et al* discuss the association of PTSD and DVA.

A meta-analysis⁵ on the prevalence of mental health problems among those who

had experienced DVA found mean prevalences of 63.8% in 11 studies of PTSD, 47.6% in 18 studies of depression, 17.9% in 13 studies of suicidality, 18.5% in 10 studies of alcohol abuse, and 8.9% in four studies of drug abuse. Dose-response relationships of violence to depression and PTSD were observed.

The best explanatory model linking domestic violence and anxiety disorders is PTSD. It makes sense that terrifying and humiliating experiences of DVA result in nightmares, flashbacks (intrusive thoughts), avoidance behaviours, and hyper-arousal. However, a positive GAD-7 score may usefully act as a tool of communication, and a prompt to the GP for further questioning about PTSD symptoms and DVA using HARK questions.

The linked editorial² correctly identifies the lack of evidence for the use of 'routine enquiry' for DVA in general practice, as opposed to its evidence-based use in antenatal clinics.⁶ This is reiterated by the Department of Health.³ I am writing the RCGP e-learning course on DVA. I encourage GPs to work from patients' symptoms, using 'diagnostic enquiry' rather than 'routine enquiry'.⁷ The course will, I hope, provide safe, pragmatic guidance that is congruent with how we GPs work.

Fiona Duxbury,

The Leys Health Centre, Dunnock Way, Greater Leys, Oxford, OX4 7EX.
E-mail: duxburycrossel@doctors.org.uk

REFERENCES

1. Sherina SM, Arroll B, Goodyear-Smith F. Prevalence of anxiety among women attending a primary care clinic in Malaysia. *Br J Gen Pract* 2011; DOI: 10.3399/bjgp11X577990.
2. Tait L, Berrisford G. Generalised anxiety disorder: the importance of life context and social factors. *Br J Gen Pract* 2011; **61**(587): 378–379.
3. Sub-group. *Report from the Domestic Violence sub-group responding to violence against women and children. Taskforce on the health aspects of violence against women and children*. London: Department of Health, 2010.
4. Sohal H, Eldridge S, Feder G. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Fam Pract* 2007; **8**: 49.
5. Golding J. Intimate Partner Violence as a risk factor for mental disorders: a meta-analysis. *J Fam Violence* 1999; **14**(2): 99–132.
6. Mezey G, Bacchus L, Bewley S, White S. Domestic violence, lifetime trauma and psychological health of childbearing women. *BJOG* 2005; **112**(2): 197–204.