

1	<b>Clinical Practice Guideline:</b>	<b>Acupuncture for the Treatment of</b>
2		<b>Abdominal/Pelvic Pain</b>
3		
4	<b>Date of Implementation:</b>	<b>April 15, 2010</b>
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8	<b>Product:</b>	<b>Specialty</b>

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23

24 **GUIDELINES**

25 American Specialty Health – Specialty (ASH) considers the use of acupuncture for the  
 26 treatment of abdominal/pelvic pain (e.g., bladder pain syndrome, dysmenorrhea; pain  
 27 related to gastrointestinal disorders, including irritable bowel syndrome (IBS),  
 28 gastroesophageal reflux disease (GERD), inflammatory bowel disease (IBD); functional  
 29 dyspepsia) as reasonable and appropriate when:

- 30 • Other evidence-based interventions have been deemed unsuccessful or
- 31 contraindicated;
- 32 • The acupuncture treatment is in combination with, and complementary to, other
- 33 treatment strategies; and
- 34 • There is medical oversight of the underlying condition for which the physician
- 35 retains primary responsibility for patient management.

1 The evidence supporting acupuncture treatment for pain associated with these  
 2 abdominal/pelvic conditions is relatively low quality, ranging from promising to  
 3 preliminary and insufficient to inconclusive. However, there is no strong evidence that  
 4 acupuncture is ineffective in treating the pain associated with these disorders; and the safety  
 5 profile of acupuncture is such that a trial of care could be considered reasonable when the  
 6 above criteria are met.

7  
 8 This guideline does not pertain to premenstrual syndrome (PMS) or premenstrual  
 9 dysphoric disorder (PMDD), menstrual irregularities, and/or fertility issues.

### 10 **Diagnosis Codes and Descriptions**

ICD-10 Code	ICD-10 Code Description
N94.4	Primary dysmenorrhea
N94.5	Secondary dysmenorrhea
N94.6	Dysmenorrhea, unspecified
R10.10	Upper abdominal pain, unspecified
R10.11	Right upper quadrant pain
R10.12	Left upper quadrant pain
R10.13	Epigastric pain
R10.20	Pelvic and perineal pain unspecified side
R10.21	Pelvic and perineal pain right side
R10.22	Pelvic and perineal pain left side
R10.23	Pelvic and perineal pain bilateral
R10.24	Suprapubic pain
R10.30	Lower abdominal pain, unspecified
R10.31	Right lower quadrant pain
R10.32	Left lower quadrant pain
R10.33	Periumbilical pain
R10.84	Generalized abdominal pain

### 12 **DESCRIPTION/BACKGROUND**

13  
 14  
 15 **Functional gastrointestinal (FGI)** and motility disorders or **Disorders of Gut-Brain**  
 16 **Interaction (DGBI)** are the most common GI disorders in the general population. This  
 17 category of conditions includes functional dyspepsia, irritable bowel syndrome (IBS),

1 functional heartburn, functional abdominal pain, functional constipation/diarrhea,  
 2 functional dysphasia, globus, functional nausea and vomiting disorders, defecation  
 3 disorders, and rumination syndrome. Symptoms are often chronic (> 3 months in a year),  
 4 frequent (> 3 episodes per week) and severe. Common symptoms include disturbances in  
 5 motility, visceral hypersensitivity, altered mucosal and immune function, changes in gut  
 6 microbiota and altered central nervous system processing of GI functions. Functional GI  
 7 symptoms are caused by multiple factors, and different conditions, symptoms and  
 8 pathophysiology may combine in individual patient presentations. Other GI conditions  
 9 such as gastroesophageal reflux (GERD) may overlap with functional disorders.

10  
 11 **Inflammatory bowel disease (IBD)**, a group of disorders in which the colon or small  
 12 intestine become inflamed (most likely as a result of an autoimmune reaction of the body  
 13 against its own intestinal tissue), includes Crohn’s disease and ulcerative colitis, affects  
 14 over one million patients in the United States, and has been reported in all continents (Huo  
 15 et al., 2009).

16  
 17 **Chronic pelvic pain (CPP)** is defined as noncyclic pain of more than 6 months that  
 18 localizes in the pelvis, the anterior abdominal wall at or below the umbilicus, the  
 19 lumbosacral region of the spine, or the buttocks. Severe CPP not only causes functional  
 20 disability in patients, but also reduces quality of life (Sung et al., 2018). The causes of CPP  
 21 are complicated and not entirely understood, but may include pelvic congestion, adhesions,  
 22 musculoskeletal nerve-related disorders, and psychosomatic factors. Interventions  
 23 targeting these factors have been used in the management of CPP. The majority of women  
 24 who experience CPP have musculoskeletal system dysfunction. These issues could include  
 25 postural changes, as well as changes in the pelvic muscles, such as spasm of the levator ani  
 26 (Prendergast and Weiss, 2003). Given the potential that psychosocial components may  
 27 influence the presence of CPP, psychological treatments may be helpful in addition to  
 28 medical and/or surgical treatments. Williams et al. (2012, 2020) noted that psychological  
 29 treatments can help reduce frequency and severity of symptoms for chronic pain in general,  
 30 including CPP. Another potential disorder causing pelvic pain is chronic prostatitis/chronic  
 31 pelvic pain syndrome (CP/CPPS). This is a common disorder with symptoms of pelvic pain  
 32 and lower urinary tract symptoms. There are currently many approaches for its  
 33 management, using both pharmacological and non-pharmacological interventions (Franco  
 34 et al., 2018).

35  
 36 **Primary dysmenorrhea** can also be considered pelvic pain and is defined as cramping  
 37 pain during menstruation without any identifiable pelvic pathology, and it affects most  
 38 women throughout the menstrual years. This condition is very common and can impact  
 39 daily activities for many women who experience this pain. In the consensus guidelines of  
 40 primary dysmenorrhea, nonsteroidal anti-inflammatory drugs (NSAIDs) and oral  
 41 contraceptives (OCs) are recommended as first-line treatments. However, some patients  
 42 did not experience pain reduction with NSAIDs and did experience side effects such as

1 nausea, dyspepsia, headache, or drowsiness. In addition, OCs would not be suitable for  
 2 patients attempting to become pregnant, and might cause adverse effects such as nausea,  
 3 vomiting, weight gain, or vaginal bleeding (Woo et al., 2018). Endometriosis is a chronic,  
 4 estrogen-dependent, inflammatory disease that affects women of reproductive-age. It is  
 5 painful and may cause infertility. Current pain therapies often involve various  
 6 pharmacological and surgical treatments. Unfortunately, these treatments may not alleviate  
 7 the pain and may present side effects that are difficult to manage (Xu et al., 2017). Pelvic  
 8 pain can also occur during pregnancy. Almost 1/5 of pregnant women experience pelvic  
 9 pain and symptoms will typically increase with advancing pregnancy. Low back pain can  
 10 also occur with pelvic pain. Symptoms can interfere with activities of daily living, sleep,  
 11 and work (Liddle and Pennick, 2015).

12  
 13 **Bladder pain syndrome/interstitial cystitis** is another disorder described as pelvic pain,  
 14 pressure or discomfort perceived to be related to the bladder, lasting for at least 6 months,  
 15 and accompanied by at least one other urinary symptom. Urinary symptoms include the  
 16 frequency or persistent urge to void without any identifiable causes. The International  
 17 Urogynecological Association (IUGA) and the International Continence Society (ICS)  
 18 produced a joint report on terminologies by Haylen et al. in 2010, defining bladder pain as  
 19 a complaint of supra pubic or retro-pubic pressure, discomfort, or pain, associated with the  
 20 bladder, generally aggravated by bladder filling. The symptom may also persist after  
 21 voiding (Verghese et al., 2016).

## 22 23 **EVIDENCE REVIEW**

### 24 **Irritable Bowel Syndrome (IBS)**

25 Lim and colleagues (Lim et al., 2006) wanted to determine whether acupuncture is more  
 26 effective than no treatment, more effective than ‘sham’ (placebo) acupuncture, and as  
 27 effective as other interventions used to treat irritable bowel syndrome. They conducted a  
 28 comprehensive search irrespective of language, date of publication, and publication status.  
 29 Two scales were used to assess the methodological quality of the studies (Jadad et al., 1996;  
 30 Linde et al., 1996A; Linde et al., 1996B; Linde et al., 1997), and very well-defined  
 31 inclusion / exclusion criteria were used. Out of 12 potentially eligible studies identified,  
 32 only 6 were included (Fireman et al., 2001; Forbes et al., 2005; Liao, 2000; Lowe et al.,  
 33 2000; Liu, 1995; Liu, 1997); representing about 464 IBS patients (221 males; 244 females);  
 34 ages ranged between 16-79 years; while duration of IBS symptoms prior to enrollment  
 35 ranged from 3 months to 32 years. The studies used different IBS assessment criteria,  
 36 varied in treatment duration, and used heterogeneous acupuncture protocols. The authors  
 37 concluded that “given the poor quality of the studies, there is no evidence to support the  
 38 use of acupuncture for treating IBS; therefore, neither positive nor negative  
 39 recommendations can be made based on this review.” The authors suggested the need for  
 40 further studies and recommended that researchers follow CONSORT (Begg et al., 1996)  
 41 and STRICTA (MacPherson et al., 2001) guidelines to improve the quality of studies, that  
 42 they follow standard outcome measures, and continue to work on the development of

1 proper protocols for placebo acupuncture (Streitberger et al., 1998). The review by  
 2 Schneider and colleagues (2007) identified 18 relevant trials, but only 4 had robust RCT  
 3 design: two trials for IBS (Forbes et al., 2005; Schneider et al., 2005). Additional IBS trials  
 4 (Rohrböck et al., 2004; Xiao et al., 2004; Fireman et al., 2001; Chan et al., 1997; Kunze et  
 5 al., 1990) were also included. The authors concluded there are only a few clinical trials of  
 6 acupuncture for gastrointestinal disorders (available in English), and that only 4 are well  
 7 designed, strong RCTs. The trials of higher methodological quality looked at acupuncture  
 8 for IBS (Forbes et al., 2005; Schneider et al., 2005). For IBS, health related quality of life  
 9 (QoL) improved remarkably after acupuncture. Altogether, in all trials where QoL or  
 10 subjective symptoms were assessed, QoL/subjective symptoms improved in both the  
 11 acupuncture and the sham acupuncture groups without significant group differences.  
 12 However, for Crohn’s disease and colitis, real acupuncture was significantly superior to  
 13 sham acupuncture with regards to disease activity. Subgroup analyses in both studies  
 14 revealed that higher activity grades and disease duration of less than 5 years seem to  
 15 correlate with the efficacy of acupuncture therapy. The authors stated that “because most  
 16 trials are hampered by major methodological deficits, it is not possible to draw sure  
 17 conclusions for (acupuncture) trials of gastrointestinal conditions.”

18  
 19 The reviewers note that in IBS all interventions, acupuncture (standardized or  
 20 individualized), and sham acupuncture control (invasive vs. non-invasive), improvement  
 21 of QoL was achieved. They conclude that this effect is similar to effect sizes achieved with  
 22 psychotherapeutic interventions and antidepressants, and that it can be interpreted as  
 23 psychological effect, due in part to incidental effects of acupuncture.

24 Three additional studies have been published on acupuncture and IBS; two smaller  
 25 preliminary studies (Reynolds et al., 2008; Anastasi et al., 2009) and a large RCT (Lembo  
 26 et al., 2009). Reynolds and colleagues (2008) conducted a pragmatic RCT of 30 patients  
 27 with IBS comparing 10 sessions of acupuncture as a package of care (including  
 28 moxibustion, and recommendations on diet, exercise, and relaxation) along with usual  
 29 general practitioner (GP) care vs. usual GP care alone. A statistically and clinically  
 30 significant difference was found between groups in favor of acupuncture (P=0.001).  
 31 Another small randomized, sham/placebo-controlled trial (n=29) recently published by  
 32 Anastasi et al. (2009) assessed the effect of an individualized traditional Chinese medicine  
 33 (TCM) acupuncture and moxibustion (Acu/Moxa) treatment plan as compared to a minimal  
 34 acupuncture treatment plan at non-acupuncture points including sham moxa. After 4 weeks  
 35 of treatment, the Acu/Moxa intervention was significantly more effective in improving  
 36 symptoms.

37  
 38 Lembo et al. (2009) compared acupuncture vs. sham acupuncture in a trial ‘nested’ within  
 39 a larger study examining the impact of the patient – practitioner interaction in 230 IBS  
 40 patients. Although there was no statistically significant difference between acupuncture  
 41 and sham acupuncture on the primary IBS outcome measures, both groups improved  
 42 significantly compared with the waitlist control group. For several secondary outcome

1 measures, within each treatment condition (augmented or limited), none of the acupuncture  
2 vs. sham acupuncture differences were statistically significant.

3  
4 Chao and Zhang (2014) performed a meta-analysis consisting of six studies of acupuncture  
5 treatment for irritable bowel that met inclusion criteria. The meta-analysis overall showed  
6 a positive result, but only one study was positive out of the six. This study was much larger  
7 in participant numbers than the five smaller negative studies. Overall small sample sizes,  
8 differing treatment modes and durations and assessments of improvement made the  
9 positive results less reliable. The authors recommended further study before conclusions  
10 are drawn.

11  
12 Manheim et al. (2012) in a Cochrane Review performed a meta-analysis of 17 RCTs  
13 including 1,806 patients. There was no evidence of improvement with acupuncture  
14 treatment vs. sham acupuncture for IBS symptoms or quality of life. Acupuncture was  
15 significantly more effective than pharmacological therapy and no treatment. Sixty-three  
16 percent of the patients in the acupuncture treatment group showed symptomatic  
17 improvement compared with 34% improved in the no treatment group.

18  
19 Chao and Zhang (2014) performed a meta-analysis that included 6 randomized, placebo-  
20 controlled qualified studies of acupuncture treatment of IBS. This meta-analysis suggested  
21 that acupuncture is effective in controlling the symptoms of IBS including abdominal pain  
22 and distention as well as abnormal frequency of defecation. Five of the six studies did not  
23 show a positive effect. The overall effect was positive due to the large number of subjects  
24 in the one positive trial. The authors commented that the results were not enough to  
25 recommend acupuncture as a first line therapy and that further studies were needed.

26  
27 Park et al. (2013) performed a systematic review of moxibustion treatment of IBS. Twenty  
28 studies were included. Moxibustion did show positive effects on IBS, but there were biases  
29 and inconsistencies in the studies. Further study was indicated.

30  
31 MacPherson et al. (2012) conducted a RCT with 233 patients with IBS comparing usual  
32 care alone and combined with acupuncture treatments. Acupuncture provided a significant  
33 benefit over usual care alone and the effect was continued over the 12-month follow-up  
34 period based on results from the IBS Symptoms Severity Score.

35  
36 Liu et al. (2016) reported the results of a RCT using electro-acupuncture for chronic severe  
37 functional constipation in over 1,075 patients. The authors noted that after 8 weeks of  
38 treatment, the primary outcome (complete spontaneous bowel movements) was increased  
39 and persisted through to the 12-week follow-up.

40  
41 Lowe et al. (2017) completed a randomized placebo-controlled trial that determined that  
42 sham acupuncture is as efficacious as true acupuncture for the treatment of IBS. Patients

1 received twice weekly true acupuncture for 4 weeks ( $n=43$ ) or sham acupuncture ( $n=36$ ).  
2 Patients returned at 12 weeks for a follow-up review. The primary endpoint of success was  
3 determined by whether patients met or exceeded their established goal for percentage  
4 symptom improvement. Questionnaires were completed for symptom severity scores, SF-  
5 36 and IBS-36 QOL tools, McGill pain score, and Pittsburg Sleep Quality Index. A total  
6 of 53% in the true acupuncture group met their criteria for a successful treatment  
7 intervention, but this did not differ significantly from the sham group (42%). IBS symptom  
8 scores similarly improved in both groups. Authors suggested that the lack of differences in  
9 symptom outcomes between sham and true treatment acupuncture suggests that  
10 acupuncture does not have a specific treatment effect in IBS.  
11

12 MacPherson et al. (2017) extended a trial follow-up to evaluate the effects of acupuncture  
13 at 24 months post-randomization. Authors concluded that there were no statistically  
14 significant differences between the acupuncture and usual care groups in IBS signs and  
15 symptoms at 24 months post-randomization, and the point estimate for the mean difference  
16 was approximately 80% of the size of the statistically significant results seen at 6, 9 and 12  
17 months.  
18

19 In a systematic review and meta-analysis by Guo et al. (2020), acupuncture was shown to  
20 be more effective than loperamide for managing defecation frequencies in patients with  
21 diarrhea-prominent IBS. Acupuncture also resulted in better scores on the IBS Quality of  
22 Life, and IBS Symptom Severity Scale, and reduced recurrence rates compared with the  
23 dicetel, tribebutine and bacillus licheniformis/deanxit treatment groups. There were more  
24 adverse events with acupuncture, but the events were all mild bleeding at needling sites.  
25

26 In a randomized controlled study, Pei et al. (2020) compared acupuncture with  
27 polyethylene glycol and pinaverium bromide for the treatment of irritable bowel syndrome.  
28 The primary endpoint of total IBS-Symptom Severity Score showed significantly more  
29 improvement with the acupuncture treatment than with the medications after 6 weeks.  
30

31 Ma et al. (2020) utilized functional MRI (fMRI) to look at brain functioning of patients  
32 with diarrhea-dominant IBS before and after acupuncture. Abnormal brain connections that  
33 were different between normal subjects and patients with IBS were improved after  
34 acupuncture. The improvement on fMRI correlated with clinical improvement and IBS  
35 symptom severity scores.  
36

37 Dai et al. (2020) reviewed 40 RCTs with over 4,000 participants and noted that acupuncture  
38 and cognitive behavioral therapy were more effective for treating IBS than  
39 pharmaceuticals. Acupuncture was the most effective therapy for improving overall  
40 clinical treatment efficacy and reducing adverse events. Wang et al. (2020) performed a  
41 systematic review and meta-analysis of acupuncture treatment for ulcerative colitis.  
42 Acupuncture was shown to be effective when compared to pharmaceutical management

1 and when combined with medications. There were no significant differences in the adverse  
2 effects between medications and acupuncture. The authors recommended caution with any  
3 conclusions because of the low number of trials available and the generally poor  
4 methodological quality of the studies reviewed.

5  
6 Wang et al. (2021) performed a systematic review and meta-analysis of 61 RCTs.  
7 Acupuncture treatments for functional gastrointestinal disorders were compared to  
8 pharmacotherapy, placebo acupuncture, no treatment, and acupuncture as an adjunctive to  
9 other therapies (Chinese herbal therapies or pharmacotherapy). Acupuncture improved  
10 symptom severity in functional dyspepsia, irritable bowel syndrome and functional  
11 constipation better than pharmacotherapy, placebo, or no treatment. Acupuncture used as  
12 an adjunctive treatment was better than other therapies alone. Adverse events were lowest  
13 with acupuncture treatments than the other treatment modalities.

14  
15 A systematic review (Amsallem et al., 2021) of non-pharmacological interventions for  
16 irritable bowel included 5 studies of acupuncture. One study showed a significant  
17 improvement in overall symptoms compared with standard medical treatment  
18 (antidiarrheals, laxatives, antispasmodics) at 3- and 6-month follow-up evaluations, but not  
19 at 12 months. Another study found better symptomatic improvement with acupuncture over  
20 standard medical treatment (SMT) at 3-month follow-up. Two studies found no significant  
21 differences in results between acupuncture treatments and sham acupuncture. One study  
22 compared auriculotherapy and sham and demonstrated no difference between the two in  
23 treating abdominal pain. Only mild, transient adverse events were noted with acupuncture  
24 therapies. The author recommends further study of acupuncture with better quality RCTs  
25 and well-defined control groups.

26  
27 Ten RCTs with fMRI data for acupuncture in functional gastrointestinal disorders  
28 (functional dyspepsia, irritable bowel, and functional constipation) were reviewed by  
29 Wang et al. (2023). Acupuncture significantly improved symptoms of these functional  
30 disorders including pain, distension, stool frequency/character, and anxiety/depression  
31 symptoms. The hypothesized mechanism of acupuncture's effects was through regulation  
32 of functional connectivity and activity in areas of the brain that are involved with visceral  
33 sensation, pain, and emotions.

34  
35 A meta-analysis and systematic review were performed by Wang et al. (2024) to evaluate  
36 the use of acupuncture for irritable bowel syndrome-D and co-morbid anxiety/depression.  
37 Sixteen randomized, controlled trials with 1,305 patients were divided into an experimental  
38 and a control group who received oral medications. Outcome measures included scores  
39 from the Hamilton Anxiety Rating Scale (HAMA), Hamilton Depression Rating Scale  
40 (HAMD), self-rated anxiety (SAS), self-rated depression (SDS) irritable bowel syndrome  
41 severity scoring system (IBS-SSS), overall response rate, and relapse rate. Studies used  
42 acupuncture alone, acupuncture with moxibustion, or acupuncture with Chinese herbal

1 medicine. Acupuncture and acupuncture with herbs were more successful than oral  
2 medications at improving the HAMD, SAS, SDS and HAMA scores as well as the relapse  
3 rates. Acupuncture and combination therapy were more effective at reducing IBS-SSS  
4 scores and improving overall response rate than oral medication alone. Acupuncture was  
5 said to be safer than other treatments. Heterogeneity was considerable in some of the  
6 outcome measures and the authors advised taking this into consideration before making  
7 treatment decisions and more, higher-quality studies in the future.

8  
9 Zhou et al. (2025) performed a systematic review and meta-analysis of 14 RCTs and 2,038  
10 participants to evaluate how acupuncture effects quality of life in patients with irritable  
11 bowel syndrome. Results demonstrated significant improvement in quality of life and  
12 symptom severity over conventional therapies; however, acupuncture did not specifically  
13 reduce abdominal pain. Optimal length of the sessions was 30 minutes. Quality of the study  
14 was rated as high. Adverse events included subcutaneous hematoma, abdominal pain, cold  
15 limbs and nerve pain, all of which were transient.

16  
17 Hou et al. (2024) included 28 articles in a meta-analysis examining the benefits of various  
18 combinations of acupuncture (ACU), moxibustion (MOX), electroacupuncture (EA), and  
19 Chinese herbal therapies (CH) and pharmaceuticals (WM) compared with placebos for  
20 treating irritable bowel syndrome-D with anxiety/depression. Outcome measures included  
21 scores from the Hamilton Anxiety Rating Scale (HAMA), Hamilton Depression Rating  
22 Scale (HAMD), self-rated anxiety (SAS), self-rated depression (SDS) irritable bowel  
23 syndrome severity scoring system (IBS-SSS), overall effective rate, and recurrence rate.  
24 The authors reported that, "...In terms of improving HAMA score, MOX was superior to  
25 EA, combined therapies, CH, WM and placebo; In terms of improving HAMD score, MOX  
26 was superior to ACU, EA, combined therapies, WM and placebo; In terms of improving  
27 the SAS score, The combined therapies were superior to EA, CH and WM; In terms of  
28 improving SDS scores, The combined therapies were superior to EA, CH and WM; In  
29 terms of improving IBS-SSS score, The combined therapies were superior to WM; In terms  
30 of reducing recurrence rates, CH was superior to combined therapies; In terms of  
31 improving total effective rates, MOX was superior to EA, CH, WM and placebo..."

32  
33 Ma et al. (2024) performed a systematic umbrella review of acupuncture treatment of  
34 irritable bowel syndrome with 15 studies. Two articles were of low methodological quality;  
35 one article concluded acupuncture and moxibustion were effective in treating IBS and the  
36 other said the treatments might be effective. Thirteen articles were deemed of critically low  
37 quality; 10 concluded acupuncture and moxa were effective, 2 articles said probably  
38 effective and 1 study stated the evidence was not sufficient to demonstrate benefits of  
39 acupuncture and moxa on IBS. The authors suggested improved studies with improved  
40 methodologies were required for higher-level evidence.

1 Zhang et al. (2022) evaluated 10 trials with 665 patients in a systematic review of  
2 acupuncture for irritable bowel syndrome. Acupuncture reduced diarrhea predominant  
3 irritable bowel symptoms, quality of life, brain-gut peptides, cerebral activities,  
4 neuroendocrine functions, GI inflammation and hypersensitivity, and psychological status  
5 vs. control groups receiving medication or sham acupuncture.

6  
7 Thirty-one randomized, controlled trials were included in a systematic review and meta-  
8 analysis by Yang et al. (2022) about acupuncture and moxa for irritable bowel syndrome.  
9 Acupuncture reduced pain, but not other symptoms. Moxa improved pain and other related  
10 symptoms. Acupuncture and moxa together were more beneficial for pain relief and quality  
11 of life than either sham treatments or medications.

12  
13 Shi et al. (2022) compared acupuncture vs. antispasmodic medications for treating irritable  
14 bowel with a meta-analysis of 35 randomized controlled trials. Acupuncture and the  
15 antispasmodic medications were all superior for pain relief when compared with placebo.  
16 Acupuncture showed greater improvement in pain over most of the antispasmodics, except  
17 not for cimetropium and drotaverine. The difference between effects of acupuncture and  
18 these two medications was not statistically significant. Acupuncture showed a lower  
19 adverse event rate when compared to most of the medications.

20  
21 Wang et al. (2024) included 25 randomized, controlled trials and 1,842 patients in their  
22 meta-analysis of acupuncture treatments for irritable bowel. Acupuncture was more  
23 effective than the Western medicine treatments in the control group. Patient compliance  
24 was better and adverse events were fewer in the acupuncture group vs. control group. The  
25 authors recommend higher-quality studies.

26  
27 External acupuncture treatments for irritable bowel syndrome with diarrhea (IBS-D)  
28 including acupuncture and moxibustion were studied in a systematic review with meta-  
29 analysis by Wei et al. (2022) Twenty-one studies of 1,862 patients being treated for IBS-  
30 D were evaluated. Acupuncture and moxa improved quality of life, IBS-D symptoms, and  
31 recurrence rates and were considered highly safe. Overall, there was moderate certainty of  
32 evidence, but there was heterogeneity and publication bias risk that prompted the authors  
33 to recommend more rigorous study designs to verify outcomes.

34  
35 Rodrigues et al. (2023) performed a systematic review of clinical trials that included  
36 electroacupuncture effects noted by MRI with treatment of several illness including  
37 irritable bowel syndrome. Electroacupuncture for this condition resulted in reduced activity  
38 in the anterior cingulate cortex and relieved pain.

### 39 **Inflammatory Bowel Disease (IBD)**

40  
41 The review by Schneider and colleagues (2007) identified 18 relevant trials, but only 4 had  
42 robust RCT design: one on Crohn's disease (Joos et al., 2004), and one on ulcerative colitis

1 (Joos et al., 2006). Additional ulcerative colitis trials (Yang et al., 1999; Yue et al., 2005)  
2 were also included. The trials of higher methodological quality looked at acupuncture for  
3 IBD (Joos et al., 2004; Joos et al., 2006). For IBD conditions, health related quality of life  
4 (QoL) improved remarkably after acupuncture. Altogether, in all trials where QoL or  
5 subjective symptoms were assessed, QoL/subjective symptoms improved in both the  
6 acupuncture and the sham acupuncture groups without significant group differences.  
7 However, for Crohn’s disease and colitis, real acupuncture was significantly superior to  
8 sham acupuncture with regards to disease activity. Subgroup analyses in both studies  
9 revealed that higher activity grades and disease duration of less than 5 years seem to  
10 correlate with the efficacy of acupuncture therapy. The authors stated that “because most  
11 trials are hampered by major methodological deficits, it is not possible to draw sure  
12 conclusions for (acupuncture) trials of gastrointestinal conditions. In contrast, the authors  
13 conclude that the studies of acupuncture for IBD (Joos et al., 2004; Joos et al., 2006) point  
14 to some specific effects of acupuncture, and that “further trials would be necessary to  
15 evaluate specific vs. nonspecific effects of acupuncture in the treatment of gastrointestinal  
16 disorders.”

17  
18 Ji et al. (2013) reported a meta-analysis including 10 trials showing that acupuncture alone  
19 or with moxibustion was superior to oral sulfasalazine therapy for IBD. The study authors  
20 recommended that double blind RCTs with large sample sizes are needed to provide high  
21 quality evidence regarding the efficacy of acupuncture and moxibustion for the treatment  
22 of IBD.

23  
24 Rodrigues et al. (2023) performed a systematic review of clinical trials that included  
25 electroacupuncture effects noted by MRI with treatment of several illnesses including  
26 Crohn’s Disease. Electroacupuncture for this condition effected activity in the homeostatic  
27 afferent processing network potentially influencing the gut immune function.

28  
29 Jia et al. (2025) performed a network meta-analysis of 62 RCTs of multiple non-  
30 pharmacological therapies for inflammatory bowel disease including acupuncture and  
31 moxibustion. Outcomes included clinical remission, disease activity, quality of life, fecal  
32 calprotectin, C-reactive protein and adverse effects. Standard medical therapy was superior  
33 to other treatments for inducing clinical remission. Dietary interventions were most  
34 effective in maintaining clinical remission and reducing fecal calprotectin levels.  
35 Acupuncture and moxibustion reduced serum TNF-a, improved intestinal health and was  
36 the non-pharmacological treatment most likely to induce remission.

37  
38 Chang et al. (2025) conducted a 5 study/292 patient systematic review and meta-analysis  
39 of acupuncture and herb-partitioned moxibustion treatment in Crohn’s disease.  
40 Acupuncture and moxa reduced scores on the Crohn’s Disease Activity Index and the  
41 Crohn’s Disease Endoscopic Index of Severity and improved quality of life compared with  
42 placebo.

1 A systematic review and network meta-analysis was performed by Zhang et al. (2025) on  
 2 76 studies and 7,484 patients to look at clinical efficacy of acupuncture therapies in  
 3 ulcerative colitis. Auricular acupuncture combined with herbal medicine improved the total  
 4 effective rate. The most effective treatment overall was acupuncture combination therapy  
 5 with herbs. Acupuncture and herbs also showed the most improvement when mucosal  
 6 healing was evaluated with endoscopy. Warm acupuncture and warm acupuncture with  
 7 herbs were the most effective treatments for reducing inflammatory cytokines Interleukin-  
 8 6 and TNF-a levels. Acupuncture significantly reduced recurrent rates when compared with  
 9 Western medical treatments. Acupuncture and related therapies were associated with a  
 10 lower incidence of adverse events (37) vs the control group (88 events). The author  
 11 suggested that acupuncture therapies may be a valuable alternative for treatment and  
 12 reducing the long-term medication burden of this illness.

### 13 14 **Functional Dyspepsia and Gastroesophageal Reflux Disease (GERD)**

15 A single randomized controlled trial (Dickman et al., 2007) examined acupuncture as an  
 16 adjunct to standard care for gastro-esophageal reflux. Two additional trials assessed  
 17 acupuncture for dyspepsia; one compared the use of classical acupuncture points to non-  
 18 channel points in treating functional dyspepsia (Park et al., 2009); the other looked at  
 19 acupuncture for the treatment of dyspepsia during pregnancy (da Silva et al., 2009).  
 20 Dickman and colleagues (2007) randomized 30 patients with classic heartburn symptoms  
 21 (minimum 3 months and 2 episodes per week) who continued to be symptomatic on  
 22 standard-dose proton pump inhibitors to one of two groups, either adding acupuncture  
 23 along with a proton pump inhibitor or doubling the proton pump inhibitor dose over a  
 24 period of 4 weeks. Acupuncture augmentation was significantly more effective than  
 25 doubling the proton pump inhibitor dose in controlling gastroesophageal reflux disease-  
 26 related symptoms in patients who failed standard-dose. Park et al. (2009) compared 2  
 27 weeks of needling acupoints versus needling non-channel points in 68 patients with  
 28 functional dyspepsia (FD). Both treatments significantly improved symptoms of FD and  
 29 QoL compared to baseline, but there were no differences in the average between groups,  
 30 except for two specific symptoms: pressure in upper abdomen and cramps in upper  
 31 abdomen, where needling acupoints outperformed the control group. da Silva et al. (2009)  
 32 conducted a study of pregnant women ( $n=42$ ) randomized to receive or not receive  
 33 additional acupuncture for the treatment of heartburn during pregnancy. Significant  
 34 improvements in heartburn and other symptoms (eating and sleeping) were found in the  
 35 women receiving acupuncture.

36  
 37 Zheng et al. (2013) performed a study of acupuncture which included 200 participants with  
 38 functional dyspepsia. One group of participants received sham acupuncture and the other  
 39 true acupuncture. Twenty sessions of acupuncture treatments were given over 4 weeks.  
 40 The primary outcome was absence of dyspepsia symptoms at 16 weeks. Secondary  
 41 outcomes were the short form Leid's Dyspepsia Questionnaire and the Nepean Dyspepsia  
 42 index. Both groups received education about lifestyle changes to improve functional

1 dyspepsia. Patients with functional dyspepsia responded to the true acupuncture treatments  
2 (46%) and to the sham acupuncture (14%). In a 2014 Cochrane review of 7 studies, there  
3 was no benefit of acupuncture treatments over medication for functional dyspepsia.  
4 Acupuncture was as equally effective as or better than sham acupuncture. All evidence was  
5 of low quality and did not allow for a definitive conclusion about acupuncture's safety or  
6 efficacy in treating functional dyspepsia. Zhu et al. (2017) explored the effectiveness of  
7 acupuncture for the treatment of GERD. A total of 12 trials involving 1,235 patients were  
8 included. Meta-analyses demonstrated that patients receiving acupuncture or  
9 electroacupuncture combined with Western Medicine (WM) had superior global symptom  
10 improvement compared with those receiving WM alone. The authors' meta-analysis  
11 suggested that acupuncture is an effective and safe treatment for GERD. However, due to  
12 the small sample size and poor methodological quality of the included trials, further studies  
13 are required to validate conclusions.

14  
15 Guo et al. (2020) completed a systematic search of the literature for randomized controlled  
16 trials about effectiveness of acupuncture and electroacupuncture for functional dyspepsia.  
17 Eight studies were included. Acupuncture and electroacupuncture showed positive effects  
18 on the regulation of gastric motility, accommodation, hormones, and central and autonomic  
19 functions. Dyspepsia and quality of life improved with the treatments. The authors  
20 recommended that further high-quality studies be completed for additional evidence.

21  
22 Through a systematic review and meta-analysis, Mao et al. (2020) found that  
23 electroacupuncture was more effective at treating functional dyspepsia than sham  
24 electroacupuncture and had fewer side effects than medications.

25  
26 Zhang et al. (2020) performed a network meta-analysis to evaluate which forms of  
27 acupuncture (manual, acupoint application, moxibustion, acupoint catgut embedding, and  
28 warm acupuncture) were most helpful in treating functional dyspepsia. All forms of  
29 acupuncture were more effective at improving the symptoms of functional dyspepsia  
30 compared with prokinetics and sham acupuncture. Manual and electroacupuncture were  
31 the most effective for improving SF-36 scores. Moxibustion and manual acupuncture were  
32 the best at improving scores on the Nepean Dyspepsia Life Quality Index.

33  
34 A randomized clinical trial by Yang et al. (2020) used 4 weeks of treatment with  
35 acupuncture vs. sham acupuncture to measure the overall treatment effect and elimination  
36 rate of the 3 primary symptoms of post-prandial distress: postprandial fullness, upper  
37 abdominal bloating, and early satiety. The response rate at 4 weeks was 83% in the  
38 acupuncture group and 51.6% in the sham group. The elimination rate of the primary  
39 symptoms was 27.8% for acupuncture and 17.3% in the sham group. The efficacy of  
40 acupuncture was still present at 16-week follow-up.

1 Sun et al. (2021) studied the effect of acupuncture with and without deqi on the symptoms  
 2 of functional dyspepsia and on fMRIs of the amygdala. Acupuncture with deqi showed a  
 3 significantly greater difference in Nepean Dyspepsia Symptom Index when compared to  
 4 acupuncture with deqi. The changes in the symptoms were consistent with alterations in  
 5 fMRI results in the right centro-medial amygdala and left medial prefrontal cortex. The  
 6 authors suggest that the effects on these brain areas may be the way that deqi influences  
 7 the brain and symptoms of functional dyspepsia.

8  
 9 Wan et al. (2025) performed a systematic review and meta-analysis of 29 RCTs and 5,000  
 10 patients with functional gastrointestinal disorders to evaluate the benefit of acupuncture on  
 11 these conditions. Illnesses included irritable bowel, functional constipation, functional  
 12 dyspepsia, functional diarrhea, and post-prandial distress syndrome. Acupuncture and  
 13 electroacupuncture were the treatments used and the control groups received sham  
 14 acupuncture, waitlist, or pharmaceuticals indicated for the condition. Outcomes included  
 15 patient self-assessment and improvement of symptoms by 30% from baseline. Very low  
 16 evidence supported a higher response rate with acupuncture than with sham acupuncture  
 17 or waitlist. Acupuncture was more distinctly superior to sham when treatments were  
 18 received at least twice a week and for at least 3-4 weeks. Overall, compared with active  
 19 controls, acupuncture was superior only for irritable bowel syndrome. Very low evidence  
 20 supported lower overall symptom scores for acupuncture treatment of functional  
 21 dyspepsia, irritable bowel and post-prandial distress than with sham or usual care on  
 22 subgroup analysis. Acupuncture didn't pose more of a health and safety risk than sham or  
 23 usual care based on adverse events. Heterogeneity was moderate and statistically  
 24 significant, likely due to several different diseases and treatment frequencies

### 25 26 **Pregnancy-related Pelvic Pain**

27 Liddle and Pennick (2015) updated the evidence assessing the effects of any intervention  
 28 used to prevent and treat low back, pelvic pain, or both during pregnancy. Thirty-four RCTs  
 29 examined 5,121 pregnant women, aged 16 to 45 years and, when reported, from 12 to 38  
 30 weeks' gestation. Fifteen RCTs examined women with low-back pain (participants =  
 31 1,847); 6 examined pelvic pain (participants = 889); and 13 examined women with both  
 32 low-back and pelvic pain (participants = 2,385). All interventions were added to usual  
 33 prenatal care and, unless noted, were compared with usual prenatal care. For pelvic pain,  
 34 results from a meta-analysis provided low-quality evidence of no significant difference in  
 35 the number of women reporting pelvic pain between group exercise, added to information  
 36 about managing pain, and usual prenatal care. For low-back and pelvic pain, results from  
 37 meta-analyses provided moderate-quality evidence that: an eight- to 12-week exercise  
 38 program reduced the number of women who reported low-back and pelvic pain; land-based  
 39 exercise, in a variety of formats, significantly reduced low-back and pelvic pain-related  
 40 sick leave. The results from a number of individual studies, incorporating various other  
 41 interventions, could not be pooled due to clinical heterogeneity. There was moderate-  
 42 quality evidence from individual studies suggesting acupuncture or craniosacral therapy

1 improved pelvic pain more than usual prenatal care. Evidence from individual studies was  
 2 largely of low quality, and suggested that pain and functional disability, but not sick leave,  
 3 were significantly reduced following a multi-modal intervention (manual therapy, exercise,  
 4 and education) for low-back and pelvic pain. When reported, adverse effects were minor  
 5 and transient. Authors concluded there is low-quality evidence that exercise (any exercise  
 6 on land or in water) may reduce pregnancy-related low-back pain and moderate- to low-  
 7 quality evidence suggesting that any exercise improves functional disability and reduces  
 8 sick leave more than usual prenatal care.

9  
 10 Vas et al. (2019) conducted a randomized trial of auricular acupuncture or non-specific ear  
 11 needling or placebo acupuncture vs. only standard obstetrical care for 220 pregnant patients  
 12 with pregnancy-related lower back pain and/or posterior pelvic girdle pain. Two sessions  
 13 were given over 2 weeks. The primary outcome was pain intensity from 0-100 and the true  
 14 acupuncture effect on this pain level was significantly greater than the other groups. The  
 15 Roland-Morris Disability Questionnaire and SF-12 scores showed significantly more  
 16 improvement in the true acupuncture group.

17  
 18 Wang et al. (2025) used network meta-analysis to evaluate 36 studies/4,511 patients  
 19 involving non-pharmacological methods for alleviating pain and improving function in  
 20 patients with pregnancy-related low back pain. Manipulative therapy (tui na and traction)  
 21 with acupuncture was the most effective combination therapy and the strongest for  
 22 improved function.

### 23 24 **Chronic Prostatitis/Chronic Pelvic Pain (CP/CPSP)**

25 Franco et al. (2018) assessed the effects of non-pharmacological therapies for CP/CPSP,  
 26 including 38 studies with 3,290 men with CP/CPSP. Based on short-term follow-up,  
 27 acupuncture typically led to clinically meaningful reductions in prostatitis symptoms when  
 28 compared with sham. It also resulted in little to no difference in adverse events.  
 29 Acupuncture did not consistently reduce sexual dysfunction when compared to sham.  
 30 There was no information available for quality of life, depression, or anxiety. Qin et al.  
 31 (2016) assessed the comparative efficacy and safety of acupuncture, alpha-blockers, and  
 32 antibiotics for CP/CPSP. Twelve trials involving 1,203 participants were included. Based  
 33 on decreases in the National Institutes of Health Chronic Prostatitis Symptom Index (NIH-  
 34 CPSI) score, a network meta-analysis indicated that electro-acupuncture, acupuncture,  
 35 alpha-blockers, antibiotics, and dual therapy were superior to placebo in decreasing this  
 36 score. Additionally, electro-acupuncture and dual therapy were more effective than alpha-  
 37 blockers in decreasing the NIH-CPSI total score. Other network meta-analyses did not  
 38 show significant differences between interventions and placebo. The incidence of adverse  
 39 events of acupuncture was relatively rare (5.4%) compared with placebo (17.1%), alpha-  
 40 blockers (24.9%), antibiotics (31%) and dual therapy (48.6%). Overall, rank tests and  
 41 safety analyses indicated that electro-acupuncture/acupuncture may be recommended for  
 42 the treatment of CP/CPSP.

1 A review of randomized controlled trials by Li et al. (2020) included 11 studies and 748  
2 patients. Acupuncture was found to lower overall National Institutes of Health-Chronic  
3 Prostatitis Symptom Index (NIH-CPSI) scores better than sham acupuncture or medication.  
4 There was no difference between true acupuncture and medication on the voiding subscore  
5 of the NIH-CPSI. There was no significant difference between acupuncture and sham  
6 acupuncture on the International Prostate Symptom Scores (IPSS). Acupuncture and  
7 medication together improved NIH-CPSI total score and pain domain subscores compared  
8 to medication alone. The authors reported significant heterogeneity and bias risk in the  
9 studies disallowing definitive conclusions.

10  
11 Zhang et al. (2021) completed a meta-analysis evaluating acupuncture for chronic  
12 prostatitis pain including the typical points and number of treatments used. True  
13 acupuncture when compared with sham acupuncture was the most effective in improving  
14 pain, urinary symptoms, and quality of life scores in the NIH-CPSI. Acupuncture was also  
15 better at pain relief without associated adverse effects when compared with medications.  
16 Combining acupuncture and medication produced a better reduction in the NIH-CPSI than  
17 either treatment modality alone. The number of acupuncture sessions in the reviewed  
18 studies ranged from 6 to 28. The more acupuncture treatments, the better the NIH-CPSI  
19 score. The authors concluded that 4 acupuncture treatments were the minimum  
20 recommended for basic efficacy especially if symptoms were more acute. Higher numbers  
21 of treatments resulted in improvement in urinary symptoms and quality of life. In Chinese  
22 Medicine theory, acupuncture points are chosen based on the individual's evaluation. The  
23 trials mostly based their point selection on combinations of three points from CV3, CV4,  
24 BL32, SP 6 and SP 9.

25  
26 In a meta-analysis, Kang et al. (2021) compared efficacy and safety of acupuncture vs.  
27 extracorporeal shockwave therapy (ESWT) for chronic prostatitis/chronic pelvic pain.  
28 Nine RCTs with 525 patients were reviewed. Outcomes included the NIH-CPSI total and  
29 sub scores for pain and urinary symptoms, IPSS score, and IIEF (International Index of  
30 Erectile Function). ESWT and acupuncture were each more effective than sham  
31 procedures. ESWT was more effective than acupuncture in the short term of less than 4  
32 weeks and mid-term of 8-12 weeks. ESWT and acupuncture had similar efficacy long-term  
33 after 24 weeks.

34  
35 A randomized controlled study by Sun et al. (2021) included 440 men with moderate to  
36 severe chronic prostatitis evenly divided into an acupuncture treatment group and a sham  
37 acupuncture group. The course of treatment or sham included 20 visits over 8 weeks. The  
38 true acupuncture participants consistently achieved clinically significant reductions in  
39 scores on the National Institutes of Health Chronic Prostatitis Symptom Index at 8 and 32  
40 weeks over the sham group. No serious adverse events were reported.

1 In a systematic review and meta-analysis of 10 RCTs involving 798 patients, Pan et al.  
2 (2023) demonstrated that acupuncture was superior in relieving chronic prostatitis/chronic  
3 pelvic pain syndrome pain when compared with sham acupuncture and Western medical  
4 care. The authors specifically excluded poor quality studies that were included in prior  
5 meta-analyses, such as studies that were not randomized, had no data for extraction, or  
6 were otherwise of low quality and required the JADAD score to be equal to or greater than  
7 4. Outcome measures included NIH-CPSI score, quality of life, urinary symptoms, and  
8 efficacy rate. Four trials listed mild hematomas and pain in the acupuncture and sham  
9 acupuncture groups. The Western Medicine treatment group reported nausea, abdominal  
10 pain, dizziness, and hypotension.

11  
12 Wang et al. (2023) performed a systematic review on acupuncture and chronic  
13 prostatitis/chronic pelvic pain syndrome including 11 studies with 570 participants. The  
14 most common areas of acupuncture points were the low back and lower extremities; most  
15 common meridians were urinary bladder, ren, and spleen. SP 6 was the most commonly  
16 used point followed by UB33, 35, and 23. Acupuncture frequency varied from 1-3 times a  
17 week. Length of treatment course was 6 weeks in most studies with a range of 2-10 weeks.  
18 Each acupuncture session lasted from 10-30 minutes. All the studies reviewed showed  
19 some degree of improvement in pain sub-scores on the NIH-CPSI scale.

20  
21 Zhang et al. (2023) compared various combinations of acupuncture techniques (e.g.,  
22 acupuncture needling, moxibustion, catgut embedding, auricular) with alpha-receptor  
23 blocking medications for treating chronic prostatitis/chronic pelvic pain. Nineteen studies  
24 with 1,739 participants were included. For the total effectiveness rating, the combination  
25 of alpha-receptor blockers and acupuncture needling was superior to other combinations.  
26 For the NIH-CPSI total score, the alpha-receptor blocker, moxibustion and auricular  
27 acupuncture was optimal with medication and needling coming in second. For the pain  
28 subgroup on the scale, medications and moxibustion was the best combination. There was  
29 no statistically significant difference between the treatment combinations for the voiding  
30 and quality of life sub-scores.

31  
32 Fang et al. (2020) produced a meta-analysis of twenty studies and 1,661 participants  
33 looking at acupuncture and moxibustion in chronic prostatitis treatment. The National  
34 Institutes of Health Chronic Prostatitis Symptom Index (NIH-CPSI) was used before and  
35 after treatment to measure progress. The control groups used in the studies were sham  
36 acupuncture and medications. The authors noted that the acupuncture points selected for  
37 the studies did vary but had some common points mostly on the lower back and lower  
38 extremities. Frequency of acupuncture varied from 3-4 times a week for 4 weeks to daily  
39 treatments for a 12-day course. There were significant differences in results between the  
40 acupuncture with moxa group and control groups including higher overall response rates  
41 and better NIH-CPSI scores.

## 1 **Endometriosis-related Pain**

2 Xu et al. (2017) studied the effects of acupuncture for the treatment of endometriosis-  
 3 related pain in a systematic review and meta-analysis. Authors noted that the pain  
 4 alleviating effects of acupuncture have been attributed to various physiological and  
 5 psychological processes, such as activation of endogenous descending pain inhibitory  
 6 systems, deactivation of brain areas that transmit pain-related signals, interaction between  
 7 nociceptive impulses and somato-visceral reflexes, and the expectation of symptom relief.  
 8 Another finding noted in the manuscript reported that women with more advanced degrees  
 9 of endometriosis showed higher CA-125 levels in both serum and peritoneal fluid. and  
 10 many studies have reported that acupuncture can reduce the level of serum CA-125,  
 11 relieving the pelvic cavity pain that is associated with endometriosis. Thus, acupuncture  
 12 may serve as a complement or alternative to other treatments. For purposes of this  
 13 systematic review, patients were classified in one of four groups: (1) cured – the symptoms  
 14 of dysmenorrhea, abdominal discomfort, abdominal pain, periodic rectal irritation, etc., as  
 15 well as the pelvic mass, had disappeared; (2) markedly effective – abdominal pain was  
 16 obviously relieved, other symptoms had improved, and the pelvic mass had narrowed by  
 17 more than 50%; (3) effective – abdominal pain was relieved, other symptoms had  
 18 improved, the pelvic mass had narrowed more than 33%, and dysmenorrhea had not  
 19 increased in severity three menstrual cycles after treatment; (4) failed – abdominal pain  
 20 and other symptoms had not changed. In the current study, they systematically reviewed  
 21 the results of 10 RCTs comparing the outcomes of acupuncture with those of other  
 22 therapies (sham acupuncture, Western medicine, or Traditional Chinese Medicine) in the  
 23 treatment of endometriosis-related pain. Among the 10 RCTs included, 6 reported  
 24 variations in main pain level, 4 reported variations in peripheral blood CA-125 levels, and  
 25 7 reported the clinical effective rate of acupuncture as a treatment for endometriosis-related  
 26 pain. In all 10 of the studies, the interventions were acupuncture, and the control  
 27 interventions were placebo, Western medicine, or Traditional Chinese Medicine. Because  
 28 so few studies were included, they did not carry out a subgroup analysis. Authors  
 29 concluded that acupuncture consistently yields better reductions in pain and serum CA-125  
 30 levels than do control treatments, regardless of the control intervention used. Given the  
 31 findings, authors concluded that the effect of acupuncture in the treatment of  
 32 endometriosis-related pain is likely mediated by endocrine and cytokine changes, as well  
 33 as by anti-inflammatory and analgesic effects. As a result, the therapy could be applied as  
 34 a complementary treatment for endometriosis-related pain. However, to confirm these  
 35 findings, additional studies with proper controls, blinding methods, and adequate sample  
 36 sizes are needed.

37  
 38 Giese et al. (2023) included 6 studies (331 participants) in their systematic review and  
 39 meta-analysis of acupuncture for endometriosis pain. Acupuncture was compared with  
 40 non-specific acupuncture or usual care (contraceptives/analgesics). They determined there  
 41 was low certainty evidence for acupuncture over non-specific acupuncture for benefit in  
 42 pelvic pain overall and non-specific pelvic pain; as well as moderate evidence for

1 dysmenorrhea. Compared with usual care, there was very low certainty evidence for relief  
2 of dysmenorrhea.

3  
4 Chen et al. (2024) completed a systematic review and meta-analysis with 14 studies and  
5 793 participants with endometriosis. Three hundred and fifty-nine participants were in the  
6 control groups that included placebo, Chinese herbology, and Western Medical treatments.  
7 Compared to the control group, acupuncture, warm acupuncture, and auricular acupuncture  
8 were superior in reducing the pain severity associated with endometriosis. Also noted were  
9 reduced serum CA-125 levels and decreased endometriosis nodule size. The authors  
10 recommended caution when interpreting results due to issues with the studies such as risks  
11 of biases/inadequate blinding processes, heterogeneity of treatments and controls, small  
12 sample sizes, subjectivity in outcome assessment scores, and lack of long-term follow-up.

13  
14 Li et al. (2024) reviewed thirty-three studies or non-pharmacological treatments for  
15 primary dysmenorrhea. Acupuncture/acupressure were the interventions in 10 of the  
16 studies with a total of 601 participants. Authors reported that exercise and acupuncture are  
17 considered the most potentially effective non-pharmacologic treatments in the short term  
18 and recommended research with improved quality.

19  
20 Liu et al. (2024) studied 60 patients randomly assigned to three groups. Each group  
21 included acupuncture and a different number of cones of moxa – either 3, 6, or 9 cones.  
22 Three treatments were given each cycle starting a week before the onset of menses and  
23 repeated for three cycles. VAS scores and uterine artery blood flow parameters were used  
24 to measure outcomes. Higher numbers of moxa cones were shown to improve uterine artery  
25 blood flow parameters and pain levels compared with lower numbers of moxa cones.

26  
27 Li et al. (2024) completed a network meta-analysis of randomized controlled trials of  
28 acupuncture therapies and endometriosis pain. Forty-two trials with 3,635 participants  
29 were studied with outcome measures such as pain scores, serum CA125 levels, and  
30 response rates to attempt to distinguish which types of acupuncture-related therapies were  
31 best for treating endometriosis pain. Therapies included acupuncture, acupressure, electro-  
32 acupuncture, moxibustion, auricular therapy, acupoint catgut embedding, Chinese herbal  
33 medicines, hormonal medications, usual care, sham acupuncture and combination  
34 therapies. Three studies that used only acupuncture and related therapies reported adverse  
35 events – subcutaneous hematomas and itching. Combination therapies was shown to be the  
36 superior treatment for reducing pain scores, decreasing CA125, and increasing response  
37 rates. All acupuncture-related therapies were better than Western Medicine alone, with  
38 electroacupuncture being the most efficacious for pain management. All acupuncture-  
39 related therapies were more effective than Western medicine for reducing CA125 and  
40 acupressure was the best for reducing this level. Response rate was improved by all  
41 acupuncture-related therapies, with auricular acupuncture showing the highest response  
42 rates. Study issues included heterogeneity in the population characteristics, a lack of

1 consistency in diagnostic criteria, and variance in the selection of acupuncture points. Since  
 2 the types of acupuncture therapies were often used in combination with each other, the  
 3 authors felt it would be difficult to isolate which ones or combinations were more effective.

4  
 5 Yang et al. (2025) in a systematic review and meta-analysis of acupuncture treatment of  
 6 endometriosis pain included 9 randomized, controlled trials with 535 patients. Controls  
 7 varied and included herbal medicine, danazol, sham acupuncture, and  
 8 methylnorgestrienone. Acupuncture significantly reduced endometriosis pain per the VAS.  
 9 No significant differences were seen in CA125 levels or overall effective rate.  
 10 Methodological issues prompted the authors to recommend further larger, and higher-  
 11 quality trials.

12  
 13 To compare the effectiveness and safety of acupuncture therapies and pharmacologic  
 14 treatments for managing endometriosis, Su et al. (2025) completed a systematic review and  
 15 network meta-analysis of 23 randomized, controlled trials with 1,545 patients. Outcome  
 16 measures were pain levels by VAS and clinical efficacy rate for relief of symptoms such  
 17 as abdominal pain, dysmenorrhea, abnormal menses, dyspareunia and endometriomas.  
 18 Control groups included conventional medicine (dydrogesterone tablets, GnRH- $\alpha$ ,  
 19 gestrinone, mifepristone tablets, contraceptive pills, etc.). Compared to the control group  
 20 (conventional treatment), ear electroacupuncture, needle warming moxibustion combined  
 21 with Modified Neiyi Zhitong Formula, auricular needle-embedding, body  
 22 electroacupuncture, acupuncture and medicine, acupoint catgut, needle warming  
 23 moxibustion, Shu-Mu acupuncture, and moxa stick moxibustion all showed superior  
 24 effectiveness with ear electro-acupuncture showing the best results. Chinese herbal  
 25 therapies on their own didn't demonstrate significant effects. The most common adverse  
 26 effect was dizziness that was treated symptomatically.

27  
 28 Xu et al. (2025) included 16 randomized controlled studies in a systematic review and  
 29 meta-analysis of women with endometriosis comparing acupuncture or Chinese herbal  
 30 medicine alone or in combination treatments. Acupuncture combined with herbal therapies  
 31 was more effective for reducing endometriosis pain and reducing CA-125 and PGE 2 levels  
 32 than herbal therapy alone. Subgroup analysis showed that accurate Chinese Medicine  
 33 diagnosis with individualized syndrome differentiation and point selection was an  
 34 important factor in enhancing the effectiveness of acupuncture.

### 35 **Bladder Pain Syndrome/Interstitial Cystitis (BPS/IC)**

36 Verghese et al. (2016) assessed the effectiveness of various complementary therapies  
 37 available for treatment of BPS. A total of 1,454 citations were identified. The key  
 38 interventions studied were acupuncture, relaxation therapy, physical therapy, hydrogen-  
 39 rich therapy, diet, and nitric oxide synthetase. Authors concluded that therapies with the  
 40 potential for benefit in patients with bladder pain syndrome are dietary management,  
 41 acupuncture, and physical therapy. These findings were obtained from small studies and  
 42

1 hence caution is advised. More studies of higher quality are needed to confirm findings.  
 2 Sönmez et al. (2017) aimed to determine the effectiveness of acupuncture treatment in  
 3 patients with refractory IC/BPS. Twelve refractory IC/BPS female patients received 10  
 4 sessions of acupuncture at a frequency of twice a week. The visual analog score (VAS),  
 5 interstitial cystitis symptom index (ICSI), interstitial cystitis problem index (ICPI),  
 6 O'Leary-Saint symptom score (OSS), Patient Health Questionnaire (PHQ9), Pelvic pain  
 7 and urgency & frequency patient symptom scale tests (PUF) and maximum voided volume  
 8 (MVV) were completed in 1st, 3rd, 6<sup>th</sup>, and 12th months following the treatment. Results  
 9 demonstrated that there were statistically significant decreases in all the scores evaluated  
 10 at first month compared with the baseline. While the change in VAS score in months 1, 3,  
 11 6, and 12 were found statistically significant, measurements of ICSI, OSS and PUF scores  
 12 and MVV values in months 6 and 12 and ICPI and PHQ scores in month 12 were not found  
 13 statistically significant compared to the pre-treatment period. Response to treatment for the  
 14 first 3 months following acupuncture application was 100%, but this ratio was measured  
 15 as 33.3% (4/12) in the sixth month and 16.6% (2/12) in the 12th month. Authors suggested  
 16 that acupuncture appeared to be an effective, useful, non-invasive method in patients with  
 17 IC/BPS. It can be used as an appropriate treatment method not only in refractory cases, but  
 18 also in non-chronic IC cases since it appeared to be better compared to other treating agents.

19  
 20 In a scoping review of research methodologies for acupuncture and interstitial  
 21 cystitis/bladder pain syndrome, Infantes Rosales et al. (2025) included 22 studies. There  
 22 were only 6 randomized, controlled trials in the experimental studies, only 2 of which gave  
 23 access to the full articles. Three of the 4 experimental studies which provided the full text  
 24 included animal studies. The treatment methods included classical acupuncture with or  
 25 without moxa, electro-acupuncture with or without moxa, transdermal laser, and  
 26 acupuncture as combinations with multiple other therapies. Placebos varied including none  
 27 at all or sham acupuncture, or laser treatments with the machine turned off. Many of the  
 28 studies didn't list details of the treatment. For those that did, the most common points used  
 29 were BL 23, SP 6, BL 35, and SP 9. Pain was the most common outcome measured with  
 30 the VAS, PUF questionnaire, and bladder pain threshold tests. Other testing included  
 31 myofascial exams, and measures of symptom burden and quality of life, bladder capacity  
 32 by maximum or average void volume, urgency and nocturia. Only 5 articles reported  
 33 adverse events and stated that none were significant such as bleeding or bruising.  
 34 Limitations included lack of blinding, small numbers of studies, high risks of bias, small  
 35 sample sizes, no or inappropriate placebo controls, use of animal models, and the use of  
 36 acupuncture in multimodal treatment plans that made analysis difficult.

### 37 38 **Dysmenorrhea**

39 Woo et al. (2018) aimed to evaluate the current evidence regarding the efficacy and safety  
 40 of acupuncture on primary dysmenorrhea in a systematic review. This review included 60  
 41 randomized controlled trials; however, the meta-analysis only included 49 RCTs. Most  
 42 studies showed a low or unclear risk of bias. Authors found that compared to no treatment,

1 manual acupuncture and electro-acupuncture were more effective at reducing menstrual  
2 pain, and compared to nonsteroidal anti-inflammatory drugs (NSAIDs), manual  
3 acupuncture and warm acupuncture were more effective at reducing menstrual pain.  
4 Authors concluded that the results of this study suggest that acupuncture might reduce  
5 menstrual pain and associated symptoms more effectively compared to no treatment or  
6 NSAIDs, and the efficacy could be maintained during a short-term follow-up period. Woo  
7 et al. (2018) suggested that despite limitations due to the low quality and methodological  
8 restrictions of the included studies, acupuncture might be used as an effective and safe  
9 treatment for females with primary dysmenorrhea.

10  
11 Yan et al. (2020) reviewed 28 systematic reviews and meta-analyses, and 281 original  
12 studies on 26,459 patients. Moderate quality evidence suggested that acupuncture and  
13 moxibustion were more effective than indomethacin or fenbid for treating pain in primary  
14 dysmenorrhea. Low quality evidence suggested that acupuncture and moxibustion can  
15 effectively treat dysmenorrhea with fewer adverse events than medication.

16  
17 In a systematic review, Wang et al. (2023) evaluated 15 trials with 1,018 participants.  
18 Acupuncture, compared to sham acupuncture, reduced the VAS pain scores for  
19 dysmenorrhea more effectively with moderate certainty evidence. Pelvic pain scores were  
20 reduced more than controls with high certainty evidence. Acupuncture combined with  
21 conventional therapy improved quality of life more than conventional therapies alone. Six  
22 studies reported on safety and documented that adverse events were less frequent in  
23 participants who received acupuncture.

24  
25 Chen et al. (2024) completed a systematic review and network meta-analysis of 57 studies  
26 with 3,903 participants with primary dysmenorrhea. Acupuncture, warm acupuncture,  
27 acupressure and moxibustion were superior for pain management for primary  
28 dysmenorrhea versus NSAIDs and waitlist groups. There were no severe adverse events  
29 noted.

30  
31 In a systematic review and meta-analysis of 11 randomized, controlled trials with 1,024  
32 patients, Zhao et al. (2025) evaluated the clinical efficacy of the combination of  
33 acupuncture and Wenjing decoction for primary dysmenorrhea. Outcome measures  
34 included serum hormone levels, pain scored, uterine artery blood flow, and overall  
35 effectiveness rate. Acupuncture and Wenjing decoction improved all of these parameters  
36 in comparison to controls (Ibuprofen with or without Rotundine). Methodological quality  
37 was noted to be less than desirable and further studies were recommended.

38  
39 Wang et al. (2025) completed a systematic review and updated meta-analysis of  
40 acupuncture for the treatment of primary dysmenorrhea including 22 randomized,  
41 controlled trials with 1955 participants. Acupuncture provided immediate and sustained  
42 moderate pain relief compared with sham acupuncture, NSAIDs, or no treatment. The

1 incidence of adverse events didn't differ significantly between treatment groups. Evidence  
2 was low to moderate certainty based on risk of bias and heterogeneity.

### 3 4 **Chronic Pelvic Pain (CPP)**

5 Sung et al. (2018) aimed to evaluate the current evidence from randomized controlled trials  
6 (RCTs) related to the effectiveness and safety of acupuncture treatment (AT), including  
7 electroacupuncture or thread-embedding therapy in combination with modern technology,  
8 for chronic pelvic pain (CPP) in women via a systematic review and meta-analysis. Four  
9 RCTs with 474 participants were included. The methodological quality of included studies  
10 was generally low. The results of meta-analysis of two studies showed that AT combined  
11 with conventional treatment (CT) was associated with significantly reduced CPP. Based  
12 on the total effectiveness, the review suggested the potential of AT combined with CT  
13 compared to CT alone for treating female CPP. However, there was insufficient evidence  
14 to conclude that AT can be recommended as a complementary and alternative (CAM)  
15 treatment for women with CPP. Larger, more rigorously designed RCTs are needed to  
16 confirm results.

17  
18 Lin et al. (2023) utilized 17 randomized, controlled trials with 1,455 participants for meta-  
19 analysis. Acupuncture, electroacupuncture, moxibustion, laser, catgut implantation,  
20 auricular acupuncture, and acupressure were included. The control intervention group  
21 included health education, western medication, physiotherapy, sham acupuncture, and  
22 herbal medicine. The visual analog scale and total pain scores from the NIH-chronic  
23 prostatitis symptom index were used for outcome evaluation. Conditions treated included  
24 endometriosis, chronic prostatitis, pregnancy-related pelvic and low back pain, and  
25 dysmenorrhea. The authors concluded that the acupuncture interventions were more  
26 beneficial for pain management than sham acupuncture, western medications or herbal  
27 medicines when used alone or with these other therapies.

28  
29 Thirteen randomized, controlled studies involving 658 patients were included in a  
30 systematic review by Wei et al. (2025) to evaluate acupuncture-related methods for pain  
31 relief and anti-inflammatory effects in chronic pelvic inflammatory disease. Outcomes  
32 included pain level on visual analog scale, multiple inflammatory biomarkers, fallopian  
33 tube patency and pelvic mass regression. Acupuncture significantly reduced pain intensity,  
34 C-reactive protein, IL-6, TNF-a, increased rates of fallopian tube patency and pregnancy,  
35 and improved quality of life. Electroacupuncture combined with herbal medicine  
36 significantly relieved pelvic pain, reduced systemic inflammation and improved  
37 reproductive outcomes.

38  
39 Acupuncture-related therapies for chronic pelvic inflammatory disease (CPID) were  
40 evaluated in a network meta-analysis by Zheng et al. (2025). Eighty-four randomized,  
41 controlled studies were included with 8,147 participants. Acupuncture injections (4 studies;

1 2 with astragalus and 2 unstated) were best for C-reactive protein regulation and TNF-  
2 alpha regulation.

### 4 **PRACTITIONER SCOPE AND TRAINING**

5 Practitioners should practice only in the areas in which they are competent based on their  
6 education, training and experience. Levels of education, experience, and proficiency may  
7 vary among individual practitioners. It is ethically and legally incumbent on a practitioner  
8 to determine where they have the knowledge and skills necessary to perform such services  
9 and whether the services are within their scope of practice.

10  
11 It is best practice for the practitioner to appropriately render services to a patient only if  
12 they are trained, equally skilled, and adequately competent to deliver a service compared  
13 to others trained to perform the same procedure. If the service would be most competently  
14 delivered by another health care practitioner who has more skill and training, it would be  
15 best practice to refer the patient to the more expert practitioner.

16  
17 Depending on the practitioner’s scope of practice, training, and experience, a patient’s  
18 condition and/or symptoms during examination or the course of treatment may indicate the  
19 need for referral to another practitioner or even emergency care. In such cases it is essential  
20 for the practitioner to refer the patient for appropriate co-management (e.g., to their primary  
21 care physician) or if immediate emergency care is warranted, to contact 911 as appropriate.  
22 See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for  
23 information.

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