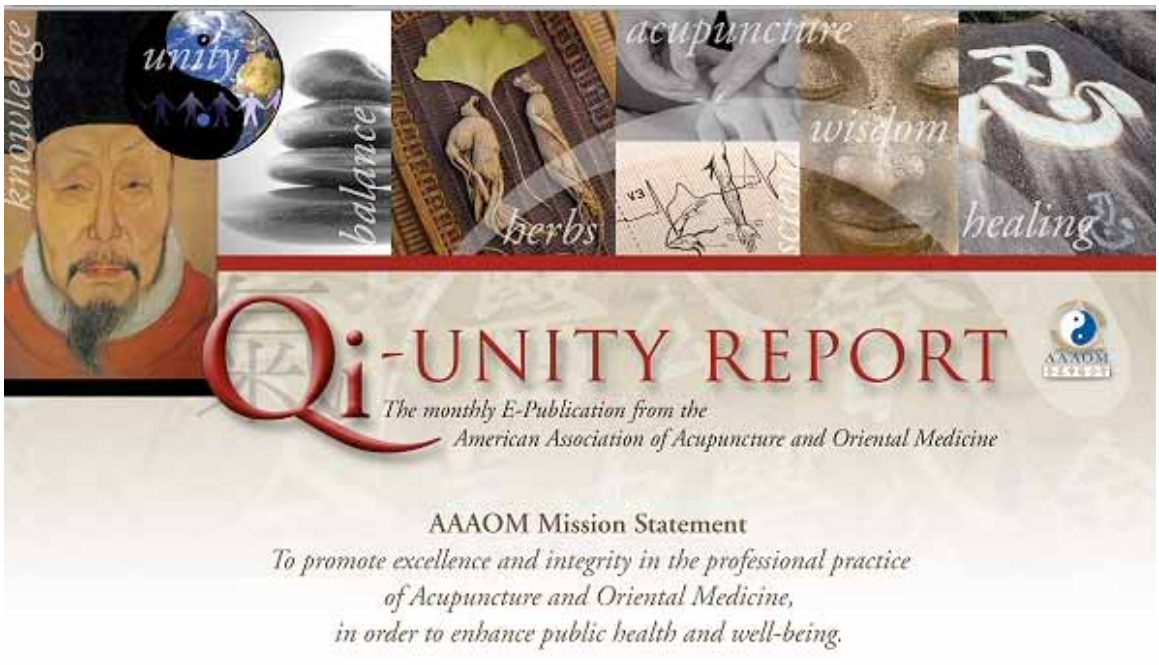

The "Dry Needling Issue"

By Jan Dommerholt, PT, MPS, FAAPM

In a recent article published in the *Qi-Unity Report* newsletter, Valerie Hobbs, DiplOM, LAc reviewed several pertinent issues regarding dry needling and acupuncture (1). One of the concerns of Ms. Hobbs, which is shared by the American Association of Acupuncture and Oriental Medicine (AAAOM), relates to an increasing number of states that have approved dry needling as a modality within the scope of physical therapy practice. On October 8, 2007, Leslie McGee, RN, LAc, DiplAc/CH and Martin Herbkersman, MTOM, DAc, who at the time were the AAAOM president and vice president respectively, issued a letter (PDF) on behalf of the AAAOM, stating that "so-called dry-needling has infringed upon the rights of acupuncture practitioners in the states of Virginia and Colorado." In the same letter, they expressed that "the AAAOM opposes the use of dry-needling by physical therapists in Colorado and elsewhere in the United States" as they "consider dry-needling to fall squarely within the range of acupuncture practice." Others have shared similar sentiments. Dr. Peter D. Lichtenstein, DC, CCSP, LAc, president of the Acupuncture Society of New York, introduced a reprint of Ms. Hobbs article as "an important article" that "may point to some challenges in the future." He also announced that he had "instructed [the] lobbyist to be on the lookout for any such movement in PT scope of practice in NY",

as “this bodes ill for the rest of the country if dry needling is allowed with the PT scope of practice.”

In this article, I would like to present some thoughts about dry needling from my physical therapy perspective. In her article, Ms. Hobbs characterized me as “a leading researcher and proponent of the addition of dry needling to the scope of Physical Therapy.” I have been teaching trigger point dry needling courses since 1996 not only in the United States, but also in many other countries. I would like to emphasize that I do not single out physical therapists in my efforts to promote dry needling as a tool to treat our patients. Past course participants have included physical therapists, but also physicians, dentists, chiropractors, nurse practitioners, physician assistants, and acupuncturists. I agree with the AAAOM that dry needling falls within the scope of acupuncture practice, which is why acupuncture practitioners are invited to attend our courses. I do not agree however, that dry needling would fall within the exclusive domain of any discipline, including acupuncture, physical therapy, or medicine. While I have published a few articles on dry needling in the physical therapy literature, I have published many more papers and book chapters in the pain management literature, which have included information about trigger point dry needling (2-15). I would also like to emphasize that in my opinion, dry needling is just one tool in the clinical toolbox. Dry needling is not a specific approach and dry needling is not appropriate for every patient (14). In our course program we emphasize that Travell rediscovered trigger points (10, 16, 17). There is no question that some of the trigger points have been described previously as acupuncture points, a shi points, kori, myogelosis, fibrosis, etc. (18, 19). Similarly, there are close similarities in between the pathways of some acupuncture meridians and referred pain patterns of myofascial trigger points (18-21). Dorsher found similar patterns for as many as 76% of corresponding points (19). That does not mean however, that the phenomenon of a localized muscle contracture and its treatment with needles belong to one discipline only.

There are many disciplines that share similar techniques or approaches in their scope of practice. Homeopathic and naturopathic physicians share the use of herbs in their practice with acupuncturists, but neither discipline owns the exclusive rights to herbal remedies. Chiropractors have argued that spinal manipulations are within their exclusive scope of practice, although physical therapists and osteopathic physicians employ the technique all over the world (22). Yet the underlying philosophy, thought process, and decision-making may be unique to each discipline. Homeopathic physicians may prescribe herbal remedies without knowing anything

about an acupuncturist's perspective on using similar remedies. Physical therapists in the United Kingdom and the state of Maryland are legally allowed to perform trigger point injections as part of their scope of practice without being accused of practicing medicine without a license. Acupuncturists and physical therapists can collaborate even when it involves dry needling. One of our acupuncture course participants has published two books on the subject of acupuncture and dry needling and I had the distinct honor of writing the preface to his most recent publication (20, 23).

During a hearing on dry needling of the Colorado Board of Regulations in October, 2007, Ms. Hobbs and I shared the opportunity to testify. Unfortunately, my testimony was delivered via telephone from my office in Bethesda, MD, rather than in person. In addition to making it rather challenging to reply at once to several speakers opposing dry needling by physical therapists, it was a bit frustrating as there was little room for dialogue. I hope that this article will open the door for further dialogue, discussion, and satisfactory resolution. Jane Goodall is quoted as "change happens by listening and then starting a dialogue with the people who are doing something you don't believe is right." I have listened intently to Ms. Hobbs and her acupuncture colleagues during their testimonies as well as to several other acupuncturists. Some expressed being in favor of physical therapists using the dry needling technique, while others vehemently opposed it. I hope the AAAOM, state acupuncture societies and associations, and individual acupuncture practitioners will be prepared to listen and engage in an active dialogue.

My background in using trigger point dry needling is based entirely on a medical perspective inspired by the work and publications of medical doctors Travell, Simons, Lewit, Gunn, Gerwin, Baldry, Dejung, and many others with whom I studied (10). I have not studied acupuncture nor have I ever suggested that I practice acupuncture. As Ms. Hobbs pointedly paraphrased, in some past articles I may have expressed a rather biased and simplistic opinion of acupuncture. After reviewing Ms. Hobbs' criticism, I believe that some of my comments were partially in response to assertive efforts of particular acupuncture practitioners to prohibit any needling procedures by physical therapists, and partially due to ignorance. In retrospect, I regret that sometimes I resorted to "turf behavior" and that I did not study the various schools of acupuncture in more detail to gain a better understanding of the varied perspectives of acupuncturists. I had restricted my perspective to the energetic concepts of traditional Chinese medicine. Interestingly, acupuncturist Amado wrote that when acupuncture is defined as an effort to control energy flow, there are few if any correlations with trigger point dry needling. He maintained that traditional

Chinese medicine would be based on pre-scientific ideas, rather than the scientific neurophysiologic and anatomic principles underlying dry needling (24). I would like to suggest that acupuncture practitioners study the medical and physical therapy perspective on dry needling before repeating my mistakes.

As Ms. Hobbs indicated in her article, there is debate in the scientific literature whether dry needling is a part of acupuncture practice (1). Dry needling techniques are performed with the same solid filament needles acupuncture practitioners are using, but dry needling does not require knowledge of the theoretical foundations of acupuncture (24). Travell, Simons, and Lewit were not familiar with the acupuncture literature when they published their observations and management strategies of trigger points, and there are no indications that earlier medical practitioners who described trigger point phenomena were familiar with the acupuncture literature (7). Historically, there are several examples of physicians inserting needles and even ladies' hat pins in points of maximum tenderness without considering the concepts of traditional acupuncture (25-27). Hobbs erroneously suggested that Simons, co-author of the Trigger Point Manuals, has been teaching dry needling techniques since the 1980s. In fact, Simons did not experience dry needling until 2006 when one of our physical therapy graduates treated him with the dry needling technique.

Lewit, a physician from the Czech Republic, published one of the first reviews in the medical literature. He reported that dry needling of myofascial trigger points caused immediate analgesia in almost 87% of the needle sites, which he referred to as the "needle effect." Nearly a third of subjects remained free of pain. About 20% of subjects experienced several months without pain, 22% several weeks, 11% several days, and approximately 14% had no pain relief. Lewit observed that the effectiveness of dry needling was directly related to the accuracy of needling (28), which in my opinion depends greatly on the ability to palpate myofascial trigger points accurately (10). In 1980, Gunn et al. published a prospective dry needling study of injured workers with low back pain and demonstrated that dry needling was an effective treatment for low back pain (29).

Whether dry needling should be considered a form of acupuncture depends to some degree on how acupuncture is defined. Seem, founder and president of the Tri-State College of Acupuncture, argued that American acupuncturists usually do not "treat tender or tight spots and, hence, never really achieve myofascial release in their recurrent and chronic pain patients" (18). I understand that not all acupuncture practitioners agree with Seem's perspective. Even acupuncture societies and

associations do not necessarily agree whether dry needling is a form of acupuncture. Where the Acupuncture Society of Virginia insisted that “dry needling is not acupuncture” when administered by physical therapists, the Acupuncture Association of Colorado maintained that “dry needling is acupuncture” (1, 30). On its website, the Acupuncture Society of Virginia does state “that the practice [of dry needling] clearly falls under the state’s definition of acupuncture, and physical therapists are not permitted by the Board of Medicine to practice acupuncture” (http://www.acusova.com/legislative.htm, accessed March 27, 2008). For the record, the Board of Medicine does not determine the scope of physical therapy practice in Virginia.

The AAAOM suggests that the dry needling education of physical therapists “constitutes a public health hazard.” The typical acupuncture education “of at least 3,000 hours” is contrasted with the hours required by the leading post-graduate education programs in trigger point dry needling. I can only hope that the AAAOM executives realize that their argument is terribly flawed. They are implying that acupuncture students would limit their studies to finding suitable points to needle without spending any time on anatomy, physiology, herbal remedies, oriental theory and diagnosis, and Western theory and diagnosis. Also, not every acupuncture program consists of at least 3,000 hours of education. For example, a quick internet search revealed that the Master of Acupuncture degree at the University of Bridgeport consists of 2,450 hours (http://www.bridgeport.edu/pages/2713.asp, accessed March 27, 2008). The program is accredited by the Accreditation Commission for Acupuncture and Oriental Medicine. According to the Council of Colleges of Acupuncture and Oriental Medicine, a professional acupuncture curriculum must consist of at least 1,950 hours, divided into at least 705 hours in Oriental medical theory, diagnosis and treatment techniques in acupuncture and related studies, 660 hours in clinical training, 450 hours in biomedical clinical sciences, and 90 hours in counseling, communication, ethics, and practice management (http://www.ccaom.org/faqs.asp, accessed March 27, 2008). Physical therapists who attend the post-graduate courses in myofascial trigger point therapy have already completed their professional training. In 2004, the average number of hours of education in entry-level doctoral physical therapy programs was 2,676. Physical therapy education emphasizes anatomical knowledge in much more depth than typical acupuncture schools. Detailed knowledge of anatomy should be one of the major regulatory concerns to protect patients undergoing dry needling procedures. The post-graduate courses build on the knowledge and skills achieved during graduate physical therapy education. I do not see how such comparable

educational levels would constitute a public health hazard. Physical therapists in many countries around the world practice trigger point dry needling without any documented health hazards. From my physical therapy perspective, the United States is far behind in allowing physical therapists to use dry needling in their scope of practice compared to countries such as Canada, the United Kingdom, Ireland, the Netherlands, Norway, Switzerland, Belgium, Spain, Chile, South Africa, Australia, and New Zealand, among others, where dry needling techniques are within the scope of physical therapy practice.

Ms. Hobbs stated that “no standards are available for dry needling education and no college of physical therapy has offered a course in dry needling to date.” The standards for our post-graduate education program are developed in close coordination with the dry needling programs at many universities and other post-graduate educational programs in Europe and South Africa. For example, many universities in Spain offer specialist certification programs in myofascial trigger point therapy, which include dry needling. Again, in my humble opinion the United States is falling behind in this respect. As Ms. Hobbs indicated, Georgia State University is the first doctoral program in physical therapy that includes specific coursework in trigger point therapy and dry needling. The curriculum at Georgia State University has been developed with the same global orientation reflective of the world we live in. I share Ms. Hobbs’ concerns that accreditation agencies and state boards of physical therapy should develop standards against which post-graduate continuing programs are measured. To the best of my knowledge, there are three post-graduate education programs in the United States and one in Canada. Our program is the only U.S.-based program that welcomes acupuncture practitioners.

Ms. Hobbs reports that physical therapists are billing for dry needling procedures using CPT trigger point injection codes 20522 and 20553 and can collect as much as $180 and $400 respectively. I must admit that I was very surprised when I read this paragraph. In our course program we do not advocate using injection codes when performing dry needling techniques, although the American Academy of Family Physicians in 2004 advocated that the trigger point injection codes can be used even when performing dry needling (http://www.aafp.org/fpm/20041000/coding.html). According to the American Academy of Family Physicians, “the intent of CPT codes 20552 and 20553 is to identify the procedure of performing the trigger-point injection, regardless of whether an injectable is supplied. If an injectable is supplied, you would need to report the supply of any injectables separately by submitting the appropriate HCPCS code(s) or code 99070, "Supplies and materials (except

spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)." Note that 20552 and 20553 should not be used for acupuncture procedures, which are more appropriately reported with CPT codes 97780-97781". However, it is illegal to bill for injections when no injectable is used in most states and under Medicare regulations. Further research revealed that the state of Colorado, Department of Labor and Employment, Division of Workers' Compensation maintains that a "trigger point injection consists of dry needling or injection of local anesthetic with or without corticosteroid……" (31). In other words, in the state of Colorado, physical therapists are instructed by the Department of Labor to use trigger point injection codes, which would make it tempting to move to Colorado, were it not that all insurance companies in Colorado have agreed to switch to a per diem reimbursement system in which the reimbursement will be the same irrespective of which CPT code is used. There are no CPT codes for dry needling and physical therapists cannot use acupuncture codes 97780-97781.

Lastly, the AAAOM maintains that "dry needling has infringed upon the rights of acupuncture practitioners in the states of Virginia and Colorado." Trigger point dry needling has been within the scope of physical therapy practice in the state of Maryland since 1987, and there have been no infringements of any acupuncturist's rights in Maryland. In 2006, I was invited to testify for the Physical Therapy Board of the Commonwealth of Virginia when the Acupuncture Society of Virginia challenged the board about physical therapists using the dry needling technique. I am not aware of any evidence that the rights of acupuncture practitioners in Virginia have been infringed. The situation in Colorado was a bit more challenging. As Ms. Hobbs summarized, the Colorado Acupuncture Practice Act would potentially prohibit acupuncturists from using the technique when physical therapists are allowed to use dry needling. At the time of my testimony for the Colorado Board of Regulations I was not aware of this complication. However, I do not believe that this infringes upon the rights of Colorado acupuncturists either.

I would like to suggest that to avoid any legal or statutory complications, the term "trigger point acupuncture" may be the most appropriate term for the techniques acupuncture practitioners use to treat myofascial trigger points, a shi points, or kori. When non-acupuncture practitioners such as physical therapists or physicians treat trigger points with solid filament needles, the term "dry needling" may be preferable (7). I agree with Ms. Hobbs that physical therapists trained in trigger point therapy, including dry needing, should emphasize that they are not practicing acupuncture,

perhaps through consent forms, newsletters, websites, posters in their clinics, etc. There are a few states where physical therapists are not allowed to use dry needling techniques (10). The Hawaii physical therapy statutes prohibit physical therapists from penetrating the skin. In Tennessee, a judge followed the advice of a member of the Board of Physical Therapy, who had concluded that since dry needling is not taught in academic institutions, it should be prohibited. Other states that currently prohibit dry needling by physical therapists are New York and North Carolina. In most other states, the issue has not been addressed. The Florida statutes are rather unusual. According to the Florida statutes, physical therapists are allowed to perform "acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs." By differentiating between "trigger point acupuncture" and "dry needling" this may be an obsolete point.

It would seem that patients would only benefit if practitioners representing different disciplines would be skilled in using these techniques (7). I do not believe that physical therapists using dry needling techniques in their practices pose any threat to acupuncturists. A longstanding history of dry needling by physical therapists in other countries and in the state of Maryland has demonstrated that ultimately the consumer of healthcare determines which practitioner becomes the practitioner of choice. I welcome the dialogue and hope that in the end the interests of our patients will be the guiding light.

References

1. Hobbs V, *Dry needling and acupuncture emerging professional issues*, in *Qi Unity Report*. 2007, AAAOM: Sacramento.
2. Dommerholt J, *Muscle pain syndromes*, in *Myofascial Manipulation*, RI Cantu and Grodin AJ, Editors. 2001, Aspen: Gaithersburg. p. 93-140.
3. Dommerholt J, *Dry needling in orthopedic physical therapy practice*. Orthop Phys Ther Practice. 16(3): 15-20, 2004
4. Dommerholt J, *Persistent myalgia following whiplash*. Curr Pain Headache Rep. 9(5): 326-30, 2005
5. Dommerholt J, *Physical therapy in an interdisciplinary pain management center*, in *Pain Practitioner*. 2005. p. 32-36.
6. Dommerholt J, Bron C, and Franssen JLM, *Myofascial trigger points; an evidence-informed review*. J Manual Manipulative Ther. 14(4): 203-221, 2006
7. Dommerholt J and Gerwin R, D., *Neurophysiological effects of trigger point needling therapies*, in *Diagnosis and management of tension type and cervicogenic headache*, C Fernández de las Peñas, Arendt-Nielsen L, and Gerwin RD, Editors. 2008, in press, Jones & Bartlett: Boston.
8. Dommerholt J and Gröbli C, *Knee pain*, in *Clinical mastery of myofascial pain syndrome*, L Whyte-Ferguson and Gerwin RD, Editors. 2005, Lippincott, Williams & Wilkins: Baltimore. p. 359-389.

9. Dommerholt J and Issa T, *Differential diagnosis: myofascial pain*, in *Fibromyalgia syndrome; a practitioner's guide to treatment*, L Chaitow, Editor. 2003, Churchill Livingstone: Edinburgh. p. 149-177.
10. Dommerholt J, Mayoral O, and Gröbli C, *Trigger point dry needling*. J Manual Manipulative Ther. 14(4): E70-E87, 2006
11. Dommerholt J and McEvoy J, *Myofascial trigger point release approach* in *Orthopaedic manual physical therapy: from art to evidence*, CH Wise, Editor. 2008, in press, FA Davis: Philadelphia.
12. Dommerholt J, Royson MW, and Whyte-Ferguson L, *Neck pain and dysfunction following whiplash*, in *Clinical mastery of myofascial pain syndrome*, L Whyte-Ferguson and Gerwin RD, Editors. 2005, Lippincott, Williams & Wilkins: Baltimore. p. 57-89.
13. Dommerholt J and Shah J, *Myofascial pain syndrome*, in *Bonica's Pain Management*, JC Ballantyne, Rathmell JP, and Fishman SM, Editors. 2008, in press, Lippincott, Williams & Williams: Baltimore.
14. Gerwin RD and Dommerholt J, *Treatment of myofascial pain syndromes*, in *Weiner's pain management; a practical guide for clinicians*, MV Boswell and Cole BE, Editors. 2006, CRC Press: Boca Raton. p. 477-492.
15. Gröbli C and Dommerholt J, *Myofasziale Triggerpunkte; Pathologie und Behandlungsmöglichkeiten*. Manuelle Medizin. 35: 295-303, 1997
16. Baldry PE, *Acupuncture, Trigger Points and Musculoskeletal Pain*. Edinburgh: Churchill Livingstone, 2005
17. Simons DG, *Muscle pain syndromes - part 1*. Am J Phys Med. 54: 289-311, 1975
18. Seem M, *A new American acupuncture; acupuncture osteopathy*. Boulder: Blue Poppy Press, 2007
19. Dorsher P, *Trigger points and acupuncture points: anatomic and clinical correlations*. Med Acupunct. 17(3): 21-25, 2006
20. Cardinal S, *Points détente et acupuncture: approche neurophysiologique*. Montreal: Centre collégial de développement de matériel didactique, 2004
21. Cardinal S, *Points-détente et acupuncture: techniques de puncture*. Montréal: Centre collégial de développement de matériel didactique, 2007
22. Paris SV, *A history of manipulative therapy through the ages and up to the current controversy in the United States*. J Manual Manipulative Ther. 8(2): 66-77, 2000
23. Cardinal S, *Points-détente et acupuncture: techniques de puncture*. Montréal: Centre collégial de développement de matériel didactique, 2007
24. Amaro JA, *When acupuncture becomes "dry needling"*, in *Acupuncture Today*. 2007. p. 33, 43.
25. Churchill JM, A treatise on acupuncturation being a description of a surgical operation originally peculiar to the Japanese and Chinese, and by them denominated zin – king, now introduced into European practice, with directions for its performance and cases illustrating its success. .London: Simpkins & Marshall, 1821
26. Elliotson J, *The use of the sulphate of copper in chronic diarrhoea together with an essay on acupuncture*. Medicochirurigical Transactions. 13(2): 451-467, 1827
27. Osler W, *The principles and practice of medicine*. New York: Appleton, 1912
28. Lewit K, *The needle effect in the relief of myofascial pain*. Pain. 6: 83-90, 1979
29. Gunn CC, Milbrandt WE, Little AS, and Mason KE, *Dry needling of muscle motor points for chronic low-back pain: a randomized clinical trial with long-term follow-up*. Spine. 5(3): 279-91, 1980
30. Virginia Board of Physical Therapy Task Force on Dry Needling, *Meeting minutes*, VBoP Therapy, Editor. 2007: Richmond. 31. Division of Workers' Compensation, *Rule XVII, Exhibit A; Low back pain medical treatment guidelines*. 2001, State of Colorado, Department of Labor and Employment: Denver.