Acupuncture for low back and/or pelvic pain during pregnancy: a systematic review and meta-analysis of randomised controlled trials

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ABSTRACT

Objective Acupuncture is emerging as a potential therapy for relieving pain, but the effectiveness of acupuncture for relieving low back and/or pelvic pain (LBPP) during the pregnancy remains controversial. This meta-analysis aims to investigate the effects of acupuncture on pain, functional status and quality of life for women with LBPP pain during the pregnancy.

Design Systematic review and meta-analysis.

Data sources The PubMed, EMBASE databases, Web of Science and Cochrane Library were searched for relevant randomised controlled trials (RCTs) from inception to 15 January 2022.

Eligibility criteria for selecting studies RCTs evaluating the effects of acupuncture on LBPP during the pregnancy were included.

Data extraction and synthesis The data extraction and study quality assessment were independently performed by three reviewers. The mean differences (MDs) with 95% CIs for pooled data were calculated. We assessed the confidence in the evidence using the Grading of Recommendations Assessment, Development and Evaluation framework.

Main outcomes and measures The primary outcomes were pain, functional status and quality of life. The secondary outcomes were overall effects (a questionnaire at a post-treatment visit within a week after the last treatment to determine the number of people who received good or excellent help), analgesic consumption, Appar scores >7 at 5 min, adverse events, gestational age at birth, induction of labour and mode of birth.

Results This meta-analysis included 10 studies, reporting on a total of 1040 women. Overall, acupuncture significantly relieved pain during pregnancy (MD=1.70, 95% CI: (0.95 to 2.45), p<0.00001, I²=90%) and improved functional status (MD=12.44, 95% CI: (3.32 to 21.55), p=0.007, I²=94%) and quality of life (MD=−8.89, 95% CI: (−11.90 to −5.88), p<0.00001, I²=57%). There was a significant difference for overall effects (OR=0.13, 95% CI: (0.07 to 0.23), p<0.00001, I²=7%). However, there was no significant difference for analgesic consumption during the study period (OR=2.49, 95% CI: (0.08 to 80.25), p=0.61, I²=61%) and Appar scores of newborns (OR=1.02, 95% CI: (0.37 to 2.83), p=0.97, I²=0%). Preterm birth from acupuncture during the study period was reported in two studies. Although preterm contractions were reported in two studies, all infants were in good health at birth. In terms of gestational age at birth, induction of labour and mode of birth, only one study reported the gestational age at birth (mean gestation 40 weeks). Thus, prospective randomised clinical studies or clinical follow-up studies were hence desirable to further evaluate these outcomes.

Conclusions Acupuncture significantly improved pain, functional status and quality of life in women with LBPP during the pregnancy. Additionally, acupuncture had no observable severe adverse influences on the newborns. More large-scale and well-designed RCTs are still needed to further confirm these results.

PROSPERO registration number CRD42021241771.

INTRODUCTION

Low back and/or pelvic pain (LBPP) are common during the pregnancy, which consist of generalised lower back pain and dull pains located in the posterior pelvic area. The prevalence estimates suggest that range from 24% to 90% of all pregnant women experience LBPP in the world. Additionally, LBPP are reported to affect daily functioning, and especially activities that involve weight bearing, and the endurance capacity for standing, walking and sitting is diminished.
which affects the quality of life and work. Moreover, the costs associated with sick leave are enormous, causing a significant financial burden on women and society. LBPP are clinically characterised as pain located between the 12th rib and the gluteal fold, and distal and posterior pelvic region lateral to the lumbar-sacral junction. The two types of pain have not been able to be distinguished. Pathologically, pregnant women have increased relaxin produced by both the corpus luteum and the uterine decidua and increased motion in the pelvic joints, which might be the cause of LBPP during pregnancy. Currently, physical therapy, massage therapy and special pillows are mainly used for LBPP during pregnancy. However, these therapies are not recommended according to the evaluation of results of clinical trials due to their unclear effectiveness. Therefore, the investigation of safe and effective therapies for the treatment of LBPP during the pregnancy seems warranted.

Acupuncture originated in China, using thin and solid metallic needles to insert into acupoints along the meridians. The meridian theory was proposed based on ancient physiological system (not western scientific empiricism). This theory suggested that the body's vital energy (qi) flows along meridians, which are associated with the internal organs. It is believed that internal disharmony of organs is reflected at specific points, known as acupoints. This intervention as an acceptable complementary therapy is recommended and commonly practised in many countries for the management of dental pain, headache, myofascial pain and pain of many origins. Although the analgesic mechanisms of acupuncture remain uncertain, several studies have shown that it was associated with neurohumoral mechanism—spinal cerebrospinal fluid endorphins and dynorphins increased after acupuncture. Recently, several studies have shown the clinical efficacy of acupuncture for reducing low back pain, but the evidence is equivocal. Additionally, there are serious concerns about drug use for pain relief in the pregnancy, and the side effects of these treatments. Acupuncture is considered as a safe, non-pharmacological treatment option that is being increasingly used for relieving discomfort during the pregnancy. Nevertheless, several studies have shown that there was an insufficient clinical evidence for acupuncture for LBPP during the pregnancy, and the results of previous studies were also inconsistent. Additionally, in view of concerns about using “forbidden points” during the pregnancy and the risk of preterm contractions, one systematic narrative review examined randomised controlled trials (RCTs) of acupuncture using forbidden points prior to 37 weeks of pregnancy to treat pain conditions, with the primary outcome of preterm contractions. It was recommending that due to the concern of high dropout rates from studies that use forbidden points, alternative points should be considered in the treatment of LBPP, which have demonstrated effectiveness. It also suggested that studies collect and report on safety outcomes for trials involving pregnancy women.

One previous review reported the effectiveness of acupuncture in treating LBPP for pregnant and postpartum women. However, the number of studies associated with LBPP during the pregnancy included were small. In addition, this review did not assess the safety of acupuncture for pregnancy outcomes and the newborns. Our study was an update of the previous review, which found high-quality evidence for acupuncture in treating LBPP during the pregnancy and only included pregnant women with LBPP. The objective of this study was to evaluate the clinical efficacy and safety of acupuncture for women with LBPP during the pregnancy.

METHODS

Search strategy
This meta-analysis follows the guidelines for Preferred Reporting Items for Systematic Reviews and Meta-analyses and the STRICTA. The protocol for this meta-analysis was registered with PROSPERO (CRD42021241771). The following electronic databases were searched for RCTs without language restrictions from the inception dates to 15 January 2022: PubMed, EMBASE, Web of Science and the Cochrane Library. The following search string was used to search: “acupuncture,” “auricular acupuncture,” “low back pain,” “lumbar pain,” “pelvic pain,” “pregnancy” and “Randomized Controlled Trial”. The search strategy is detailed in online supplemental table 1. Two reviewers (JY and YW) independently screened all search results for potentially eligible studies after reading the titles and abstracts. We determined the final inclusion after reading the full text strictly. Disagreements were resolved by a discussion with a third reviewer (ZO).

Selection criteria
The eligibility criteria of the studies were formulated according to the participants, interventions, comparison, outcomes and study design criteria. (1) Participants: Women with LBPP (pain located between the 12th rib and the gluteal fold, and distal and posterior pelvic region lateral to the lumbar-sacral junction) during the pregnancy without contraindications to acupuncture or significant risk factors; (2) Intervention: acupuncture, including traditional acupuncture (using thin and solid metallic needles to insert into specific parts), needle and auricular acupuncture (auricular pressure needles, 1.5 mm long and 0.20 mm in diameter,) acupuncture combined with other treatments; (3) Comparators: acupuncture versus other treatments, acupuncture versus no intervention, acupuncture versus placebo acupuncture, acupuncture combined with other treatments vs other treatments; (4) Outcomes: primary outcomes were pain (Visual Analogue Scale shows pain intensity where 0 describes ‘no pain’ and 10 ‘worst possible pain’), functional status (Disability Rating Index (DRI) contains 12 common daily activities and the participants were required to rate their level of disability in each activity where 0 describes ‘no disability’ and 100 ‘maximum disability’), and quality of life (Short...
Form-12 Health Survey shows quality of life). Secondary outcomes were overall effects, analgesic consumption (using analgesic drugs as an adjunct for pain treatment during the study period), Apgar scores >7 at 5 min (Apgar scores were used to assess the physical condition of the newborns, if scores were >7, the newborns were in good condition), and adverse events (adverse pregnancy outcomes and other effects from acupuncture): (5) Study design: RCTs. Studies met any of following criteria would be excluded: (1) pain caused by reasons other than pregnancy; (2) conference abstracts, repeated publications, animal experiments, case reports, observational studies or reviews.

Data extraction
Two reviewers (JY and YW) independently extracted the following data from the included studies. These included participant characteristics (eg, age, gestation weeks), study characteristics (eg, author names, publication year, region, study design, sample size, intervention type, intervention characteristics) and study outcomes. If necessary, the corresponding authors would be contacted for additional information.

Quality assessment
The methodological quality of included studies was assessed by two reviewers (JY and YW) according to the Cochrane Handbook for Systematic Reviews of Interventions. Each study was evaluated from seven items: random sequence generation (checking for possible selection bias), allocation concealment (checking for possible selection bias), blinding of participants and personnel (checking for possible performance bias), blinding of outcome assessment (checking for possible detection bias), incomplete outcome data (checking for possible attrition bias due to the amount, nature and handling of incomplete outcome data), selective reporting (checking for reporting bias), and other bias (checking for bias due to problems not covered by (1) to (5) above). Each item was assessed as low, high or unclear risk of bias. According to the Grading of Recommendations Assessment, Development and Evaluation System (GRADEprofiler, V.3.6), the quality of evidence was also assessed by two reviewers (JY and YW). Disagreements were resolved by a discussion with a third reviewer (ZO).

Statistical analysis
Review Manager (V.5.3) was used to conduct statistical analyses. All continuous variables were pooled by mean differences (MDs) with 95% CIs. Heterogeneity was evaluated by using Higgins $I^2$ statistic, which ranges from 0% to 100%. $I^2$ describes the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance). A rough guide to interpretation in the context of meta-analyses of randomised trials is as follows: 0%–40% might not be important; 30%–60% may represent moderate heterogeneity; 50%–90% may represent substantial heterogeneity; 75%–100% may represent considerable heterogeneity. In terms of the overlapping $I^2$, we did note the overlapping ranges and the equivocation (“may”). After all, this was a rough guide according to Cochrane Handbook for Systematic Reviews of Interventions. Inevitably, studies brought together in a systematic review will differ. Any kind of variability among studies in a systematic review may be termed heterogeneity. A $\chi^2$ test $p<0.1$ or $I^2>50%$ indicates statistically significant heterogeneity. Fixed-effect meta-analyses ignore heterogeneity. The summary effect estimate from a fixed-effect meta-analysis is normally interpreted as being the best estimate of the intervention effect. However, the existence of heterogeneity suggests that there may not be a single intervention effect but a variety of intervention effects. Thus, the summary fixed-effect estimate may be an intervention effect that does not actually exist in any population, and therefore, have a CI that is meaningless as well as being too narrow. A random-effects meta-analysis may be used to incorporate heterogeneity among studies. This is not a substitute for a thorough investigation of heterogeneity. It is intended primarily for heterogeneity that cannot be explained. The random-effects method and the fixed-effect method will give identical results when there is no heterogeneity among the studies. Fixed effect models would be applied to combine results if statistical heterogeneity is low; If $p<0.1$ or $I^2>50%$ we combined results using a random-effect model. Additionally, funnel plots were constructed, if possible, to assess publication bias. The difference was considered statistically significant when $p<0.05$.

Patient and public involvement
Patients and public were not involved in this study.

RESULTS
Study selection
A total of 228 potentially eligible studies were identified by searching electronic databases, and none were included via other sources. All studies were imported into EndNote V.X9 (Bld,12062) for detection of duplicates. Following that, 188 were removed through title and abstract screening, and the remaining 20 studies were screened through full-text review, and 10 further studies were removed. Finally, 10 RCTs were included in the final analysis (figure 1).

Study characteristics
The countries in which the studies conducted were varied. Six studies were conducted in Sweden, one each in the UK, the USA, Spain and Brazil. All studies were published in English between 2000 and 2020. In total, 1040 participants were examined, with study sample sizes ranging from 18 to 130. All participants were healthy pregnant women (on average, 17–30 weeks of gestational age) with LBPP. Moreover, the two types of pain were not distinguished clearly in all studies. All studies recorded that the research team was multidisciplinary.
and the therapists involved were trained for acupuncture intervention. In three studies, acupuncture intervention was delivered by acupuncturists,21 35 36 in four by physical therapists,27 30 34 35 in two by midwives32 37 and unclear in another study.31 Seven studies reported that participants in acupuncture group received body acupuncture,21 27 30–34 and three studies used auricular press needles.35–37 All studies reported the acupuncture points for treatment, needle retaining time and intervention dose. However, seven studies used ‘forbidden points’ (GB 21, BL 60, BL 67, BL 32 or BL 33) during the pregnancy.21 27 30–34 Seven studies were supported by government or a professional organisation.21 27 30 32 34–36 Three studies did not report the funding.30 33 38 Two studies had greater than 20% drop-out rate.30 35 The characteristics of included studies were summarised in table 1.

**Risk of bias in included studies**

The methodological quality of these studies was assessed by two reviewers (JY and YW) according to the Cochrane Handbook for Systematic Reviews of Interventions (figures 2 and 3).26 All subjects of these studies were randomly allocated to groups using adequate allocation procedure. Six studies stated that the allocation was concealed,30 31 34–37 while four studies were unclear.21 27 32 33 Two of the studies used subject blinding,30 34 three studies blinded assessors21 27 37 and none of the studies blinded the therapists. In addition, all studies provided an adequate summary of drop-outs. The drop-out rates are specifically reported fully in table 1. However, only one study employed intention-to-treat analysis.

**Meta-analysis**

**Primary outcomes**

All studies recorded outcomes on pain, but one of these studies provided insufficient data. We did not receive response by contacting authors. Meta-analysis results suggested that acupuncture significantly relieved pain during pregnancy (MD=1.70, 95% CI: (0.95 to 2.45), p<0.0001). High heterogeneity was detected between studies (p<0.0001, I²=90%; figure 4). However, the heterogeneity was still high heterogeneity after excluding extreme outliers,32 and the overall effect remained unchanged.

Functional status was recorded in four studies. Two studies evaluated functional status using DRI. Meta-analysis results suggested that acupuncture significantly improved functional status for pregnant women with LBPP (MD=12.44, 95% CI: (3.32 to 21.55), p=0.007) High heterogeneity was detected between studies (p<0.0001, I²=94%; figure 5). In addition, one study used Oswestry Disability Index and the other used Roland Morris Disability Questionnaire to measure the outcome on functional status. The results of two studies also indicated that acupuncture significantly improved functional status for pregnant women with LBPP, although were not included in the meta-analysis.

Quality of life was recorded in five studies. Meta-analysis results suggested that acupuncture significantly improved quality of life for pregnant women with LBPP (MD=−8.98, 95% CI: (−11.90 to −5.88), p<0.00001). Moderate heterogeneity was detected between studies (p=0.06, I²=57%; figure 6). However, there was no heterogeneity after excluding extreme outliers,37 while the overall effect remained unchanged.

**Secondary outcomes**

Overall effects were recorded in four studies. Meta-analysis results suggested that there was a significant difference in overall effects when acupuncture was compared with other interventions or no intervention (OR=0.13, 95% CI: (0.07 to 0.23), p<0.00001). Low heterogeneity was detected between studies (p=0.36, I²=7%; figure 7).

Analgesic consumption was recorded in two studies. Meta-analysis results suggested that there was no significant difference in analgesic consumption during the study period when acupuncture was compared with no intervention (OR=2.49, 95% CI: (0.08 to 80.25), p=0.61). Moderate heterogeneity was detected between studies (p=0.11, I²=61%; figure 8).

In addition, Apgar scores >7 at 5 min were recorded in four studies. Meta-analysis results suggested that acupuncture is a safe treatment and there was no significant difference in Apgar scores of newborns when acupuncture was compared with other interventions or no intervention (OR=1.02, 95% CI: (0.37 to 2.83), p=0.97). No heterogeneity was detected between studies (p=0.62, I²=0%; figure 9).

In terms of gestational age at birth, induction of labour and mode of birth, only one study reported the gestational age at birth (mean gestation 40 weeks). This study was unable to be included in the Meta-analysis. Thus, prospective randomised clinical studies or clinical follow-up studies were hence desirable to further evaluate these outcomes.

**Adverse events**

All studies examined adverse events. Preterm birth from acupuncture during study period were reported in two
Table 1  Characteristics of the included studies

<table>
<thead>
<tr>
<th>Reference, year</th>
<th>Country</th>
<th>Study design</th>
<th>Sample size</th>
<th>Age (years)</th>
<th>Gestation weeks</th>
<th>Intervention</th>
</tr>
</thead>
</table>
| Bishop et al, 2016  
UK | RCT | 42 | 41 | 28.1±5.1 | 18 | True acupuncture, Placebo acupuncture, standard care |
| Elden et al, 2005  
Sweden | RCT | 125 | 130 | 30.6±4 | 24 | Traditional acupuncture, Standard care |
| Guerreiro et al, 2015  
Brazil | RCT | 27 | 34 | 27.4±6.1 | 20 | Traditional acupuncture, Paracetamol and hyoscine |
| Ekdahl and Petersson, 2010  
Sweden | RCT | 20 | 20 | 28.6 | 26 | Traditional acupuncture at week 26, Acupuncture at week 20 |
| Lund et al, 2006  
Sweden | RCT | 25 | 22 | 29.0±5.5 | 26 | True acupuncture, Placebo acupuncture |
| Kvorning et al, 2004  
Sweden | RCT | 37 | 35 | 30±5.9 | 30 | Traditional acupuncture, No intervention |
| Jorge et al, 2010  
Spain | RCT | 53 | 53 | 31.4±4.4 | 30 | Auricular acupuncture, Standard care |
| Ekdahl and Petersson, 2010  
Sweden | RCT | 58 | 47 | 33±5 | 30 | Traditional acupuncture, No intervention |
| Wang et al, 2009  
USA | RCT | 28 | 28 | 28.4 | 24 | Auricular acupuncture, Physiotherapy |
| Wedenberg et al, 2000  
Sweden | RCT | 125 | 130 | 30.6±4 | 24 | Traditional acupuncture, Standard care |

<table>
<thead>
<tr>
<th>Reference, year</th>
<th>Acupuncture points</th>
<th>Needle retaining time</th>
<th>Intervention dose</th>
<th>Outcome measures</th>
<th>Adverse intrapartum events</th>
<th>Drop out rate</th>
</tr>
</thead>
</table>
| Bishop et al, 2016  
UK | BL23, BL25, BL27, BL28, BL54, GB30, BL32 in both sides | 20–30 min | Once/week, 6 weeks | NRS, ODI, PGQ, SF12-PCS, Apgar scores >7 at 5min | None | 14.50% |
| Elden et al, 2005  
Sweden | GV20, LI4, BL26, BL32, BL33, BL54, KI11, BL60, EX21, GB30, SP12, ST36 in both sides | 30 min | Twice/week, 6 weeks | VAS | None | 14.50% |
| Guerreiro et al, 2015  
Brazil | KI3, S13, BL62, BL40, TE5, GB30, GB41, the huatojiaji points | 25 min | Once/week, 8 weeks | VAS, SF12-PCS, Apgar scores>7 at 5min | None | 0 |
| Ekdahl and Petersson, 2010  
Sweden | Known anatomical sites as reference points | 30 min | Once or Twice/week, 6 weeks | VAS, EQ-5D, SF12-PCS, | None | 10% |
| Lund et al, 2006  
Sweden | BL27, BL28, BL29, BL31, BL32, BL54, KI11, CV3 | 30 min | Twice/week, 5 weeks | VAS, NHP, EQ-5D, SF12-PCS | None | 23% |

Continued
Although preterm contractions were reported in two studies, all infants were in good health at birth. Additionally, seven studies recorded other expected minor adverse intrapartum events.

<table>
<thead>
<tr>
<th>References, year</th>
<th>Acupuncture points</th>
<th>Needle retaining time</th>
<th>Intervention dose</th>
<th>Outcome measures</th>
<th>Adverse intrapartum events</th>
<th>Drop out rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kvorning et al, 2004</td>
<td>LR3, GV20, local tender points</td>
<td>30 min</td>
<td>Once or Twice/week, 6 weeks</td>
<td>VAS, SF12-PCS, Apgar scores&gt;7 at 5 min, Analgesic consumption</td>
<td>None</td>
<td>12%</td>
</tr>
<tr>
<td>Jorge et al, 2019</td>
<td>Shenmen, Kidney, reflex points in the region of the ear</td>
<td>Not mentioned</td>
<td>Once/day, 2 weeks</td>
<td>VAS, SF12--PCS, RMDQ disability questionnaire</td>
<td>None</td>
<td>5.70%</td>
</tr>
<tr>
<td>Wang et al, 2009</td>
<td>Shenmen, Kidney, analgesia</td>
<td>Not mentioned</td>
<td>Once/day, 1 week</td>
<td>VAS, DRI, Analgesic consumption</td>
<td>None</td>
<td>4.40%</td>
</tr>
<tr>
<td>Wedenberg et al, 2009</td>
<td>Reflex points</td>
<td>30 min</td>
<td>three or four times/week, 4 weeks</td>
<td>VAS, DRI</td>
<td>None</td>
<td>23%</td>
</tr>
<tr>
<td>Elden et al, 2008</td>
<td>GV20, LI4, BL26, BL54, KI11, BL60, EX21, GB30, SP12, ST36</td>
<td>30 min</td>
<td>Twice/week, 6 weeks</td>
<td>VAS, Apgar scores&gt;7 at 5 min, Analgesic consumption</td>
<td>None</td>
<td>7%</td>
</tr>
</tbody>
</table>

AG, acupuncture group; CG, control group; DRI, Disability Rating Index; NHP, Nottingham Health Profile; NRS, Numerical Rating Scale; ODI, Oswestry Disability Index; PGQ, Pelvic Girdle Questionnaire; RCT, randomised controlled trials; RMDQ, Roland Morris Disability Questionnaire; SF12-PCS, Short Form-12 Health Survey-Physical Component Scale; VAS, Visual Analogue Scale.

**Table 1** Continued

**Figure 2** Risk of bias graph.

**Figure 3** Risk of bias graph.
adverse effects from acupuncture. Bishop et al reported that all were expected minor adverse events with the most common being pain and slight bleeded at the needle sites. Slight bruising, drowsiness and slight soreness which occurred in less than 4% of treatment sessions. Guerreiro et al reported that two women mentioned small bruises, three ecchymosis at one or two points. Kvorning et al reported that one or more of the following symptoms were reported by or found in 38% of women given acupuncture: local pain, sweating, local haematoma, tiredness, nausea and weakness. Jorge et al reported that two women suffered pain and redness at the acupuncture site. Wang et al reported that one woman experienced transient ear tenderness that resolved spontaneously. Wedenberg et al reported that most women reported a feeling of tiredness or sleepiness but also a sensation of well-being, and two women experienced small subcutaneous haematomas in the ear. Elden et al reported that the following symptoms: Headache plus severe drowsiness (n=1); headache (n=1); rash developed on the place of the needles at (n=2); severe nausea with feeling faint, sweating and dizziness (n=4). However, these responses disappeared spontaneously with no impact on continuation of treatment. Nevertheless, in spite of the minor adverse events, the women rated acupuncture favourably and a majority of them were willing to use the same treatment in the future if needed (table 2). Additionally, two studies had greater than 20% dropout rate.30 35 Nevertheless, in the study reported by Lund et al,30 13 women (19%) were excluded from analysis due to noncompliance in submitting pain diaries not due to the adverse events rate. In the study reported by Wedenberg et al,35 20% drop-out rate occurred in the control group.

Sensitivity analysis
We conducted sensitivity analyses of primary outcomes using the leave-one-out approach (online supplemental table 2). The analysis results indicated that the meta-analysis results for pain outcome did not alter when each study was removed in turn, and the findings were robust. For example, meta-analysis results suggested that acupuncture significantly relieved pain during pregnancy (p<0.00001), and p value was associated with test for overall effect. In addition, high heterogeneity was detected between studies (I²=90%), and I² >50% indicates statistically significant heterogeneity. However, the meta-analysis results for pain outcome did not change when the study by Bishop et al was removed, suggesting that this study was not responsible for the between-study heterogeneity (p<0.0001 (p value was associated with test for overall effect), I²=90%). Similarly, the analysis results for pain outcome did not change when other studies were removed in turn, which suggested that maternal age and gestational weeks might be the primary source of heterogeneity. The heterogeneity of functional status outcome was very high. Except for the difference in pregnant woman’s age, gestational age and the number of children. The outcome of functional status was measured by different methods, which might lead to the heterogeneity. There was no heterogeneity for the outcome of quality of life after excluding the study by Lund et al, which suggested that this study could be the potential source of heterogeneity.

Publication bias
Funnel plot for pain was constructed to examine publication bias and revealed a degree of asymmetry (figure 10). Funnel plots are the primary visual tool for investigation of publication bias in a meta-analysis, yet the use of a funnel plot is subjective to researchers and may be interpreted differently by different researchers. This is a scatter of the estimate of the effect size (binary: logOR or logRR) against the measure of precision for each study that is included in the meta-analysis. In the absence of publication bias, the plot resembles a symmetrical inverted funnel; otherwise, it is asymmetrical. It is important to realise that publication bias is not the only source that contributes to asymmetry. There are at least two main
sources that can contribute to asymmetry of a funnel plot. One is publication bias: small and unfavourable treatment effects are more likely to be missing, and small studies with large effect sizes are likely to be published. Another one is the heterogeneity, for example, smaller studies may select women who are more likely to benefit from the intervention. Visual inspection of funnel plots revealed that it was asymmetrical. This might be related to the fact that some trials showing adverse effects from acupuncture may not be published and are not included in this meta-analysis.

**Reporting quality assessment**

The reporting quality of included RCTs according to the STRICTA checklists was shown in table 3. There are 17 subitems included in 6 items. Item 1: for style of acupuncture, treatment theory and the extent to which treatment was varied, three studies used segmental acupuncture, one study used the principles of Western acupuncture and trigger point acupuncture, and five studies provided ‘the extent to which treatment was varied’. Item 2: number of needle insertions per subject per session, names (or location if no standard name) of points used, depth of insertion, responses sought, needle stimulation, needle retention time and needle type were generally well described. Item 3: number of treatment sessions and frequency and duration of treatment sessions were well reported in all studies. Item 4: details of other interventions administered to the acupuncture group were reported in four studies. Setting and context of treatment, including instructions to practitioners, and information and explanations to patients were not described in any study. Item 5: All studies recorded that the research team was multidisciplinary and the therapists involved were trained for acupuncture intervention. Item 6: the rationale for the control or comparator in the context of the research question were described in six studies. A precise description of the control or comparator was described in five studies.

**Quality of evidence**

Nine studies (n=815) contributed data for the outcome of pain. Adjusted pooled results showed that acupuncture significantly relieved pain during pregnancy (MD=1.70, 95% CI 0.95 to 2.45, p<0.00001). There is low evidence for pain outcomes regarding the GRADE confidence in this estimate. Two studies (n=151) contributed data for the outcome of functional status. Adjusted pooled results suggested that acupuncture significantly improved functional status for pregnant women with LBPP (MD=12.44, 95% CI 3.32 to 21.55, p<0.0001). There is moderate evidence for functional status regarding the GRADE confidence in this estimate. Five studies (n=337) contributed data for the outcome of quality of life. Adjusted pooled results showed that acupuncture significantly improved quality of life for pregnant women with LBPP (MD=−0.98, 95% CI −1.35 to −0.61, p<0.00001). There is low evidence for quality of life regarding the GRADE confidence in this estimate. Four studies (n=284) contributed data for the outcome of overall effects. Adjusted pooled results suggested that there was a significant difference on overall effects when acupuncture was compared with other interventions or no intervention (OR=0.13, 95% CI 0.07 to 0.23, p<0.00001). There is moderate evidence for overall effects regarding the GRADE confidence in this estimate. Two studies (n=177) contributed data for the outcome of analgesic consumption. Adjusted pooled results showed that there was no significant difference on analgesic consumption during the study period when acupuncture was compared with no intervention (OR=0.80, 95% CI 0.08 to 80.25, p=0.61). There is low evidence for analgesic consumption regarding the GRADE confidence in this estimate. Four studies (n=471) contributed data for the outcome of Apgar score of newborns. Adjusted pooled results suggested that there was no significant difference on Apgar scores of newborns when acupuncture was compared with other interventions or no intervention (OR=0.99, 95% CI 0.37 to 2.83, p=0.97). There is low evidence for Apgar scores regarding the
GRADE confidence in this estimate (online supplemental table 3).

DISCUSSION
Summary of main results
This meta-analysis included 10 studies, reporting on a total of 1040 women with LBPP during the pregnancy. Results of this study demonstrated that acupuncture significantly relieved LBPP and improved functional status and quality of life during the pregnancy. Moreover, there was a significant difference of acupuncture in overall effects. There was no significant difference in analgesic consumption during the treatment and Apgar scores of newborns after the treatment.

For the adverse events, no preterm labour or other adverse pregnancy outcomes were reported during acupuncture. In addition, "forbidden points" were used in seven studies. Preterm birth from acupuncture during the study period were reported in two studies. But all infants were in good health at birth despite preterm contractions were reported in two studies, which might result in women withdrawing from the research studies. Other expected minor adverse effects from acupuncture were recorded in seven studies, but these responses disappeared spontaneously with no impact on continuation of treatment. Therefore, acupuncture could be considered a relatively safe and effective intervention in the treatment of LBPP during the pregnancy.

Comparison with other reviews
In recent years, only a few studies have systematically investigated the effects of acupuncture for LBPP during pregnancy. One systematic review revealed that acupuncture was effective in treating LBPP during pregnancy using limited evidence.41 However, the authors did not conduct meta-analyses because of the paucity of additional high-quality evidence, which limited the comparison with our study. Koukoulithras et al.42 conducted a study to compare the effectiveness between various methods and typical care on low back pain during pregnancy. However, only one study used auricular acupuncture in the intervention group from all the studies included in this meta-analysis, the rest were exercise, manipulation, transcutaneous electrical nerve stimulation and neuroemotional technique in the intervention group, which precluded comparison with our study. In a recent review and meta-analysis,23 the results suggested that acupuncture significantly relieved pain for both pregnant and postpartum women, but the number of studies associated with LBPP during the pregnancy included was small and the safety of maternal acupuncture on the outcomes for the newborn was not assessed. One existing literature tested the effects of adding acupuncture to standard care for pregnancy-related back pain, but it was not a review. In addition, this study mainly assessed the feasibility of a future large, multicentre RCT through surveying midwives, physiotherapists and pregnant women.19

How the intervention might work
LBPP, always difficult to distinguish between the two types for pregnant women, are a common and serious ailment worldwide.43 Pregnant women with LBPP often suffered from insomnia, depression, anxiety, disturbance of activity and low quality of life as well.10 41 43 Pregnancy was a time where interventions were necessarily minimal, and should not include pharmaceuticals unless absolutely required. This was due to concerns of teratogenicity for the fetus and harm to the mother.44 Thus, non-pharmacological therapies are potentially attractive, such as exercise, physical therapy, massage, yoga and acupuncture, which could reduce pain and relieve some comorbidities.45–47 Acupuncture is often thought to be an alternative form or complementary therapy in pain. It has been identified that acupuncture can promote the release of endogenous opioids, which could be one of the analgesic mechanisms for pain management.48 It also significantly increases blood flow of local skin and muscle to relieve various pain conditions.49 Moreover, acupuncture appears to be

Figure 8 Forest plot of meta-analysis for analgesic consumption. M-H, Mantel-Haenszel.

Figure 9 Forest plot of meta-analysis for Apgar scores. M-H, Mantel-Haenszel.
effective in reducing the severity of depression, which also might alleviate pain caused by emotional problems.

**Implications for clinical practice and further research**

Given the poor methodological quality of the included studies and the limited strength of evidence, future trials should use more rigorous and robust methodology. Future trials should reduce the risk of bias by ensuring intention-to-treat analysis. To minimise publication bias, the researchers should register their studies in the clinical trial registry before recruiting participants. Moreover, in our study, the average age of the participants was rather young (mostly <35 years of age), the possibility of serious adverse effects to acupuncture in pregnant women older than 35 years of age could not be excluded despite that no serious complications (abortion) were observed. Further trials are hence needed to further evaluate the efficacy or adverse effects of acupuncture in pregnant women older than 35 years of age. Additionally, some important outcome measures were not included in these studies, including: mode of birth (vaginal birth, instrumental vaginal birth, caesarean section), pain relief used during labour (opioid, epidural, sterile water injections) and onset of labour (induced, spontaneous). These were vital components that needs to be included in future studies. With regard to Apgar scores, if researchers were able to capture this data, presumably by accessing patient records following birth as part of routinely collected data, it could feasibly be included in the outcome data. Considering that acupuncture has potential therapeutic value, therefore, it is necessary to further evaluate the optimal intervention programme of acupuncture (eg, acupoints, frequency and duration).

**Limitations**

The limitations of this study are similar to most systematic reviews. First, the number of studies included was limited. Second, the results of the study should be interpreted with caution given the quality of the included studies. Third, some factors related to heterogeneity remained uncertain despite we explained statistical heterogeneity.
Table 3  Quality of reporting according to stricta guideline

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
<th>No of papers adequately reporting (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1: Acupuncture rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1) Style of acupuncture (eg, Traditional Chinese Medicine, Japanese, Korean, Western medical, Five Element, ear acupuncture, etc.)</td>
<td>3 (30)</td>
<td></td>
</tr>
<tr>
<td>1.2) Reasoning for treatment provided, based on historical context, literature sources and/or consensus methods, with references where appropriate</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>1.3) Extent to which treatment was varied</td>
<td>5 (50)</td>
<td></td>
</tr>
<tr>
<td>Item 2: Details of needling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1) No of needle insertions per subject per session (mean and range where relevant)</td>
<td>8 (80)</td>
<td></td>
</tr>
<tr>
<td>2.2) Names (or location if no standard name) of points used (uni/bilateral)</td>
<td>9 (90)</td>
<td></td>
</tr>
<tr>
<td>2.3) Depth of insertion, based on a specified unit of measurement or on a particular tissue level</td>
<td>8 (80)</td>
<td></td>
</tr>
<tr>
<td>2.4) Responses sought (eg, de qi or muscle twitch response)</td>
<td>10 (100)</td>
<td></td>
</tr>
<tr>
<td>2.5) Needle stimulation (eg, manual or electrical)</td>
<td>10 (100)</td>
<td></td>
</tr>
<tr>
<td>2.6) Needle retention time</td>
<td>9 (90)</td>
<td></td>
</tr>
<tr>
<td>2.7) Needle type (diameter, length and manufacturer or material)</td>
<td>8 (80)</td>
<td></td>
</tr>
<tr>
<td>Item 3: Treatment regimen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1) No of treatment sessions</td>
<td>10 (100)</td>
<td></td>
</tr>
<tr>
<td>3.2) Frequency and duration of treatment sessions</td>
<td>10 (100)</td>
<td></td>
</tr>
<tr>
<td>Item 4: Other components of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1) Details of other interventions administered to the acupuncture group (eg,.c., moxibustion, cupping, herbs, exercises, lifestyle advice)</td>
<td>4 (40)</td>
<td></td>
</tr>
<tr>
<td>4.2) Setting and context of treatment, including instructions to practitioners, and information and explanations to patients</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Item 5: Practitioner background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1) Description of participating acupuncturists (qualification or professional affiliation, years in acupuncture practice, other relevant experience)</td>
<td>10(100)</td>
<td></td>
</tr>
<tr>
<td>Item 6: Control or comparator interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1) The rationale for the control or comparator in the context of the research question, with sources that justify this choice</td>
<td>6 (60)</td>
<td></td>
</tr>
<tr>
<td>6.2) A precise description of the control or comparator. If sham acupuncture or any other type of acupuncture-like control is used, provide details as in items 1–3 above</td>
<td>5 (50)</td>
<td></td>
</tr>
</tbody>
</table>

Through sensitivity analyses to some extent. However, considerable heterogeneity remained unclear. This might associate with the differences in characteristics of participants (eg, age, gestational weeks and numbers of children), acupuncture intervention characteristics (eg, acupoints, frequency and duration) and the measuring method of outcomes. Moreover, no study reported cost of acupuncture treatment. Therefore, the cost-effectiveness of acupuncture could not be evaluated.

**CONCLUSION**

Acupuncture significantly improved pain, functional status and quality of life in women with LBP during the pregnancy. Additionally, acupuncture had no observable severe adverse influences on the newborns. More large-scale and well-designed RCTs are still needed to further confirm these results.

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**Contributors** JY, TY and ZM performed the data extraction. JY, TY and ZM analysed and interpreted the data. JY, WD and ZS did statistical analyses. JY, WY, JX and ZO performed the literature search. JX, ZM and TY performed the language editing. All authors revised the article for important content and approved the final version for the article. JY is responsible for the overall content as guarantor.

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**Competing interests** None declared.

**Patient and public involvement** Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

**Patient consent for publication** Not applicable.

**Ethics approval** Not applicable.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** Data are available on reasonable request.

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**ORCID iD** Jiaman Yang http://orcid.org/0000-0003-1116-2139
REFERENCES


## Supplementary Material

### Table S1-Search strategy used

<table>
<thead>
<tr>
<th>Database</th>
<th>Search Strategy</th>
</tr>
</thead>
</table>
| **#1** | ((((((("Acupuncture"[Mesh]) OR (Acupuncture[Title/Abstract])) OR (pharmacopuncture[Title/Abstract])) OR (((((((Acupuncture, Ear[Title/Abstract]) OR (Acupuncture, Ear[Title/Abstract]) OR (Ear Acupuncture[Title/Abstract])) OR (Auricular Acupuncture[Title/Abstract])) OR (Ear Acupuncture [Title/Abstract])) OR (Acupuncture, Auricular[Title/Abstract])) OR (Ear Acupuncture)[Title/Abstract])) OR ("Acupuncture, Ear"[Mesh]))  
| Pubmed | 25,413 |
| **#2** | (((((((((((((((((((((((((((((((((((((((((((((((((("Low Back Pain"[Mesh]) OR (Low Back Pain [Title/Abstract])) OR (Back Pain, Low[Title/Abstract])) OR (Back Pains, Low [Title/Abstract])) OR (Low Back Pains[Title/Abstract])) OR (Pain, Low Back [Title/Abstract])) OR (Pains, Low Back[Title/Abstract])) OR (Lumbago [Title/Abstract])) OR (Lower Back Pain[Title/Abstract])) OR (Back Pain, Lower [Title /Abstract])) OR (Back Pains, Lower[Title/Abstract])) OR (Lower Back Pains[Title/Abstract])) OR (Pain, Lower Back [Title/Abstract])) OR (Pains, Lower Back[Title/Abstract])) OR (Low Back Ache[Title/Abstract])) OR (Ache, Low Back[Title/Abstract])) OR (Aches, Low Back[Title/Abstract])) OR (Back Ache, Low[Title/Abstract])) OR (Back Aches, Low[Title/Abstract])) OR (Low Back Aches[Title/Abstract])) OR (Backache, Low [Title/Abstract])) OR (Backaches, Low [Title/Abstract])) OR (Low Backaches [Title/Abstract])) OR (Postural[Title/Abstract])) OR (Postural Low Back Pain[Title/Abstract])) OR (Low Back Pain, Posterior Compartment[Title/Abstract])) OR (Low Back Pain, Recurrent [Title/Abstract])) OR (Recurrent Low Back Pain [Title/Abstract])) OR (Low Back Pain, Mechanical[Title/Abstract])) OR (Mechanical Low Back Pain[Title/Abstract])) OR ("Pelvic Pain"[Mesh])) OR (Pelvic Pain [Title/Abstract])) OR (Pelvic Pain[Title/Abstract])) OR (Pain, Pelvic [Title/Abstract])) OR (Pains, Pelvic[Title/Abstract])) OR (Pelvic Pains [Title/Abstract])) | 77,924 |
| #3 | ((("Pregnancy"[Mesh]) OR (Pregnancy[Title/Abstract])) OR (Pregnancies [Title/Abstract])) OR (Gestation[Title/Abstract])) | 1,076,327 |
| #4 | ((((("Randomized Controlled Trial" [Publication Type]) OR (Randomized Controlled Trial[Title/Abstract])) OR (controlled clinical trial[Publication Type])) OR (randomized[Title/Abstract])) OR (placebo[Title/Abstract])) OR (randomly [Title/Abstract])) OR (trial[Title/Abstract])) OR (groups[Title/Abstract])) | 1,076,327 |
| #5 | #1 AND #2 AND #3 AND #4 | 45 |
| **#1** | ("acupuncture"/exp OR "acupuncture therapy":ab,ti OR 'shonishin':ab,ti) OR 'auricular acupuncture'/exp OR 'acupuncture, ear':ab,ti OR 'acupuncture, earlobe':ab,ti OR 'auriculo acupuncture':ab,ti OR auriculoacupuncture:ab,ti OR auriculotherapy:ab,ti OR 'ear acupuncture':ab,ti OR 'earlobe acupuncture':ab,ti | 51,374 |
| Embase |  
| **#2** | ('low back pain'/exp OR 'acute low back pain':ab,ti OR 'back pain, low':ab,ti OR 'acute back pain':ab,ti OR 'back pain':ab,ti) | 51,374 |
| Web of Science | #1 TS=(acupuncture OR pharmacopuncture Acupunctures, Ear OR Ear Acupunctures OR Auricular Acupuncture OR Ear Acupuncture OR Acupuncture, Auricular OR Acupunctures, Auricular OR Auricular Acupuncture) | 42,898 |
| #2 TS=(Low Back Pain OR Back Pain, Low OR Back Pain, Low OR Low Back Pains OR Pain, Low Back Pains, Low Back OR Lumbago OR Lower Back Pain OR Back Pain, Lower OR Back Pains, Lower OR Lower Back Pains OR Pain, Lower Back OR Pains, Lower Back OR Low Back Ache OR Ache, Lower Back OR Aches, Low Back OR Back Ache, Low OR Back Aches, Low OR Low Back Aches OR Low Backache OR Backache, Low OR Backaches, Low OR Low Backaches OR Low Back Pain, Postural OR Postural Low Back Pain OR Low Back Pain, Posterior Compartment OR Low Back Pain, Recurrent OR Recurrent Low Back Pain OR Low Back Pain, Mechanical OR Mechanical Low Back Pain OR Pelvic Pain OR Pain, Pelvic OR Pains, Pelvic OR Pelvic Pains) | 110,071 |
| #3 TS=(Pregnancy OR Pregnancies OR Gestation) | 1,229,871 |
| #4 TS=(Randomized Controlled Trial OR Randomized) | 1,112,535 |
| #5 #1 AND #2 AND #3 AND #4 | 72 |

| Cochrane Library | #1 MeSH descriptor: [Acupuncture] explode all trees OR [Acupuncture, Ear] explode all trees | 364 |
| #2 (pharmacopuncture):ti,ab,kw (Word variations have been searched) | 66 |
| #4 #1 OR #2 OR #3 | 12,879 |
Table S2-Results of the sensitivity analyses

1. Sensitivity analysis for pain relief

<table>
<thead>
<tr>
<th>References</th>
<th>MD (95%CI)</th>
<th>P</th>
<th>F²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bishop2016</td>
<td>1.68 (0.89,2.47)</td>
<td>&lt; 0.0001</td>
<td>90%</td>
</tr>
<tr>
<td>Guerreiro2015</td>
<td>1.54 (0.79,2.28)</td>
<td>&lt; 0.0001</td>
<td>89%</td>
</tr>
<tr>
<td>Ekdahl2010</td>
<td>1.58 (0.82,2.34)</td>
<td>&lt; 0.0001</td>
<td>90%</td>
</tr>
<tr>
<td>Lund2006</td>
<td>1.54 (0.79,2.29)</td>
<td>&lt; 0.0001</td>
<td>90%</td>
</tr>
<tr>
<td>Kvorning2004</td>
<td>1.51 (0.78,2.24)</td>
<td>&lt; 0.0001</td>
<td>88%</td>
</tr>
<tr>
<td>Jorge2019</td>
<td>1.98 (0.84,3.13)</td>
<td>= 0.0007</td>
<td>91%</td>
</tr>
<tr>
<td>Wang2009</td>
<td>1.76 (0.95,2.57)</td>
<td>&lt; 0.0001</td>
<td>91%</td>
</tr>
<tr>
<td>Wedenberg2000</td>
<td>1.73 (0.94,2.52)</td>
<td>&lt; 0.0001</td>
<td>91%</td>
</tr>
<tr>
<td>Elden2008</td>
<td>2.02 (1.13,2.91)</td>
<td>&lt; 0.00001</td>
<td>83%</td>
</tr>
</tbody>
</table>

2. Sensitivity analysis for quality of life

<table>
<thead>
<tr>
<th>References</th>
<th>MD (95%CI)</th>
<th>P</th>
<th>F²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bishop2016</td>
<td>-9.80 (-12.99,-6.61)</td>
<td>0.10</td>
<td>53%</td>
</tr>
<tr>
<td>Guerreiro2015</td>
<td>-9.19 (-12.81,-5.56)</td>
<td>0.03</td>
<td>67%</td>
</tr>
<tr>
<td>Ekdahl2010</td>
<td>-9.41 (-13.56,-5.26)</td>
<td>0.04</td>
<td>65%</td>
</tr>
<tr>
<td>Lund2006</td>
<td>-7.88 (-9.86,-5.91)</td>
<td>0.43</td>
<td>0</td>
</tr>
<tr>
<td>Jorge2019</td>
<td>-8.71 (-12.81,-4.61)</td>
<td>0.04</td>
<td>65%</td>
</tr>
</tbody>
</table>
Table S3- Evidence quality assessment according to GRADE.

**Acupuncture for Pain for low back pain and pelvic pain**

**Patient or population:** patients with low back pain and pelvic pain during pregnancy

**Settings:** Acupuncture

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Illustrative comparative risks* (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>No of Participants (studies)</th>
<th>Quality of the evidence (GRADE)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
<td>The mean pain in the intervention groups was 1.70 standard deviations higher (0.95 to 2.45 higher)</td>
<td></td>
<td>815 (9 studies)</td>
<td>⊕ ⊗ ⊗ ⊗ low^1,2</td>
<td>This is a small effect that may be clinically relevant in this patient group</td>
</tr>
<tr>
<td><strong>Functional Status</strong></td>
<td>The mean functional status in the intervention groups was 12.44 standard deviations higher (3.32 to 21.55 higher)</td>
<td></td>
<td>151 (2 studies)</td>
<td>⊕ ⊗ ⊗ ⊗ moderate^3</td>
<td>This is a moderate effect that is clinically relevant in this patient group</td>
</tr>
<tr>
<td><strong>Quality of Life</strong></td>
<td>The mean quality of life in the intervention groups was 0.98 standard deviations lower (1.35 to 0.61 lower)</td>
<td></td>
<td>337 (5 studies)</td>
<td>⊕ ⊗ ⊗ ⊗ low^1,3</td>
<td>This is a small effect that may be clinically relevant in this patient group</td>
</tr>
<tr>
<td><strong>Total Efficacy</strong></td>
<td>Study population 780 per 1000; 315 per 1000 (199 to 449)</td>
<td>OR 0.13 (0.07 to 0.23)</td>
<td>284 (4 studies)</td>
<td>⊕ ⊗ ⊗ ⊗ moderate^3</td>
<td>This is a moderate effect that is clinically relevant in this patient group</td>
</tr>
<tr>
<td>Analgesic Consumption</td>
<td>Study population</td>
<td>OR 2.49</td>
<td>177</td>
<td>⊕ ⊕ ⊕</td>
<td>This is a small effect that may be clinically relevant in this patient group</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------</td>
<td>---------</td>
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<td>--------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>794 per 1000</td>
<td>(212 to 470)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>334 per 1000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1 to 461)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11 per 1000</td>
<td>26 per 1000</td>
<td>(1 to 461)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 per 1000</td>
<td>22 per 1000</td>
<td>(1 to 422)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 per 1000</td>
<td>22 per 1000</td>
<td>(1 to 422)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 per 1000</td>
<td>22 per 1000</td>
<td>(1 to 422)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>970 per 1000</td>
<td>971 per 1000</td>
<td>(924 to 989)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>963 per 1000</td>
<td>964 per 1000</td>
<td>(906 to 987)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>970 per 1000</td>
<td>971 per 1000</td>
<td>(924 to 989)</td>
<td></td>
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</tr>
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<td></td>
<td>963 per 1000</td>
<td>964 per 1000</td>
<td>(906 to 987)</td>
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<tr>
<td></td>
<td>970 per 1000</td>
<td>971 per 1000</td>
<td>(924 to 989)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>963 per 1000</td>
<td>964 per 1000</td>
<td>(906 to 987)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The basis for the assumed risk (e.g. the median control group risk across studies) is provided in footnotes. The corresponding risk (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; OR: Odds ratio;
GRADE Working Group grades of evidence

High quality: Further research is very unlikely to change our confidence in the estimate of effect.

Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very low quality: We are very uncertain about the estimate.
1 Downgraded one level due to inconsistency ($I^2 > 50\%$).
2 Downgraded one level due to publication bias.
3 Downgraded one level due to imprecision (fewer than 400 participants, total).
4 Downgraded one level due to clear inconsistency of results.
Acupuncture can relieve lower back/pelvic pain often experienced during pregnancy

And no observable major side effects for newborns of mums-to-be who opted for therapy

Acupuncture can significantly relieve the lower back and/or pelvic pain frequently experienced by women during their pregnancy, suggests a pooled data analysis of the available evidence, published in the open access journal BMJ Open.

And there were no observable major side effects for newborns whose mums opted for the therapy, the findings indicate, although only a few of the published studies included in the analysis evaluated outcomes, such as premature birth, note the researchers.

Acupuncture is emerging as a potential therapy for various different types of pain, because it doesn't involve the need for drugs and is considered safe, say the researchers.

Exactly how it might ease pain isn’t clear, but is thought to involve the release of the body’s innate 'happy' chemicals—endorphins—plus increases in blood flow to local skin and muscle.

But whether it can ease the debilitating low back and/or pelvic pain experienced by up to 90% of women during their pregnancy remains hotly contested.

To add to the evidence base, the researchers trawled research databases for relevant clinical trials that compared the pain relief afforded to pregnant women given acupuncture, alone or when combined with other therapies, with other/no/dummy treatments, as well as the potential impact on their newborns.

The final analysis included 10 randomised controlled trials, involving 1040 women. Every study was published between 2000 and 2020, and carried out variously in Sweden, the UK, the USA, Spain and Brazil.

The mums-to-be were all healthy, 17 to 30 weeks into their pregnancy on average, and had lower back and/or pelvic pain.

Acupuncture was delivered either by trained acupuncturists, physiotherapists, or midwives. Seven trials described body acupuncture; three described auricular (ear lobe) acupuncture.
All the studies reported the acupuncture points for treatment, needle retention time, and dose. In 7, points usually regarded as contraindicated in pregnancy—‘forbidden points’—were used.

Pooled data analysis of the trial results for 9 studies suggested that acupuncture significantly relieved pain during pregnancy.

Of those studies (4) reporting on the potential of acupuncture to restore physical function, the results showed that this was significantly improved.

Quality of life was recorded in 5 studies. When the results of these were pooled, the findings suggested that acupuncture significantly improved this too.

Pooled data analysis of 4 studies indicated that there was a significant difference in overall effects when acupuncture was compared with other or no interventions.

But pooled data analysis of 2 studies reporting on pain relief medication indicated no difference in intake between those given acupuncture and those given nothing.

The adjusted pooled data analysis also suggested that acupuncture is safe, and for the 4 studies reporting on it, that there was no significant difference in health (Apgar) scores of newborns when acupuncture was compared with other intervention(s) or none.

Only one study reported on gestational age and that study wasn’t included in the pooled data analysis. Preterm contractions were reported in 2 studies, but these babies were in good health at birth.

Seven studies recorded other expected minor side effects for the mums-to-be, such as pain, soreness and bleeding at the needle site, and drowsiness. Nevertheless, participants rated acupuncture favourably and most were willing to repeat it, if needed.

The researchers sound a note of caution about their findings, however: the number of included studies was relatively small and their quality variable. What’s more, the design, methodology, outcomes, and participant characteristics differed substantially. And in 2 studies, the drop-out rate exceeded 20% among the comparison group.

Nevertheless, they conclude that acupuncture merits closer attention for its potential to ease pain at a time when it’s preferable to avoid drugs because of their potential side effects for mother and baby.

“Acupuncture significantly improved pain, functional status, and quality of life in women with [lower back/pelvic pain] during the pregnancy. Additionally, acupuncture had no observable severe adverse influences on the newborns,” they write.

“More large-scale and well-designed [randomised controlled trials] are still needed to further confirm these results,” they add.