

Osteopathy Evidence Briefing

Osteopaths specialise in the diagnosis, treatment, prevention and rehabilitation of certain musculoskeletal conditions, including offering guidance on diet, lifestyle and exercise [1]. Osteopathy is classed as complementary therapy (not involving the use of surgery or drugs) which is often used alongside traditional medicines and procedures in the UK [2].

The purpose of this review is to establish whether it is an effective and/or cost-effective technique to treat conditions such as the ones mentioned above.

Background

- Osteopathy is most commonly used to treat conditions caused by problems with the nerves, joints and muscles such as: back and neck problems (especially neck stiffness and lower back pain); sports or work injuries; arthritis, and bad posture (the position of the body) caused by work, driving or being pregnant [2].
- Osteopaths commonly stretch, massage and touch the body in a variety of ways using a mixture of gentle and forceful techniques designed to reduce pain and swelling, improve movement and encourage the movement of blood to and from tissues and organs [2].
- Osteopathy is available on the NHS in some areas of England. Patients usually need a referral by their GP, although the Department of Health's Musculoskeletal Services Framework (2006) does recommend that patients with joint pain be given the right to choose, 'who to consult for first line treatment and experience a seamless service between disciplines (including osteopathy)'. The framework also states, 'people with joint pain can seek assessment by physiotherapists, chiropractors or osteopaths directly without the need for GP referral' [1].
- By law, osteopaths must be registered with the General Osteopathic Council (GosC) which has a statutory duty to regulate, develop and promote the practice of osteopathy in the UK [1].

Guidance

- There is no NICE guidance on the use of osteopathy for any condition. In addition, NICE Guidance on Osteoarthritis (Reference Number: CG59) does not mention osteopathy at all in its findings or recommendations on treatment. There is NICE guidance due in May 2009 on 'Low Back Pain'. It will be interesting to note if this mentions osteopathy.
- There is no SIGN (Scottish Intercollegiate Guidelines Network) guidance on osteopathy (for any condition).
- The Musculoskeletal Services Framework (2006) does however recommend that primary care develop capacity by offering a wider range of non-surgical alternatives, e.g specialist practitioners...osteopathy etc...'. The framework also specifies that health economies will want to ensure they have a skilled team able to provide care for people with musculoskeletal condition, specifically mentioning osteopaths [2].

Evidence

- There have been two Cochrane reviews conducted on 2 therapies offered by osteopaths (it should be noted that other professionals such as physiotherapists and

chiropractors also offer these therapies). The first is manual therapy (for asthma) and the second is spinal manipulation (for primary and secondary dysmenorrhea, or as it is commonly known, painful period cramps).

- Cochrane review concluded that, 'there was insufficient evidence to support the use of manual therapies for patients with asthma' and recommended that further trials were needed [3]
- Cochrane review concluded that, 'there is no evidence to suggest that spinal manipulation is effective in the treatment of primary or secondary dysmenorrhea'.
- A cost-utility analysis reported by the NHS Economic Evaluation Database (NHS EED) in 2005 concluded that GP care plus osteopathy was more effective than GP care alone in treating sub-acute spinal pain. The additional osteopathy consisted of 3-4 sessions from a GP who was also a registered osteopath. The conclusion was that a primary care osteopathy clinic may be a cost-effective addition to usual general practice care since there was an improvement in mean quality-adjusted life years (QALYs). The estimate of cost per QALY gained with osteopathic treatment was 3,560 compared with the ceiling ratio of 30,000 used by NICE. The study was carried out in the North-West of the UK [5].
- The same study was also subject to further evaluation by the NHS EED, namely to assess effects on pain and disability (using the Extended Aberdeen Spine Pain Scale (EASPS), the Short form McGill Pain Questionnaire, the SF-12 health profile and the EuroQol index of health utility). At two months, the osteopathy group scored significantly higher on the SF-12 mental score and the EASPS ($p=0.02$). By 6 month follow up, only the mental score SF-12 was significantly better in the osteopathy group ($p=0.02$). Authors concluded that effectiveness analysis had demonstrated short-term physical outcomes and long-term psychological outcomes. They also reported that the service was cost-neutral in comparison with standard care [6].
- A study from the US on patients with low-back pain aged 20-59 (pain lasting more than 3 weeks but less than 6 months, excluding those with neurological causes, pregnancy and root nerve compressions, the authors called these, 'sensible exclusions') found mixed results. Patients were randomised to either standard medical care (which included analgesics, heat, cold, corsets and TENS) or standard medical care with additional osteopathic manipulation. Outcomes were pain and back scales and questionnaires plus measurements of flexion and extension. At 12 week follow up, there was no difference between the groups on any outcome except quantity of NSAIDs (non-steroidal anti-inflammatory medication) prescribed. It was noted that 54% of patients receiving standard care were prescribed NSAIDs compared to 24% amongst those receiving osteopathy. The authors note that for many people who find NSAIDs difficult to tolerate or who just prefer not to take medicines, osteopathy could offer a valuable choice [7].
- A meta-analysis of several trials carried out in both the UK and US on the effect of osteopathic manipulative treatment (OMT) as a complementary treatment alongside usual care for low-back pain found that patient outcomes were significantly improved. Overall, the reduction in pain in the group who received OMT was significant at short (2-4 weeks), medium (41-51 days) and long-term (12-15 weeks) follow up [8].

Summary

There is very little research on the effectiveness of osteopathy and guidelines appear to be non-existent.

Evidence on the effectiveness of osteopathy could only be sourced for a limited number of conditions; dysmenorrhoea, asthma, sub-acute spinal pain and low-back pain.

The research evidence **does not** appear to support the use of osteopathy for asthma or painful period cramps [3,4].

The evidence **does** appear to support osteopathy for spinal pain and low-back pain however, but only when given alongside usual care as a complementary therapy.

For spinal pain, osteopathy decreased reported pain and improved mental health outcomes and did so in a cost-effective way, at well below the 30,000 QALY threshold set by NICE [5,6].

For low-back pain, results were more mixed, with one study finding no differences between usual care and usual care plus osteopathy (except a reduction in prescribed NSAIDs) and one study finding significantly improved pain outcomes at short, medium and long-term follow up [7,8].

In light of this and the fact that the DoH's Musculoskeletal Services Framework [1] recommends that people should have access to a range of non-surgical alternatives to help them deal with joint pain (to include osteopathy), it would seem sensible to offer the therapy to appropriate patients.

Recommendations

- Osteopathy is not a substitute for usual care and when offered, should always take place alongside treatment from a patient's GP (because all research detailed offered osteopathy alongside usual care, not alone)
- Painful periods or asthma are not appropriate indications for osteopathy (because the evidence found no improvements for patients)
- Sub-acute spinal pain or low-back pain are appropriate conditions to refer to an osteopath (because the evidence suggests patients may derive significant physical and psychological benefit from the therapy, it is cost-effective and may result in fewer prescriptions for NSAIDs).

References

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