

1 **Clinical Practice Guideline:** **Direct Moxibustion**

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3 **Date of Implementation:** **February 9, 2006**

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5 **Product:** **Specialty**

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8 • Policy terminated. Content has been incorporated into CPG 48 Revision 17 – S.

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10 **GUIDELINES**

11 American Specialty Health – Specialty (ASH) considers direct moxibustion not medically
12 necessary due to risk of direct harm.

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14 The potential for direct harm from burns and the availability of the safer alternative of
15 indirect moxibustion has led ASH clinical committees to only allow the use of the indirect
16 form of moxibustion by contracted practitioners. When indirect moxibustion is used, there
17 is no direct contact between the patient’s skin and the moxa (e.g., warming needle, moxa
18 box, or placing the moxa on ginger, garlic, aconite, or another appropriate physical barrier).
19 Creams, oils, and other non-solid substances are not considered acceptable barriers for
20 adequate patient safety. For more information, see the *Indirect Moxibustion (CPG 48 - S)*
21 policy and *Techniques and Procedures Not Widely Supported as Evidence Based (CPG*
22 *133 – S)* policy.

23
24 **DESCRIPTION/BACKGROUND**

25 Direct moxibustion is also known as “festering moxibustion, open moxibustion, or scarring
26 moxibustion.” Traditionally, this technique involves placing a small cone-shaped amount
27 of an herb called *moxa* (dried Mugwort [*Artemisia vulgaris*]) on acupuncture points on the
28 body. The moxa is then lit and permitted to burn down to the skin.

29
30 When lit, moxa burns slowly and provides a penetrating heat which in Traditional East
31 Asian Medicine is believed to enter the meridians (energetic pathways throughout the
32 body) to enhance the circulation of blood and qi (vital energy). The purpose is to warm,
33 stimulate, and strengthen the blood and *qi* of the body to promote healing or normal
34 functioning of the body.

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36 **EVIDENCE AND RESEARCH**

37 Yamashita et al. (1999) reviewed all relevant cases of adverse events of acupuncture
38 (including moxibustion) reported by therapists at the Tsukuba College of Technology
39 Clinic in Japan over a six-year period. A total of 84 therapists participated in this study
40 which included a total of 65,482 treatments. Among the 94 adverse events, seven cases of
41 burn injury and one case of numbness in the extremities were reported. An adverse event
42 was defined as an unfavorable medical event that occurred during or after the treatment

1 regardless of causal relationships. No serious or severe cases were reported by the
 2 participants. The results indicate that serious or severe adverse events are rare in standard
 3 practice. The reviewers suggest that most severe or serious cases of adverse events caused
 4 by acupuncture reported in journals are actually cases of negligence.

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 6 A literature review by Dharmananda (2004) was inconclusive as to whether moxibustion
 7 is more effective than acupuncture or other stimulus methods administered for the same
 8 condition. In the absence of more detailed studies, moxa is applied primarily on the basis
 9 of the traditional acupuncture point therapeutic indications, such as treating syndromes
 10 associated with cold, retention of food, and local stagnation of fluids with formation of
 11 masses. Moxa may be utilized in some cases of heat syndromes.

12
 13 One systematic review evaluating the effectiveness of direct and indirect moxibustion was
 14 found. The study found two (2) randomized controlled trials (RCTs) involving *direct*
 15 moxibustion that met all inclusion criteria. These suggested positive effects for *indirect or*
 16 *direct* moxibustion on pain in scleroma or herpes zoster compared with drug therapy. Due
 17 to only a few studies, most with a high risk of bias, the authors concluded that more
 18 rigorous studies are needed to determine the effectiveness of moxibustion (Lee, Choi,
 19 Kang, Lee, & Ernst, 2010). Another review by Lee et al. (2010) assessed the effectiveness
 20 of moxibustion for supportive cancer care. The authors concluded again that the evidence
 21 is limited to suggest moxibustion is an effective supportive cancer care in nausea and
 22 vomiting. All studies had a high risk of bias so there was not enough evidence to draw any
 23 conclusions. No controlled trials (randomized or non-randomized) evaluating the
 24 effectiveness of *direct* moxibustion were found. Yuan et al. (2015) reviewed the use of
 25 traditional Chinese medicine (TCM) for neck pain (NP) and low back pain (LBP). As part
 26 of a larger review, the authors concluded that the efficacy of moxibustion is unknown
 27 because no direct evidence was obtained. A pilot study completed in 2014 by Thorne et al.
 28 using direct moxibustion to treat a form of fatigue could not be considered as evidence due
 29 to lack of robust study design.

30 31 **References**

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