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Hip Osteoarthritis

Coxarthrose : évaluation de l'acupuncture

1. Systematic Reviews and Meta-Analysis

1.1. Generic acupuncture

1.1.1. Park 2023 ★

Park HS, Jeong HI, Sung SH, Kim KH. Acupuncture Treatment for Hip Pain: A Systematic Review and Meta-Analysis. Healthcare (Basel). 2023 Jun 1;11(11):1624. https://doi.org/10.3390/healthcare11111624

Background	Acupuncture treatment (AT) is an effective treatment for pain relief; however, there are few systematic reviews that have reported on the effectiveness of AT for hip pain. This systematic review aimed to evaluate the efficacy and safety of AT of hip pain.
Methods	We searched eight databases for randomised controlled trials (RCTs) evaluating the effect of AT on hip pain until August 2022.
Results	**Twelve RCTs (806 patients)** were included: two reported a significant effect of AT compared with that of conventional medicine (CM) alone for hip pain; two reported significant effects of AT + CM compared with that of CM alone in terms of Visual Analogue Scale (VAS); two reported a significant effect of AT + CM compared with that of Sham AT + CM in terms of anaesthetic dosage; two reported a significant effect of AT + CM compared with that of Sham AT + CM in terms of the side effects associated with analgesic use; one study reported a significant effect of AT compared to that of no-treatment. No serious adverse events were reported.
Conclusion	Our findings demonstrate the potential of AT in managing hip pain. Given the low quality and small sample sizes of the studies, the evidence supporting AT for hip pain management was weak. Further clinical trials and systematic reviews are required. The protocol of the current study was registered in the PROSPERO International prospective register of systematic reviews (CRD42017079586).

1.1.2. Manheimer 2018 ∅

Manheimer E, Cheng K, Wieland LS, Shen X, Lao L, Guo M, Berman BM. Acupuncture for hip osteoarthritis. Cochrane Database Syst Rev. 2018;:. [168615].

Background	Hip osteoarthritis (OA) is a major cause of pain and functional limitation. Few hip OA treatments have been evaluated for safety and effectiveness. Acupuncture is a traditional Chinese medical therapy which aims to treat disease by inserting very thin needles at specific points on the body.
Objectives	To assess the benefits and harms of acupuncture in patients with hip OA.

Methods	SEARCH METHODS: We searched Cochrane CENTRAL, MEDLINE, and Embase all through March 2018. SELECTION CRITERIA: We included randomized controlled trials (RCTs) that compared acupuncture with sham acupuncture, another active treatment, or no specific treatment; and RCTs that evaluated acupuncture as an addition to another treatment. Major outcomes were pain and function at the short term (i.e. < 3 months after randomization) and adverse events. DATA COLLECTION AND ANALYSIS: We used standard methodological procedures expected by Cochrane.
Main results	**Six RCTs with 413 participants were included**. Four RCTs included only people with OA of the hip, and two included a mix of people with OA of the hip and knee. All RCTs included primarily older participants, with a mean age range from 61 to 67 years, and a mean duration of hip OA pain from two to eight years. Approximately two-thirds of participants were women. Two RCTs compared acupuncture versus sham acupuncture; the other four RCTs were not blinded. All results were evaluated at short term (i.e. four to nine weeks after randomization).In the two RCTs that compared acupuncture to sham acupuncture, the sham acupuncture control interventions were judged believable, but each sham acupuncture intervention was also judged to have a risk of weak acupuncture-specific effects, due to placement of non-penetrating needles at the correct acupuncture points in one RCT, and the use of penetrating needles not inserted at the correct points in the other RCT. For these two sham-controlled RCTs, the risk of bias was low for all outcomes. The combined analysis of two sham-controlled RCTs gave moderate quality evidence of little or no effect in reduction in pain for acupuncture relative to sham acupuncture. Due to the small sample sizes in the studies, the confidence interval includes both the possibility of moderate benefit and the possibility of no effect of acupuncture (120 participants; Standardized Mean Difference (SMD) -0.13, (95% Confidence Interval (CI) -0.49 to 0.22); 2.1 points greater improvement with acupuncture compared to sham acupuncture on 100 point scale (i.e., absolute percent change -2.1% (95% CI -7.9% to 3.6%)); relative percent change -4.1% (95% CI -15.6% to 7.0%)). Estimates of effect were similar for function (120 participants; SMD -0.15, (95% CI -0.51 to 0.21)). No pooled estimate, representative of the two sham-controlled RCTs, could be calculated or reported for the quality of life outcome. The four other RCTs were unblinded comparative effectiveness RCTs, which compared (additional) acupuncture to four different active control treatments. There was low quality evidence that addition of acupuncture to the routine primary care that RCT participants were receiving from their physicians was associated with statistically significant and clinically relevant benefits, compared to the routine primary physician care alone, in pain (1 RCT; 137 participants; mean percent difference -22.9% (95% CI -29.2% to -16.6%); relative percent difference -46.5% (95% CI -59.3% to -33.7%)) and function (mean percent difference -19.0% (95% CI -24.41 to -13.59); relative percent difference -38.6% (95% CI -49.6% to -27.6%)). There was no statistically significant difference for mental quality of life and acupuncture showed a small, significant benefit for physical quality of life. The effects of acupuncture compared with either advice plus exercise or NSAIDs are uncertain. We are also uncertain whether acupuncture plus patient education improves pain, function, and quality of life, when compared to patient education alone.In general, the overall quality of the evidence for the four comparative effectiveness RCTs was low to very low, mainly due to the potential for biased reporting of patient-assessed outcomes due to lack of blinding and sparse data.Information on safety was reported in four RCTs. Two RCTs reported minor side effects of acupuncture, which were primarily minor bruising, bleeding, or pain at needle insertion sites. Four RCTs reported on adverse events, and none reported any serious adverse events attributed to acupuncture.

Authors' conclusions	**Acupuncture probably has little or no effect in reducing pain or improving function relative to sham acupuncture in people with hip osteoarthritis**. Due to the small sample size in the studies, the confidence intervals include both the possibility of moderate benefits and the possibility of no effect of acupuncture. One unblinded trial found that acupuncture as an addition to routine primary physician care was associated with benefits on pain and function. However, these reported benefits are likely due at least partially to RCT participants' greater expectations of benefit from acupuncture. Possible side effects associated with acupuncture treatment were minor.

1.1.3. Manheimer 2010 Ø

Manheimer E, Cheng K, Linde K, Lao L, Yoo J, Wieland S, van der Windt DAWM, Berman BM, Bouter LM. Acupuncture for peripheral joint osteoarthritis. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD001977. DOI:10.1002/14651858.CD001977.pub2. [154597]

Purpose	To assess the effects of acupuncture for treating peripheral joint osteoarthritis.
Methods	We searched the Cochrane Central Register of Controlled Trials (The Cochrane Library 2008, Issue 1), MEDLINE, and EMBASE (both through December 2007), and scanned reference lists of articles. Randomized controlled trials (RCTs) comparing needle acupuncture with a sham, another active treatment, or a waiting list control group in people with osteoarthritis of the knee, hip, or hand.

Results	Sixteen trials involving 3498 people were included. Twelve of the RCTs included only people with OA of the knee, **3 only OA of the hip,** and 1 a mix of people with OA of the hip and/or knee. **In comparison with a sham control, acupuncture showed statistically significant, short-term improvements in osteoarthritis pain** (standardized mean difference -0.28, 95% confidence interval -0.45 to -0.11; 0.9 point greater improvement than sham on 20 point scale; absolute percent change 4.59%; relative percent change 10.32%; 9 trials; 1835 participants) and function (-0.28, -0.46 to -0.09; 2.7 point greater improvement on 68 point scale; absolute percent change 3.97%; relative percent change 8.63%); however, these pooled short-term benefits did not meet our predefined thresholds for clinical relevance (i.e. 1.3 points for pain; 3.57 points for function) and there was substantial statistical heterogeneity. In comparison with sham acupuncture at the six-month followup, acupuncture showed borderline statistically significant, clinically irrelevant improvements in osteoarthritis pain (-0.10,-0.21 to 0.01; 0.4 point greater improvement than sham on 20 point scale; absolute percent change 1.81%; relative percent change 4.06%;4 trials;1399 participants) and function (-0.11, -0.22 to 0.00; 1.2 point greater improvement than sham on 68 point scale; absolute percent change 1.79%; relative percent change 3.89%). In a secondary analysis versus a waiting list control, acupuncture was associated with statistically significant, clinically relevant short-term improvements in osteoarthritis pain (-0.96, -1.19 to -0.72; 14.5 point greater improvement than sham on 100 point scale; absolute percent change 14.5%; relative percent change 29.14%; 4 trials; 884 participants) and function (-0.89, -1.18 to -0.60; 13.0 point greater improvement than sham on 100 point scale; absolute percent change 13.0%;relative percent change 25.21%). **The three hip OA RCTs (Fink 2001; Haslam 2001; Stener-Victorin 2004) each had outcome data collected during the followup time relevant for our predefined long-term time point analysis. However, because for each of these trials, the attrition rate was so high (almost 50%for at least one of the comparison groups), a post hoc decision was made to exclude these follow-up data from our meta-analyses**. However, these outcomes are briefly described here. Namely, in the Fink 2001 study, only 41 out of 67 randomized participants (and only 17 out of 33 randomized to the acupuncture group) were available at the six month follow-up point, at which time there were no differences in pain or function between the acupuncture and sham groups. In the Haslam 2001 study, the dropout rate in the control group was very high (almost 44%) at the 14 week follow-up point, at which time therewas a “significant improvement in group A [acupuncture] compared with group B [supervised exercise] P = .03.” In the Stener-Victorin 2004 study, only 25 out of 45 randomized were available for follow-up at the 6 month point, at which time there were no differences between the groups on the pain outcome but greater improvements on the function outcome in the group that received adjuvant electroacupuncture compared with the group that received patient education alone.
Conclusion	**Waiting list-controlled trials of acupuncture for peripheral joint osteoarthritis suggest statistically significant and clinically relevant benefits**, much of which may be due to expectation or placebo effects.

1.1.4. Kwon 2006 Ø

Kwon YD, Pittler MH, Ernst E. Acupuncture for peripheral joint osteoarthritis : a systematic review and meta-analysis. Rheumatology (Oxford).2006;45(11):1331-7. [141385]

Purpose	To evaluate the evidence for the effectiveness of acupuncture in peripheral joint osteoarthritis (OA).

Methods	Systematic searches were conducted on Medline, Embase, AMED, Cochrane Library, CINAHL, British Nursing Index, PsychiNFO and CAMPAIN until July 2005. Hand-searches included conference proceedings and our own files. There were no restrictions regarding the language of publication. All randomized controlled trials (RCTs) of acupuncture for patients with peripheral joint OA were considered for inclusion. Trials assessing needle acupuncture with or without electrical stimulation were considered if sham- or placebo-controlled or controlled against a comparator intervention. Trials testing other forms of acupuncture were excluded. Methodological quality was assessed and, where possible, meta-analyses were performed.
Results	Thirty-one possibly relevant studies were identified and 18 RCTs were included (**3 RCTs in hip OA, 144 patients**). In the meta-analysis, mean pain reduction was 14.43 (on a 0–100 visual analog scale [VAS]) for the intervention group and 15.31 for the sham treatment group (mean difference of □0.03, 95% confidence interval [CI]□□0.52– 0.45). One of three studies or OA of the hip had intergroup differences on pain measures favouring acupuncture.
Conclusion	**On the basis of the meta-analysis, there were no statistically significant results, and thus there was no evidence that acupuncture is beneficial for reducing OA pain**. Further studies are required particularly for manual or electroacupuncture for hip OA.

1.2. Special Clinical Forms

1.2.1. Osteonecrosis of the femoral head

1.2.1.1. Jin 2021

Jin H, Li L, Yu W, Fu Y. The efficacy of acupuncture and moxibustion for early and middle-stage osteonecrosis of the femoral head: A systematic review and meta-analysis of randomized controlled trials. Medicine (Baltimore). 2021;100(22). [217806]. doi

Background	Osteonecrosis of the femeral head (ONFH) occurs predominantly in young- and middle-aged people, and the disability rate is high in the late stage of the disease and most patients have to undergo total hip replacement. Clinically, increasing attention is paid to intervening early and middle-stage ONFH so as to delay its progress. Acupuncture and moxibustion (AM) is a unique method for treating ONFH in China. This study aims to summarize the advantages of AM for the treatment of ONFH.
Methods	A comprehensive literature search was conducted on the database with languages of English and Chinese. The medical subject titles used are “Osteonecrosis of the femoral head” and “acupuncture and moxibustion.” Related words in the title or abstract including but were not limited to “necrosis of the femoral head,” “avascular necrosis of the femoral head,” “ischemic necrosis of the femoral head,” “caput femoris necrosis,” “bone paralysis,” “bone erosion,” and “bone atrophy.”
Results	Nine randomized controlled trials were identified in this meta-analysis that included 630 subjects. Meta-analysis showed that the trial group that treated with conventional therapy combined with AM had a higher effective rate ($Z = 2.27$ $P = 0.02$) and excellent and good rate ($Z = 4.85$ $P < 0.00001$) and Harris hip function score (HHS) ($Z = 2.31$ $P = 0.02$) and lower incidence of related adverse reactions during treatment ($Z = 2.82$ $P = 0.005$) compared with the control group that treated with conventional therapy alone.

Conclusions	AM for early and middle-stage ONFH is an effective and relatively safe intervention, which can improve the effective rate and excellent and good rate and HHS, and reduce the adverse reaction rate. Clinically, early and middle-stage ONFH can be intervened by combining with AM while taking conventional therapy to improve the efficacy.

2. Cost-effectiveness Analysis

See corresponding item

3. Clinical Practice Guidelines

⊕ positive recommendation (regardless of the level of evidence reported)
Ø negative recommendation (or lack of evidence)

3.1. Academy of Orthopaedic Physical Therapy, American Academy of Sports Physical Therapy (AOPT, AASPT, USA) 2025 ⊕

Koc TA Jr, Cibulka M, Enseki KR, Gentile JT, MacDonald CW, Kollmorgen RC, Martin RL. Hip Pain and Mobility Deficits-Hip Osteoarthritis: Revision 2025. J Orthop Sports Phys Ther. 2025 Nov;55(11):CPG1-CPG31. https://doi.org/10.2519/jospt.2025.0301

Clinicians should use DN to treat MTrP in the iliopsoas, rectus femoris, tensor fasciae latae, gluteus medius, and gluteus minimus muscles for shortterm (3 weeks) improvements in muscle extensibility, pain, ROM, function, and muscle force production, in those with	Grades II and III hip OA.

3.2. American College of Rheumatology (ACR, USA) 2020 ⊕

Kolasinski SL, Neogi T, Hochberg MC, Oatis C, Guyatt G, Block J, Callahan L, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee. Arthritis Rheumatol. 2020;Jan 6:. [175069]. CrossRef.

Acupuncture is conditionally recommended for patients with knee, **hip**, and/or hand OA.

3.3. Department of Veterans Affairs Department of Defense (VA/DOD, USA) 2020 Ø

VA/DOD clinical practice guideline for the non-surgical management of hip & knee osteoarthritis. Department of Veterans Affairs Department of Defense. 2020;:127P. [219381]. URL

Recommendation 18. There is insufficient evidence to recommend for or against the use of complementary and integrative health interventions for the treatment of osteoarthritis of the hip or knee, including: **Acupuncture** Massage Light touch Meditation Tai chi Yoga (Neither for nor against). Reviewed, New-replaced).

3.4. Osteoarthritis Research Society International (OARSI) 2019 Ø

Bannuru RR, Osani MC, Vaysbrot EE, Arden NK, Bennell K, Bierma-Zeinstra SMA, Kraus VB, Lohmander LS, Abbott JH, Bhandari M, Blanco FJ, Espinosa R, Haugen IK, Lin J, Mandl LA, Moilanen E, Nakamura N,

Snyder-Mackler L, Trojian T, Underwood M, McAlindon TE. OARSI guidelines for the non-surgical management of knee, hip, and polyarticular osteoarthritis. Osteoarthritis Cartilage. 2019 Nov;27(11):1578-1589. https://doi.org/10.1016/j.joca.2019.06.011

Hip Osteoarthritis. Recommendation against : Aquatic Exercise, Balneotherapy, Cognitive Behavioral Therapy with Exercise, Conventional, **Acupuncture**, Mobilization & Manipulation, Thermotherapy (hot or cold)

3.5. Aetna (insurance provider, USA) 2018 ⊕

Acupuncture. Aetna (insurance provider, USA). 2018. 73P. [188029].

Aetna considers needle acupuncture (manual or electroacupuncture) medically necessary for any of the following indications:**Pain from osteoarthritis of the knee or hip (adjunctive therapy)**

3.6. The Royal Australian College of General Practitioners (RACGP, Australia) 2018 Ø

Guideline for the management of knee and hip osteoarthritis. The Royal Australian College of General Practitioners. 2018:82P. [196824].

Acupuncture – Knee and/or hip We suggest not offering acupuncture (ie traditional, laser, electro) for people with knee and/or hip osteoarthritis (OA). Strength of recommendation: Conditional against recommendation. Quality of evidence : Low (knee) Very low (hip).

3.7. Finnish Medical Association and the Finnish Orthopedic Association (Finland) 2018 ⊕

[Osteoarthritis of the knee and hip]. by the Duodecim of the Finnish Medical Association and the Finnish Orthopedic Association. 2018;:20p. [219462]. URL

Acupuncture apparently reduces pain B and improves function B, at least for a short time in osteoarthritis.

3.8. Department of Veterans Affairs, Department of Defense (VA/DoD, USA) 2014 ⊕

Non-Surgical Management of Hip and Knee Osteoarthritis Working Group. VA/DoD clinical practice guideline for the non-surgical management of hip and knee osteoarthritis. Washington (DC): Department of Veterans Affairs, Department of Defense. 2014; : 126P. [165832].

In adults with hip and/or knee osteoarthritis, there is insufficient evidence to recommend for or against referral for short term trial needle acupuncture or chiropractic therapy for relief of pain and improved function.

3.9. American College of Rheumatology (ACR, USA) 2012 Ø

Hochberg MC, Altman RD, April KT, Benkhalti M, Guyatt G, McGowan J, Towheed T, Welch V, Wells G, Tugwell P; American College of Rheumatology. American College of Rheumatology 2012

recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee.Arthritis Care Res (Hoboken). 2012 Apr;64(4):465-74. [165333]

Interventions for which data are available only for knee OA and not hip OA were not considered for patients with only hip OA (e.g., insoles, patellar taping, **acupuncture**, transcutaneous electrical stimulation, tai chi).

3.10. American College of Occupational and Environmental Medicine (ACOEM, 2011) ⊕

American College of Occupational and Environmental Medicine (ACOEM). Hip and groin disorders. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM). 2011;:440P. [166172].

Hip Osteoarthrosis. Recommended: Acupuncture for select use for chronic osteoarthrosis of the hip as an adjunct to more efficacious treatments (B) *Acute, Subacute, or Chronic Hip and Groin Pain.* No Recommendation: Acupuncture for acute or subacute hip pain (I) *Pre-, Peri-, and Post-operative Issues Related to Hip and Groin Disorders.* Recommended: Acupuncture for hip arthroplasty procedures (B)

4. Overviews of Clinical Practice Guidelines

4.1. Gibbs 2023

Gibbs AJ, Gray B, Wallis JA, Taylor NF, Kemp JL, Hunter DJ, Barton CJ. Recommendations for the management of hip and knee osteoarthritis: A systematic review of clinical practice guidelines. Osteoarthritis Cartilage. 2023 Oct;31(10):1280-1292. https://doi.org/10.1016/j.joca.2023.05.015

Objectives	Guideline adherence for hip and knee osteoarthritis management is often poor, possibly related to the quality and/or inconsistent recommendations. This systematic review of hip and knee osteoarthritis guidelines aimed to appraise the quality and consistency in recommendations across higher-quality guidelines.
Methods	Eight databases, guideline repositories, and professional associations websites were searched on 27/10/2022. Guideline quality was appraised using the Appraisal of Guidelines for Research and Evaluation II (AGREE II tool) (six domains). Higher quality was defined as scoring ≥60% for domains 3 (rigour of development), 6 (editorial independence), plus one other. Consistency in recommendations across higher-quality guidelines was reported descriptively. This review was registered prospectively (CRD42021216154).
Results	**Seven higher-quality and 18 lesser-quality guidelines** were included. AGREE II domain scores for higher-quality guidelines were > 60% except for applicability (average 46%). Higher-quality guidelines consistently recommended in favour of education, exercise, and weight management and non-steroidal anti-inflammatory drugs (hip and knee), and intra-articular corticosteroid injections (knee). Higher quality guidelines consistently recommended against hyaluronic acid (hip) and stem cell (hip and knee) injections. Other pharmacological recommendations in higher-quality guidelines (e.g., paracetamol, intra-articular corticosteroid (hip), hyaluronic acid (knee)) and adjunctive treatments (e.g., **acupuncture**) were less consistent. Arthroscopy was consistently recommended against in higher-quality guidelines. No higher-quality guidelines considered arthroplasty.

Conclusion	Higher-quality guidelines for hip and knee osteoarthritis consistently recommend clinicians implement exercise, education, and weight management, alongside consideration of Non-Steroidal Anti-Inflammatory Drugs and intra-articular corticosteroid injections (knee). Lack of consensus on some pharmacological options and adjunctive treatments creates challenges for guideline adherence. Future guidelines must prioritise providing implementation guidance, considering consistently low applicability scores.

5. Randomized Controlled Trials

5.1. Sources

1. **Acudoc2**: RCT included in the GERA database and not included in other sources cited.
2. **ACR 2019**: Kolasinski SL, Neogi T, Hochberg MC, Oatis C, Guyatt G, Block J, Callahan L, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Management of Osteoarthritis of the Hand, Hip, and Knee. Arthritis Rheumatol. 2020;Jan 6:. [175069].
3. **Manheimer 2018**: Manheimer E, Cheng K, Wieland LS, Shen X, Lao L, Guo M, Berman BM. Acupuncture for hip osteoarthritis. Cochrane Database Syst Rev. 2018. [168615].
4. **NICE 2014**: National Clinical Guideline Centre. Osteoarthritis: care and management; London (UK): National Institute for Health and Clinical Excellence (NICE). 2014. 505P. [188816].
5. **Manheimer 2010**: Manheimer E, Cheng K, Linde K, Lao L, Yoo J, Wieland S, van der Windt DAWM, Berman BM, Bouter LM. Acupuncture for peripheral joint osteoarthritis. Cochrane Database of Systematic Reviews 2010, CD001977. [154597].
6. **Kwon 2006**: Kwon YD, Pittler MH, Ernst E. Acupuncture for peripheral joint osteoarthritis : a systematic review and meta-analysis. Rheumatology (Oxford).2006;45(11):1331-7. [141385].

5.2. List

	RCT	Sources
2012	White P, Bishop FL, Prescott P, Scott C, Little P, Lewith G. Practice, practitioner, or placebo? A multifactorial, mixed-methods randomized controlled trial of acupuncture. Pain. 2012;153(2):455-62. [168182].	Manheimer 2018
2010	Sheng XP, Fan TY. [Comparative observation on hip osteoarthritis treated with electroacupuncture and medication]. Chinese Acupuncture and Moxibustion. 2010;30(12):982-4. [155014].	Manheimer 2018
2006	Witt CM, Jena S, Brinkhaus B, Liecker B, Wegscheider K, Willich SN. Acupuncture in patients with osteoarthritis of the knee or hip: a randomized, controlled trial with an additional nonrandomized arm. Arthritis Rheum. 2006;54(11):3485-349. [141492].	ACR 2019, Manheimer 2018, NICE 2014, Manheimer 2010
2005	Zheng Xiaoche Tao. Clinical observations on treatment of hip osteoarthritis by electroacupuncture. Journal of Acupuncture and Tuina Science. 2005;3(2):52. [140331].	Acudoc2
2004	Stener-Victorin E, Kruse-Smidje C, Jung K. Comparison between electro-acupuncture and hydrotherapy, both in combination with patient education and patient education alone, on the symptomatic treatment of osteoarthritis of the hip. Clinical journal of pain 2004;20(3):179–85. [126400]	Manheimer 2018, Manheimer 2010, Kwon 2006

	RCT	Sources
2001	Fink MG, Wipperman B, Gehrke A. Non-specific effects of traditional Chinese acupuncture in osteoarthritis of the hip. Complementary Ther Med 2001; 9:82–9. [100432].	ACR 2019, Manheimer 2018, NICE 2014, Manheimer 2010, Kwon 2006
	Haslam R. A comparison of acupuncture with advice and exercises on the symptomatic treatment of osteoarthritis of the hip–a randomised controlled trial. Acupuncture in medicine 2001;19(1): 19–26. [115172]	Manheimer 2018, Manheimer 2010

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