PT inMotion

APTA
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FEATURE

Dry Needling: Getting to the Point

Dry needling by physical therapists is a hot topic. What's fact? What's fiction? Take a look beneath the surface.

By Eric Ries
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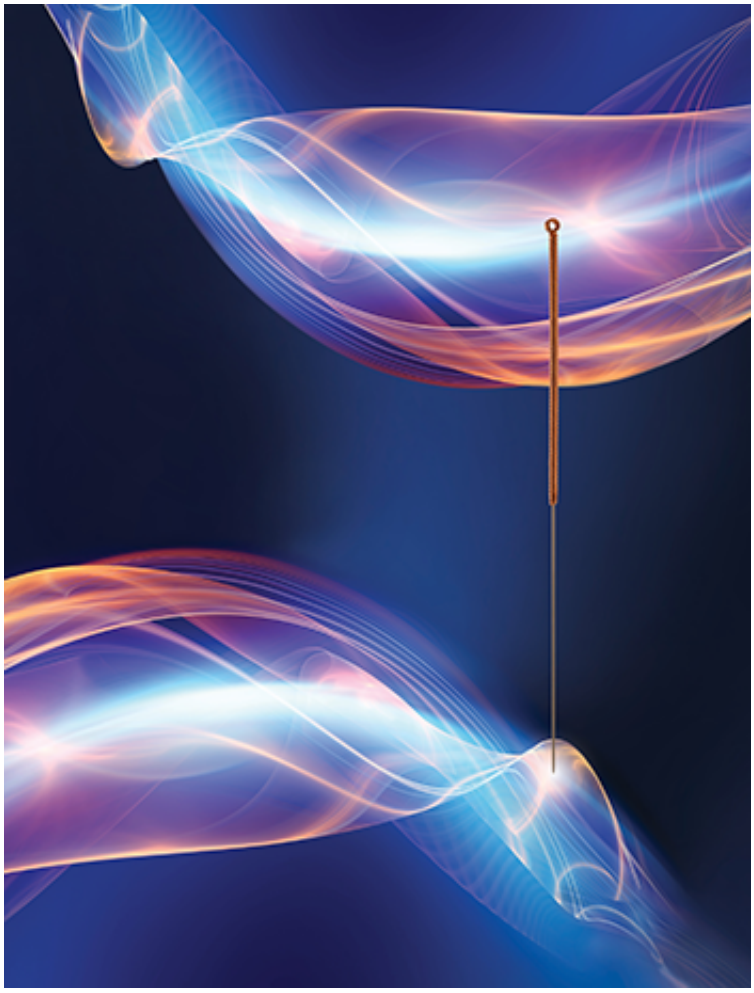

Ask Karen Kitchener what the words "dry needling" mean to her and there is no equivocation.

"Transformation," she says. "Five years ago I primarily was sitting in a wheelchair. Today I'm regularly walking 3 miles. The difference dry needling has made in my life hasn't simply been physical, but also social and psychological. I feel more hopeful and less depressed. I can do so much more that I could do before. The effects have been cumulative."

Kitchener, now-retired former director of the counseling psychology program at the University of Denver, is speaking in late January 2015 from her winter home in Hawaii. It was there that, 2 years earlier, members of her book group had exclaimed, "You look completely different!" when she first arrived for the season from Colorado. That was because she'd undergone dry needling treatments the previous fall, and her face no longer was tight with pain and tension.

Those sessions had been the culmination of a 15-year journey to address her chronic pain that led her through a rheumatologist and a total of 9 neurologists. Along the way, she was misdiagnosed by the Mayo Clinic as having fibromyalgia and had been prescribed "heavy pain meds" that made her feel "drugged" for an entire decade. Finally, she ended up in the Bethesda, Maryland, office of Robert Gerwin, MD, FAAN, who had worked with myofascial pain pioneer Janet Travell, MD, onetime personal physician to President John F. Kennedy. Gerwin diagnosed myofascial pain disorder and small fiber sensory neuropathy, and connected Kitchener with Fort Collins, Colorado-based private practitioner Tim Flynn, PT, PhD, OCS, FAAOMPT.

"Karen presented with a Parkinson-like gait," Flynn recalls. "Very rigid in all her movements. Restricted range of motion in both the upper and lower body. A systematic appearance to her presentation suggested an underlying neurological disorder."

Flynn had undergone dry needling training in 2008 through Colorado-based KinetaCore, one of the nation's larger providers of training in dry needling to physical therapists (PTs). Before Kitchener walked through the doors of Colorado Physical Therapy Specialists, Flynn's practice had seen "good benefits" incorporating dry needling into the wider care plans of patients with common musculoskeletal issues such as shoulder, heel, hip, and back pain. However, Flynn concedes, his "expectation

of benefit" in a patient with Kitchener's severe presentation was "not high."

Dry needling surprised him. "Karen's gait is fluid now—there's been about an 80% gain," he says. "Her joints move. Her stride length has doubled. She can swing her arms. She can move her neck from side to side if she wants. The results from dry needling, in conjunction with movement-based therapy, were pretty transformational."

In fact, Flynn says, his experience with Kitchener led him to expand his use of trigger point dry needling—the dominant form of the intervention, so named because it targets the tight points within muscular tissue that produce and refer pain. "Karen's case opened up a broader perspective," he says. "I now use dry needling with patients who've had partial nerve injuries after spinal surgery. We're using it post-CVA [cerebrovascular accident] in folks who have movement disorders."

Still, for all of Flynn's enthusiasm for dry needling, he adds that he—and his PT colleagues at Evidence in Motion, another training provider for which he teaches the intervention—are "very cautious about overselling the tool." He notes that the mechanism behind dry needling—precisely why it works, when it does—is as yet unclear, although a growing body of evidence confirms that it does work, particularly at trigger points. (It also is used by some practitioners to treat such conditions as cervicogenic headaches, carpal tunnel syndrome, lateral epicondylitis, and plantar fasciitis.)

In a way, Flynn's qualifying remarks hint at a duality when it comes to the practice and perceptions of dry needling. Jan Dommerholt, PT, DPT, DAAPM, a Maryland-based, Dutch-trained therapist who says he taught the first US course in the intervention for PTs in 1997, marvels at the results dry needling sometimes can achieve, yet describes the technique rather more blandly as simply a form of instrument-assisted manual therapy. Practitioners interviewed for this article characterize it, with similarly qualified enthusiasm, as a safe, easy-to-learn, minimally discomforting, and often-effective technique for patients with certain presentations. They've witnessed grand results but make no grand claims. They don't tout dry needling as a panacea. They express dismay, and a degree of surprise, that so much as a whiff of controversy surrounds an intervention they see as nothing more than a single tool in the PT's toolbox.

"The technique is very simple, and it's very safe in the hands of PTs," Dommerholt says. "People who have issues with it are blowing things far out of proportion."

Yet controversial it is. Yes, it is firmly within PTs' scope of practice—cited in the APTA Board of Directors policy Guidelines: Physical Therapist Scope of Practice1 as a therapeutic intervention for "alleviating impairment and functional limitation" and listed among valid manual therapy techniques in the Guide to Physical Therapist Practice 3.0.2 And yes, the numbers of PTs who see value in it and are adopting it clearly are growing. (Those numbers likely are in the thousands, based on course numbers and class sizes, but even a rough estimate is anyone's guess, given that training providers don't share records and states don't keep registries.)

In the words of Justin Elliott, director of state government affairs at APTA, "PTs who do dry needling love it, swear by it, and are very passionate about it."

But passions run north and south, and other factors can complicate issues. Elliott is the association's point man on a

longstanding, oft-heated scope-of-practice battle between PTs and acupuncturists over dry needling. (See "Definition and Distinction" on this page and "Scope of the Battle" on page 20.) Partly as a consequence of this dispute, the intervention is explicitly permitted for PTs' use in only about half of US states. Also, there is no Current Procedural Terminology (CPT) code specifically for dry needling, and some payers won't reimburse for it. While the body of evidence for its efficacy is growing, considerable research remains to be done.

Joe Donnelly, PT, DHS, OCS, was mentored in the treatment of myofascial pain by David Simons, MD—who, with Janet Travell, authored the landmark textbook *Myofascial Pain and Dysfunction: The Trigger Point Manual*—and was mentored in dry needling by Dommerholt. As more and more PTs learn of dry needling's "powerful effects" on myofascial pain from their colleagues who use it, Donnelly predicts, its adoption will continue to spread.

But dry needling's growing popularity upsets some manual therapists. Dommerholt—a private practitioner who also owns Myopain Seminars, another major provider of dry needling training to PTs—felt compelled about a year and a half ago to engage online a small group of highly vocal critics within the profession in the United States. The PTs participating in the discussion forum had roundly condemned dry needling, describing it as an invasive procedure that is insufficiently grounded in evidence and pointlessly "uses pain to treat pain." Some participants criticized Dommerholt by name for his high-profile advocacy of the use of dry needling by PTs.

Dommerholt staunchly defended the intervention, while advising that his purported evangelization of it was overstated and inaccurate. "Serious research into trigger points is very much in its infancy," he conceded. However, he added, such research "has come very far." Furthermore, he wrote, "The observations of tens of thousands of PTs, physicians, and acupuncturists worldwide strongly suggest that dry needling works quite well."

"Part of a Broader Approach"

"Much of the basic anatomical, physiological, and biomechanical knowledge that dry needling uses is taught as part of the core physical therapist education," notes the APTA document Physical Therapists & the Performance of Dry Needling.3 PTs' training in "pathology, clinical sciences, clinical interventions, clinical applications, and screening," the document states, create a solid grounding that needs only the supplement of "specific dry needling skills" to produce a safe and effective practitioner of the intervention.

Another APTA resource paper, Description of Dry Needling in Clinical Practice,4 emphasizes that "DN [dry needling] is rarely a stand-alone procedure and should be part of a broader physical therapy approach." It elaborates that "manual soft tissue mobilization, therapeutic exercise, neuromuscular reeducation, and functional retraining should be used in combination with DN interventions. The patient," the document continues, "should be educated in appropriate self-care techniques post-DN treatment, which may include specific stretches of the involved muscles, thermo applications, or gentle TrP [trigger point] pressure."

Taken together, those descriptions encapsulate 2 articles of faith among interviewed PTs who use dry needling: that (1) by virtue of their knowledge and training, PTs arguably are the best suited of all health care practitioners to perform the procedure, and that, (2) as Donnelly puts it, "Dry needling is not a magic bullet, but it is something that can achieve profound results when its use is based on sound clinical reasoning and patient selection."

"What defines a profession is education, training, intent, and application," says Jennifer "JJ" Thomas, PT, MPT, CMTPT, who owns Primal Physical Therapy in Delaware and also teaches dry needling for KinetaCore. "As PTs, we're deeply knowledgeable in the area of neuromusculoskeletal function. Whenever we apply a technique—dry needling or joint mobilization or whatever it is—we're coming into it with a strong foundation in anatomy, physiology, and biomechanics, and we're using our clinical reasoning skills to apply the sum of our knowledge to the optimal restoration of function based on that individual's current injury."

"In most cases dry needling should not be a stand-alone procedure," Dommerholt says, echoing the APTA document. "It's something a PT does in conjunction with determining range of motion, stretching, exercise, posture correction—whatever he or she otherwise would do with the patient. You might do 10 minutes of dry needling in a half-hour session. Let's say you do cervical dry needling in the neck. You're doing mobilization and manipulation, as well as dry needling."

Dommerholt puts the current number of dry needling education providers to PTs in the US at 18, and says many have

opened their doors in the past few years. (Although Dommerholt himself had begun offering dry needling education in the US 10 years earlier, Myopain Seminars first offered courses in 2007.) The number of training hours depends in part on state requirements, ranging upward from the 40s to as many as 100.

In addition, an increasing number of doctor of physical therapy (DPT) programs are introducing students to the intervention.

"The University of Delaware is making students aware that dry needling is out there as a tool," says Thomas—noting that the modality was unknown to her until about 6 years ago, nearly a decade after she had graduated from school.

"All of the schools here in Arizona introduce the concepts and principles of dry needling in one way or the other," reports Sean Flannagan, PT, DPT, Cert SMT, Cert DN, owner of One Accord Physical Therapy in that state. Flannagan is certified in dry needling by 2 major postprofessional education providers—the Spinal Manipulation Institute and the American Dry Needling Institute. His contributions to last year's successful push to add dry needling to Arizona's physical therapy practice act earned him a State Legislative Leadership Award from the APTA Board of Directors. "Every DPT student in Arizona is aware of the battles surrounding PTs' right to practice dry needling," he says.

Donnelly, who is a clinical associate professor of physical therapy at Mercer University in Atlanta, also serves as faculty advisor for Myopain Seminars. In the latter capacity he is a liaison to PT education programs around the country. "When a residency program calls us and says 'We want to do this,' I'm their contact," he explains. "I draw on my academic background and experience in dry needling to teach people how best to integrate this into the entry-level curriculum, residency programs, and fellowship programs."

The integration possibilities afforded by clinical residencies particularly excite Donnelly.

"These programs are 12 and 13 months long," he notes, "which gives me the opportunity to challenge participants' clinical reasoning process, knowledge and abilities in pain science, grounding in anatomy, and expertise in manual therapy techniques. I add dry needling instruction on top of all of those competencies."

His sense, Donnelly says, is that the movement toward integrating dry needling instruction in residency programs is "gaining traction" nationwide.

Flannagan is not surprised by the increase in PT interest in dry need-ling despite the ongoing turf war, reimbursement concerns, and need for continued research.

"Dry needling is a great adjunct," he says, "It allows us to get into places where our hands can't go. It carries very low risk and can be highly effective with the right patient population."

Flannagan's "hands" reference has personal resonance for Donnelly. The aforementioned David Simons—the textbook author—had been Donnelly's patient before becoming the PT's mentor. During one physical therapy session, the PT recounts, the physician turned to him and drily noted, 'If you knew how to needle this trigger point, I wouldn't have to go through all this pain and suffering from your thumbs.'"

Evident Benefits

APTA's *Physical Therapists & the Performance of Dry Needling* document notes that in 2011 the association conducted "a synthesis and evaluation of the related literature." That study determined that on a scale from 0 to 5, with 5 indicating the highest level of research support for dry needling (specifically, for trigger point dry needling), the intervention rated a mid-range score of 3. Based on those findings, dry needling was included in the list of manual therapy techniques in the Guide to Physical Therapist Practice 3.0. (That research is comprehensively referenced in the APTA's companion document Description of Dry Needling in Clinical Practice.)

That was 4 years ago. "There's more research now—but still not enough, probably, to really convince insurers," Dommerholt says. "The problem is that we need a lot more outcome studies. That's what's lacking in the research world right now." He adds, however, "All the studies that have been done show that dry needling speeds up the recovery process. Patients are out of pain more quickly and moving more quickly. JOSPT [the Journal of Orthopaedic & Sports Physical Therapy]," he notes,

"has published quite a few case reports, and every single one of them says the same thing: Function is restored much more quickly when you incorporate dry needling as part of your total package."

Thomas gives an extreme example that qualifies only as anecdotal evidence but illustrates why she calls dry needling "hands-down, my most effective tool in getting people back to what they need to do, faster." A single dry needling session "reset" a triathlete patient of hers who'd experienced hamstring pain for 9 years, she says. "One treatment was all he needed. It's been 4 years now."

"The research is out there that dry needling works," says Donnelly. He cites in particular a 2014 article in JOSPT5 on the efficacy of trigger point dry needling for patients with neck pain, and urges his colleagues to look beyond the physical therapy literature to journals such as Cephalalgia and Pain, and to investigate European research, as well.

There's also the matter of whether dry needling, in the hands of PTs, is safe. That often is raised as a red flag by acupuncturists, but PTs interviewed for this article call it a straw man that roundly fails the evidence test.

"Given the surge in course providers and PTs who are performing dry needling in this country and others, if this were a public health issue, there would be data by now," Dommerholt says. "There's been no concomitant upward trend in malpractice claims or known cases of injury."

Arguably the most serious potential outcome of inexpertly applied dry needling is pneumothorax—a collapsed lung. Brendan Carney, LAc, MAOM, JAS, is a licensed acupuncturist who has no issue with PTs performing the technique. The "classic case" his fellow acupuncturists often cite to spread fear of other professions using acupuncture needles, he says, is a pneumothorax incident that destroyed an accomplished judo athlete's Olympic dreams in 2006.

While noting that "there always will be good practitioners and bad practitioners in every profession," Carney points out that the culprit in that case was a Canadian massage therapist.

Billing Issues

Dommerholt calls billing insurance for dry needling "a very hot potato."

While APTA considers it to be a manual therapy technique, the association's position is that this applies only to the practice of dry needling, not to how the modality should be coded and billed.6 "Practitioners who seek to bill a third-party payer should first check the payer's coverage policy to determine if dry needling is a covered service and if the policy specifies which code is used to report the service," APTA advises.

Dommerholt's own hands have not been singed by this hot potato, given that his private practices—Bethesda Physiocare and Rockville, Maryland-based PhysioFitness, are cash-based. He notes, however, that one of his state's major health insurers, Blue Cross/Blue Shield of Maryland, deems dry needling "experimental" and thus ineligible for payment.

"Billing is a big issue," APTA's Elliott confirms. "Some private insurance companies won't pay for it, while others will. APTA's advice always is to first determine the insurer's policy toward dry needling, then, if the company will pay for it, to ask what code they want you to use."

Many PTs, Elliott says, "just provide dry needling on a cash basis."

An Analgesic Analogy

Flynn and Thomas hardly are the only PTs who've seen remarkable patient improvement from dry needling. Joe Donnelly cites the case of a fellow PT to whom he was teaching the technique.

"He'd undergone a microdiscectomy for extruded fragments at L5-S1 in his lumbar spine that left him with residual calf pain and lower extremity pain that he'd been battling for almost a year," Donnelly recalled. "He already was taking the dry needling course, so I said, 'Let's use you as the patient example.' We came up with a treatment plan for him, and by the end of the weekend—2 dry needling treatments—he was pain-free for the first time in 11 months."

Dommerholt had a patient who flew to Maryland from Dubai to seek dry needling. "I teach courses in Dubai," notes Dommerholt; Myopain Seminars offers courses overseas as well as in the United States. "But this individual was in severe stomach pain, and he said, 'Let me come to you.' He'd been treated in Dubai, Egypt, and Germany without having gotten significant relief. He'd looked online, done a lot of homework, and bought books on myofascial pain. He'd decided, 'I bet that's what I have,' and came here to Bethesda."

When he first arrived, Dommerholt notes, the man barely could walk the 2 blocks from his hotel to Dommerholt's practice because of the intensity of his pain. "We first did mostly dry needling with him to manage the pain, then sent him to our Rockville clinic for therapeutic exercise and conditioning. He now is pain-free. He participates in sports and plays with his kids."

All of this despite the fact that, as *Description of Dry Needling in Clinical* Practice puts it, "The physiological basis for DN treatment of excessive muscle tension, scar tissue, fascia, and connective tissues is not well-described in the literature."

The way Dommerholt puts it is, "Why the needle does what it does, no one knows." What is known, he says, is that certain chemicals—termed "inflammatory mediators"—are dissipated by needling.

Tim Flynn draws an analogy to the history of aspirin. Throughout recorded history, people chewed on willow bark for pain relief, he notes, but only in the 19th century did scientists isolate acetylsalicylic acid in willow bark and begin commercially manufacturing it as aspirin.

"We effectively used aspirin before we knew why or how it worked," Flynn observes. "We needn't fully understand the mechanisms of things as long as the benefits outweigh the risks. That's clearly the case with dry needling."

Moving Toward the Mainstream?

The PTs interviewed for this article note that the profession of physical therapy has undergone other scope-of-practice battles with other professions, and has endured other internal debates, that have been resolved and in some cases are scarcely remembered now as ever having been controversial. Such likely will be the case with dry needling in the fairly near future, they say, although the timeline is uncertain.

"It's definitely going to be mainstream," Sean Flannagan asserts. "You'll have your hot pockets around the country where it may take several years yet for dry needling to become a legal part of PT practice, but it's going to happen. Some schools already are incorporating dry needling into their residencies and fellowships for orthopedic physical therapy," he adds. "There could be a day when it's part of the foundational sciences for physical therapy schools."

A decade from now, Tim Flynn forecasts, instruction in dry needling in DPT programs will be part of certification criteria by the Commission on Accreditation in Physical Therapy Education. Accordingly, he also foresees the modification of current prohibitions in some states against PTs performing dry needling until they have at least 2 years of experience.

"I'm quite optimistic about the future of dry needling by PTs," Dommerholt says, "and it's patients who truly will benefit as more and more PTs employ this tool. Millions of Americans are in chronic pain. Dry needling must not be proprietary. There are plenty of patients to go around."

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Definition and Distinction

What is dry needling?

"Dry needling is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. [It] is a technique used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, and to diminish persistent peripheral nociceptive input, and reduce or restore impairments in body structure and function, leading to improved activity and participation."

Source: APTA document Description of Dry Needling in Clinical Practice: An Educational Resource Paper. www.apta.org/StateIssues/DryNeedling/.

How is it different from acupuncture?

"Health care education and practice have developed in such a way that most professions today share some procedures, tools, or interventions with other regulated professions. It is unreasonable to expect a profession to have exclusive domain over an intervention, tool, or modality."

"The practice of acupuncture by acupuncturists and the performance of dry needling by physical therapists differ in terms of historical, philosophical, indicative, and practical context. The performance of modern dry needling by physical therapists is based on western neuroanatomy and modern scientific study of the musculoskeletal and nervous system. Physical therapists who perform dry needling do not use traditional acupuncture theories or acupuncture terminology."

Source: APTA document Physical Therapists & the Performance of Dry Needling: An Educational Resource Paper. www.apta.org/StateIssues/DryNeedling/.

Where can I find out more?

The "Dry Needling in Physical Therapy" page at www.apta.org/StateIssues/DryNeedling features resource papers describing what the intervention is, how it is used by PTs, APTA positions, evidence, and more. The site features state resources, as well, including attorneys general opinions.

Scope of the Battle

"Dry needling is the number-one scope of practice battle facing the profession of physical therapy," says Justin Elliott, director of state government affairs at APTA.

It is a battle characterized by both progress and occasional setbacks. Dry needling was added to the physical therapy practice acts of 3 states last year—Arizona, Delaware, and Utah. This brings to about 25 states and the District of Columbia the total number of jurisdictions within which dry needling has been confirmed to be within PTs' scope of

practice. Still, many challenges remain.

There are 5 states in which PTs expressly are not legally permitted to perform the technique—Hawaii, Idaho, New York, South Dakota, and Tennessee. In Idaho, New York, and South Dakota, that is due to an unfavorable opinion by the state regulatory board. In Tennessee, the state's attorney general issued the unfavorable opinion. Language in Hawaii's practice act prohibits PTs from puncturing the skin.

Dry needling's status for PTs in the remaining states is "silent," Elliott says. There is nothing in their laws that explicitly forbids the use of dry needling by PTs, but there also is no confirmation from the state regulatory board that it is within PTs' scope of practice.

Key battleground states this year are Maryland, New Jersey, North Carolina, Tennessee, and Washington. Maryland was the first state to add dry needling to its practice act in 1984, but training requirements now are being debated via Senate Bill 580. Legislation has been introduced in New Jersey to add dry needling to PTs' scope of practice. In North Carolina, dry needling is within scope, but the state chapter is gearing up for a potential legislative challenge to that status. Efforts are under way in Tennessee to overturn an unfavorable ruling on scope of practice that was issued last year by the state's attorney general. The Washington Chapter, meanwhile, is opposing House Bill 1042, which would prohibit PTs from performing dry needling.

Acupuncturists have opposed the use of dry needling by PTs, charging that PTs are practicing acupuncture, are unqualified to do so, and are a risk to public safety.

Brendan Carney, LAc, MAOM, JAS, however, says his profession's stance is ill-informed and driven by irrational fear. He is a licensed acupuncturist who owns a practice in Newton, Massachusetts, and teaches the International Structural Acupuncture Course for Physicians at Harvard Medical School.

In fact, Carney says, he deepened his skills in dry needling while being certified in it by training provider Myopain Seminars, owned by Jan Dommerholt, PT DPT, DAAPM.

"It was me and 29 physical therapists," Carney notes. "I was slightly apprehensive at first, but it was a great experience. It made my clinical practice and palpation skills better. What I learned about dry needling from a pain sciences perspective helps me empower patients by sharing that knowledge with them."

He rejects the notion that PTs are performing acupuncture when they use dry needling on patients.

"Acupuncture and dry needling, as it is practiced by physical therapists, are completely distinct from each other in terms of diagnostic criteria, palpation, selection, location, and needle manipulation," he says. "Physical therapists use dry needling as a modality," he says. "With proper education, they can—and do—use it safely and effectively. It's a nonissue as far as I'm concerned."

Carney attributes attacks by acupuncturists to 2 things: poor understanding of what PTs do and fear that PTs will hurt acupuncturists' economic livelihood. On the latter score, his colleagues needn't worry, he says. Not only is there little patient or client overlap between the 2 professions, but when it comes to dry needling, "There's a gaping hole in the health care system's ability to offer people relief from myofascial pain. Given the huge need, the more practitioners there are to help fill that hole, the better."

Vanessa Valdes, PT, DPT, OCS, LAc, has a unique perspective on the dispute. She is both a licensed PT and a licensed acupuncturist. Because she practices in New York City, where dry needling is not considered to be within the legal scope of PT practice, she performs dry needling as part of the broad scope of acupuncture in her private acupuncture practice, rather than offering it as an intervention in her physical therapy job at Mount Sinai Hospital.

"It's a shame that I can't use such an effective treatment with patients at Mount Sinai who are in chronic pain," she says, adding, "I find this whole scope of practice can of worms very interesting—and quite appalling from the standpoint of someone who knows what both professions do."

"I find that myofascial trigger point needling works better and faster than some other release techniques that are part of the manual PT's toolbox," Valdes says. "The improvement in active mobility sometimes is dramatic."

She is a proud member of 2 different professions, she says—albeit one whose views on PTs and dry needling surely wouldn't sit well with many of her colleagues in acupuncture. Suffice it to say, she's not displeased that few of them are likely to read about her stance in *PT in Motion*.

PT in Motion, APTA's official member magazine, is the successor to *PT—Magazine of Physical Therapy*, which published 1993-2009. All links within articles reflect the URLs at the time of publication and may have expired.

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Been certified for 11 years now. Without it, we miss so much.

Posted by David Bullock -> >LU`CH on 4/30/2015 3:20:58 PM

Very biases! Missed titled, The other side of the coin was not presented

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