Review Article

Acupuncture for the Treatment of Chronic Rhinosinusitis: A PRISMA-Compliant Systematic Review and Meta-Analysis

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Background. Chronic rhinosinusitis (CRS) is a highly prevalent disease associated with poor quality of life. In this paper, we appraised the role of acupuncture in the treatment of CRS.

Methods. Electronic databases were searched for randomized controlled clinical trials (RCTs) that examined the role of acupuncture in CRS. The primary outcome measures included posttreatment CRS severity, as measured by the Visual Analogue Scale (VAS) and Total Effective Rate (TER). The risk of bias and quality of evidence were evaluated according to the Cochrane Collaboration’s risk-of-bias tool and GRADE tool, respectively.

Results. Evidence from the RCTs (n = 10) suggested that acupuncture as a monotherapy or adjunctive therapy to conventional treatment was associated with significant improvements in VAS, TER, and quality of life when compared with conventional treatments for CRS. However, there was a similar incidence of adverse events. The risk of bias was unclear and the quality of evidence for each finding was generally moderate to low.

Conclusions. Acupuncture as a stand-alone or adjunctive treatment for CRS was associated with clinical symptom improvement and better quality of life, without any risk for serious adverse events. However, the high clinical heterogeneity of the included RCTs and overall moderate-to-low quality of evidence necessitates rigorous, well-designed trials to confirm these findings.

Trial Registrations. This trial is registered with PROSPERO (no. CRD42021292135).

1. Introduction

Chronic rhinosinusitis (CRS) is diagnosed when at least two of the symptoms (nasal drainage, nasal obstruction, facial pain/pressure, and hyposmia/anosmia) are present for at least 12 consecutive weeks. Additionally, diagnosis is based on a comprehensive physical examination or objective radiographic findings [1]. The estimated prevalence of CRS is 3.0–6.4% in the general population [1]. It places a tremendous burden on healthcare services and is associated with severe morbidity and poor health-related quality of life [2]. A survey conducted by a tertiary care sinus center in Canada showed that the total out-of-pocket expenses incurred due to CRS are $614.06 per patient per year [3].

The goal of CRS treatment is to provide symptomatic relief and improve the health-related quality of life. Conventional treatments for CRS include intranasal saline and medications, including corticosteroids, antibiotics, and leukotriene receptor antagonists. Surgical treatment may be considered if there is no improvement with medication [1]. However, evidence for the efficacy of medications, especially antibiotics, is limited [4]. Moreover, the possible adverse effects, drug resistance, and recurrence rates are high [5, 6]. The limitations of conventional treatments and chronic nature of the disease motivate patients to seek out complementary and integrative medicine (CIM) treatments, such as acupuncture, moxibustion, and herbal medicine [7, 8]. In keeping with these needs, some clinics attempt to treat refractory CRS using CIM because of the evidence that it improves the symptoms and quality of life [9].
Acupuncture, one of the representative CIMs, has long been used to treat various diseases, including CRS. According to a modified Delphi study conducted in the United States, alternative treatments for CRS, such as herbal medicines, vitamin supplementation, diet, and acupuncture, lack sufficient evidence to support their use in isolation. However, acupuncture could be considered as an adjuvant treatment due to its low risk [10]. The anti-inflammatory effects of acupuncture are mediated by a complex neuroendocrine-immunological network, which may help improve CRS [11]. Therefore, this treatment is a promising and cost-effective candidate for alleviating the disease burden associated with CRS.

Two reviews summarizing the effect of acupuncture on the treatment of CRS have been published [12, 13]; however, one was not systematic or comprehensive enough because they only searched the PubMed database and only a descriptive analysis was performed on the included studies [12]. The remaining study employed a systematic review protocol but no evaluation plan for assessing the quality of evidence on the key findings was provided [13]. The aim of this review was to provide a comprehensive overview of evidence concerning the efficacy and safety of acupuncture treatment for CRS by comprehensively searching databases and assessing the quality of evidence on major findings. Insight gathered from this review could help inform policy decision-making and guide patient management by clinicians.

2. Methods

We performed the research in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [14]. Ethical approval was not required for this systematic review because we used publicly accessible documents as evidence.

2.1. Inclusion and Exclusion Criteria

2.1.1. Type of Study Design. Parallel-group, randomized controlled clinical trials (RCTs) evaluating the effect and safety of acupuncture for CRS were included. To lower the risk of potential bias, crossover trials were excluded. There were no restrictions applied to the publication language (e.g., English, Korean, Chinese, or Japanese were included).

2.1.2. Type of Participants. We included trials involving patients with CRS without limitation on age, sex, or race. However, studies in which a diagnosis of CRS could not be confirmed were excluded.

2.1.3. Type of Treatment and Control Interventions. Studies using any type of acupuncture-related therapies, such as manual acupuncture, electroacupuncture, and moxibustion, were included. We excluded studies that did not provide information regarding the acupuncture points used. Sham acupuncture, no medical treatment, and conventional Western medicine treatments, such as antibiotics and antihistamines, were allowed as control interventions. However, studies using other CIM interventions as a control intervention were excluded. Studies involving acupuncture combined with conventional treatments were also included if the use of conventional treatments was equal across the treatment and control groups.

2.1.4. Type of Outcome Measures. The primary outcome measure of interest was posttreatment CRS severity. This was measured using the 0–10 cm Visual Analogue Scale (VAS) and Total Effective Rate (TER). The VAS is a subjective outcome to measure the severity of disease-related symptoms; higher scores indicate greater severity [15]. The TER is defined according to specific evaluation criteria, including symptomatic improvement and the improvement rates of other quantified outcomes.

Secondary outcome measures of interest included (1) posttreatment health-related quality of life, measured using instruments like the Sino-Nasal Outcome Test (SNOT)-20 [16]; (2) posttreatment endoscopic scores like the Lund-Kennedy endoscopic scores [17]; (3) posttreatment computed tomography (CT) scan scores like the Lund-Mackay CT scores [18]; (4) CRS recurrence rates; and (5) the incidence of adverse events (AEs) during the study period. The SNOT-20 is one of the most widely used quality-of-life tools for sinus diseases and evaluates 20 items using a 0–5 scale; higher scores indicate poorer quality of life [16]. The Lund-Kennedy score assesses the bilateral presence and severity of edema, scarring and crusting of the nasal mucosa, discharge, and polyps (from 0 to 2), for a total score range of 0–20; higher scores indicate higher severity [17]. The Lund-Mackay CT score assesses 6 bilateral areas (maxillary, anterior ethmoids, posterior ethmoids, sphenoid, frontal, and ostiomeatal complex) of sinus opacification (from 0 to 2), for a total score range of 0–24; higher scores indicate greater sinus opacity [18].

2.2. Information Sources and Search Strategy. The following 14 databases were searched for studies published from their inception dates: Medline, EMBASE, Cochrane Central Register of Controlled Trials, Allied and Complementary Medicine Database, Cumulative Index to Nursing and Allied Health Literature, Oriental Medicine Advanced Searching Integrated System, Korean Studies Information Service System, Korean Medical Database, Research Information Sharing Service, ScienceON, China National Knowledge Infrastructure, Wanfang Data, Chongqing VIP, and CNKI. The initial search date was July 6, 2021; we conducted another search on April 7, 2022, to collect more up-to-date evidence. The reference lists of the included studies and trial registries, including the international clinical trials registry platform of the World Health Organization, were reviewed to include as many eligible studies as possible. In addition to journal publications, we considered grey literature, including degree theses. This search strategy was developed through consultation with systematic review experts. The search strategies and corresponding search results for each database are summarized in Supplementary File 1.
2.3. Study Selection and Data Extraction. The studies selected following our search of the databases and other sources were imported into EndNote 20 and duplicates were removed. The titles and abstracts of the remaining studies were then reviewed for the first inclusion. The full-text versions of all eligible studies were retrieved and reviewed for final inclusion. Study selection was conducted by one researcher (BL), while another researcher (CYK) reviewed the results. Disagreement was resolved by discussion with a third researcher (MYK). The following information was extracted from the included studies and documented in a standardized Excel 2016 form: basic study information, sample size, participant characteristics, treatment and control intervention, outcome measures, results, and information used to assess the risk of bias were recorded. We referred to the Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA) checklist [19] to extract detailed information regarding acupuncture treatment for each included study. Two researchers (BL and CYK) independently conducted the data extraction; any disagreement was resolved by discussion with a third researcher (MYP). We contacted the authors of the included studies via e-mail wherever possible, if the data were ambiguous.

2.4. Risk of Bias Assessment. We assessed the risk of bias of the included studies using the Cochrane Collaboration’s risk-of-bias tool [20]. This instrument includes the domains of random sequence generation, allocation concealment, blinding of participants, personnel, and outcome assessors, completeness of outcome data, selective reporting, and other biases. Each domain was assessed as “low risk,” “unclear risk,” or “high risk” of bias by two researchers (BL and CYK); consensus was reached through discussions between them if there was any disagreement.

2.5. Data Analysis and Synthesis. Descriptive analysis of the details of all included studies was performed. Meta-analysis was conducted for our primary and secondary outcomes using the Review Manager (RevMan) software package (version 5.4). Continuous and binary outcomes were presented as the mean difference (MD) and risk ratio (RR) along with 95% confidence intervals (CIs). Heterogeneity among the studies was evaluated using the $\chi^2$ test and the $I^2$ statistics. We considered an $I^2$ value $\geq 50\%$ and $\geq 75\%$ as indicative of substantial and considerable heterogeneity, respectively. Owing to the lack of precision of the estimates of between-study variance, a fixed-effects model was used if the heterogeneity was not significant ($I^2 < 50\%$), or if the number of studies included in the meta-analysis was small [21]. Otherwise, a random-effects model was used. To determine the cause of heterogeneity, a subgroup analysis was conducted according to the type of acupuncture treatment (manual acupuncture, electroacupuncture, or moxibustion). A sensitivity analysis was conducted to identify the robustness of the meta-analysis by excluding studies without any details of the random sequence generation method.

2.6. Quality of Evidence Assessment. The quality of evidence for key findings was assessed using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) tool as “very low,” “low,” “moderate,” or “high” [22]. The risk of bias, inconsistency, indirectness, imprecision, and publication bias were assessed for each finding using GRADEpro (https://gradepro.org/). The assessment was performed by one researcher (BL), while another researcher (CYK) reviewed the results. Any disagreements were resolved via discussion between them.

3. Results

3.1. Study Selection. The initial search of the electronic databases identified 2433 studies; no records were identified while searching the trial registry and citations. After removing 808 duplicates, the titles and abstracts of 1625 studies were screened, and 1583 studies were excluded. The full texts of the remaining 42 studies were reviewed; two articles were not retrieved. Therefore, the final full-text publications of 40 available studies were assessed for eligibility. After excluding studies other than RCTs ($n = 10$), those not about CRS ($n = 6$), those including treatments other than acupuncture ($n = 8$), those using other CIM interventions in the control group ($n = 3$), and those using duplicate data ($n = 3$), a total of 10 studies [23–32] were included in this review (Figure 1 and Supplementary File 2).

3.2. Study Characteristics. The studies included in this review ($n = 10$) were published between 2005 and 2022. Nine studies were conducted in China and one study was conducted in Norway [30]. Five studies [24, 25, 27, 29, 31] compared acupuncture to conventional treatment and four studies [23, 26, 28, 32] compared acupuncture plus conventional treatment to conventional treatment alone. One study [30] was a three-arm clinical trial comparing acupuncture, sham acupuncture, and conventional treatment. In most studies, CRS was diagnosed based on clinical symptoms, nasal endoscopy, and/or sinus CT. Four studies specified the pattern identification of participants. There was one study of Qi-blood deficiency complicated by stasis [24], lung Qi-deficiency cold [25], and wind and cold damage [27]. One study [30] recruited participants corresponding to four pattern identifications (retention of damp in the Yangming channel, damp combined with heat, retention of phlegm in the Shaoyang channel, and liver fire), and acupuncture treatment was performed accordingly. Four studies [23, 28, 30, 32] reported that they had obtained permission from an institutional review board before conducting the study, and five studies [23–25, 28, 32] reported that informed consent was obtained from the participants. Four studies [25, 29, 30, 32] mentioned funding sources, all of which were provided by the state or local province.

Five studies [24, 28–31] used manual acupuncture, two studies [26, 32] used electroacupuncture, two studies [25, 27] used moxibustion, and one study [23] used transcutaneous electrical acupuncture stimulation (TEAS). For the acupuncture points, the most frequently used was LI4 [23, 24, 28, 30–32],
followed by EX-HN3 [24, 25, 27, 28, 31] and LI20 [23–25, 28, 31] in five studies and GV20 in three studies [24, 28, 31]. In most studies, the needle retention time was 20–30 min and treatment frequency was once or twice daily. The treatment duration varied between 1 and 70 days, with a mean duration of 2 weeks (Tables 1 and 2).

3.3. Risk of Bias Assessment. As five studies [23–25, 29, 30] used appropriate random sequence generation methods, the risk of selection bias was low. No studies reported information regarding allocation concealment, blinding of participants, personnel, or outcome assessors. Three studies [24, 26, 30] that performed only per-protocol analysis, and two studies [27, 28], which only reported TER without corresponding raw data, were evaluated as having a high risk of attrition bias and reporting bias, respectively. All studies included in this review mentioned statistical baseline homogeneity between the treatment and control groups. The risk of other biases was low (Figure 2).

3.4. Acupuncture versus Conventional Treatment. A meta-analysis showed that acupuncture resulted in a higher TER than conventional treatment (5 studies, RR 1.17, 95% CI 1.05 to 1.30, $I^2 = 59$%; Figure 3). Subgroup analysis stratified according to the type of acupuncture significantly lowered the statistical heterogeneity, although the significance of acupuncture was maintained only in the case of moxibustion. Moreover, sensitivity analysis, performed by excluding studies without any details of the random sequence generation method, showed that the significance of acupuncture was maintained only in the case of moxibustion. In addition, the severity of CRS measured by VAS (3 studies, MD $-2.04$, 95% CI $-2.1$ to $-1.98$, $I^2 = 89$%; Figure 4), the quality of life measured by SNOT-20 (1 study, MD $-3.48$, 95% CI $-3.58$ to $-3.38$), Lund-Kennedy endoscopic scores (1 study, MD $-1.25$, 95% CI $-1.82$ to $-0.68$), and Lund-Mackay CT scores (1 study, MD $-1.23$, 95% CI $-1.8$ to $-0.66$) were all significantly improved in the acupuncture group when compared with the conventional treatment group. The statistical significance was maintained when sensitivity analysis was performed by excluding studies without any details of the random sequence generation method. There was no difference between the two groups in CRS recurrence rates after 6 months (1 study, RR 0.55, 95% CI 0.23–1.32) and Lund-Mackay CT scores (1 study, MD $-1.23$, 95% CI $-1.8$ to $-0.66$) were all significantly improved in the acupuncture group when compared with the conventional treatment group. The incidence of AEs was similar between the two groups (1 study, RR 0.60, 95% CI 0.06–6.26; Table 3).

Two studies [24, 31] examined patients with CRS after functional endoscopic sinus surgery (FESS) and compared manual acupuncture with sustained-release ibuprofen treatment. Both studies found improvements in total and

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**Figure 1:** A PRISMA flow diagram of the literature screening and selection processes.
<table>
<thead>
<tr>
<th>Study ID</th>
<th>Sample size (A): (B)</th>
<th>Mean age (range) (yr)</th>
<th>CRS disease period</th>
<th>CRS diagnosis</th>
<th>Population</th>
<th>(A) Treatment intervention</th>
<th>(B) Control intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen et al. [23]</td>
<td>70 (35:35) ——&gt; 70 (35:35)</td>
<td>(A) 42.18 ± 5.30 (20–57) (B) 42.15 ± 5.78 (22–58)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>CRS, population after FESS</td>
<td>Transcutaneous electrical acupoint stimulation + (B)</td>
<td>Routine perioperative nursing</td>
<td>(1) VAS (0–10) (2) Self-rating anxiety score (3) Total time of deep sleep</td>
</tr>
<tr>
<td>Guo et al. [25]</td>
<td>120 (60:60) ——&gt; 120 (60:60)</td>
<td>(A) 22–61 (B) 19–63</td>
<td>&gt;12 wk</td>
<td>Clinical symptom, nasal endoscopy, and/or sinus CT</td>
<td>CRS, excluded population with nasal polyps</td>
<td>Moxibustion</td>
<td>Budesonide nasal spray, roxithromycin tablets</td>
<td>(1) TER (2) VAS (0–10) (3) SNOT-20 (4) Lund-Kennedy endoscopic score (5) Lund-Mackay CT score</td>
</tr>
<tr>
<td>He et al. [26]</td>
<td>72 (36:36) ——&gt; 65 (32:33)</td>
<td>(A) 38.23 ± 1.32 (26–71) (B) 36.87 ± 2.14 (22–67)</td>
<td>&gt;12 wk (A) 13.64 ± 2.01 yr (1–26) (B) 11.64 ± 1.23 yr (1–21)</td>
<td>Clinical symptom, nasal endoscopy, and/or sinus CT</td>
<td>CRS</td>
<td>Electroacupuncture + (B)</td>
<td>Amoxicillin capsule, topical furosemide nasal drops</td>
<td>(1) TER (2) Symptom score (3) Recurrence after 1 mo f/u (4) Recurrence after 3 mo f/u</td>
</tr>
<tr>
<td>Huang et al. [27]</td>
<td>687 (367:320) ——&gt; 687 (367:320)</td>
<td>(A) 16–80 (B) 17–78</td>
<td>(A) 6 mo–25 yr (B) 3 mo–23 yr</td>
<td>Clinical symptom, nasal endoscopy, and sinus CT or MRI</td>
<td>CRS, excluded population with indications for surgery</td>
<td>Moxibustion + roxithromycin</td>
<td>Budesonide nasal spray, roxithromycin tablets</td>
<td>(1) TER</td>
</tr>
<tr>
<td>Study ID</td>
<td>Sample size (A) : (B) (enrolled —— analyzed)</td>
<td>Mean age (range) (yr)</td>
<td>CRS disease period</td>
<td>CRS diagnosis</td>
<td>Population</td>
<td>(A) Treatment intervention</td>
<td>(B) Control intervention</td>
<td>Outcome</td>
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<tr>
<td>Li and Fu</td>
<td>100 (50:50) —— 100 (50:50)</td>
<td>(A) 48.79 ± 6.47</td>
<td>Not reported</td>
<td>Not reported</td>
<td>CRS</td>
<td>Manual acupuncture + (B)</td>
<td>1% ephedrine saline into</td>
<td>(1) TER</td>
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<td></td>
<td></td>
<td>(20–70)</td>
<td></td>
<td></td>
<td></td>
<td>the turbinate, antibiotics</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(B) 48.25 ± 6.92</td>
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<tr>
<td>Ma et al.</td>
<td>100 (50:50) —— 100 (50:50)</td>
<td>(A) 30.0 ± 11.6</td>
<td>&gt;3 mo</td>
<td>Clinical symptom, sinus radiology, and/or endoscopy</td>
<td>CRS</td>
<td>Manual acupuncture</td>
<td>Antibiotics (roxithromycin, penicillin, or cephalosporin), chlorpheniramine, furosemide nasal drops</td>
<td>(1) TER (2) Headache disappearance time (3) Treatment period of effective cases (4) Recurrence rate after 6 mo-f/u</td>
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<td></td>
<td></td>
<td>(B) 29.0 ± 10.5</td>
<td>(A) 14.5 ± 5.6 yr</td>
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<td></td>
<td>(B) 12.8 ± 4.5 yr</td>
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<tr>
<td>Rossberg et al.</td>
<td>55 (25:19:21) —— 39 (16:13:10)</td>
<td>(A) 41.1 ± 14.7</td>
<td>&gt;3 mo</td>
<td>Clinical symptom, and sinus CT</td>
<td>CRS, excluded population with nasal polyps and pansinusitis</td>
<td>Manual acupuncture</td>
<td>(B1) minimal acupuncture at non-acupoints (B2) local vasoconstrictor agent (xylometazoline), 0.9% sodium chloride solution, oral corticosteroids, (if needed) cefalexin and azithromycin</td>
<td>(1) Sinus soft tissue swelling as assessed by CT (mm) (change) (2) Self-administered questionnaire (change) (3) SF-36 PCS (change) (4) SF-36 MCS (change) (5) Euroqol VAS (change)</td>
</tr>
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<td></td>
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<td>(B1) 47.3 ± 13.7</td>
<td>(A) 7.0 ± 7.8 yr</td>
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<td></td>
<td>(B2) 41.0 ± 13.0</td>
<td>(B1) 12.4 ± 13.5 yr</td>
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<td></td>
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<td></td>
<td>(B2) 9.7 ± 10.5 yr</td>
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<tr>
<td>Sun [31]</td>
<td>80 (40:40) —— 80 (40:40)</td>
<td>(A) 37.5 ± 5.5</td>
<td>Clinical symptom, nasal endoscopy, and/or sinus CT</td>
<td>CRS, population after FESS under local anesthesia</td>
<td>Manual acupuncture</td>
<td>Ibuprofen sustained-release capsule</td>
<td>(1) TER (2) VAS (0-10) (3) SF-MPQ total score (0-16) (4) SF-MPQ present pain intensity score (0-5)</td>
<td>(1) TER (2) VAS (0-10) (3) SF-MPQ total score (0-16) (4) SF-MPQ present pain intensity score (0-5)</td>
</tr>
<tr>
<td>Study ID</td>
<td>Sample size (A) : (B)</td>
<td>Mean age (range) (yr)</td>
<td>CRS disease period</td>
<td>CRS diagnosis</td>
<td>Population</td>
<td>(A) Treatment intervention</td>
<td>(B) Control intervention</td>
<td>Outcome</td>
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<tr>
<td>Zhang et al. [32]</td>
<td>120 (60:60) ——&gt; 120 (60:60)</td>
<td>(A) 40</td>
<td>Not reported</td>
<td>Clinical symptom, and sinus CT</td>
<td>CRS, conservative treatment is not effective and has no contraindications to FESS</td>
<td>Electroacupuncture + (B)</td>
<td>FESS under intravenous general anesthesia combined with endotracheal intubation</td>
<td></td>
</tr>
</tbody>
</table>

CRS: chronic rhinosinusitis; CT: computer tomography; FESS: functional endoscopic sinus surgery; MCS: mental component summary; PCS: physical component summary; SF-MPQ: the short-form McGill pain questionnaire; SF-36: the 36-item short-form survey; SNOT: sinonasal outcome test; TER: total effective rate; and VAS: visual analogue scale.
<table>
<thead>
<tr>
<th>Study ID</th>
<th>Style of acupuncture</th>
<th>Number of needles</th>
<th>Acupuncture points</th>
<th>Depth of insertion</th>
<th>Response sought</th>
<th>Needle stimulation</th>
<th>Retention time</th>
<th>Needle type</th>
<th>Number of treatment sessions</th>
<th>Frequency</th>
<th>Treatment duration</th>
<th>Follow-up period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen [24]</td>
<td>Manual acupuncture</td>
<td>13</td>
<td>Bilateral LI20, BL2, EX-HN5, LI4, ST36, EX-HN3, GV20, GV24</td>
<td>Not reported</td>
<td>Perform needle manipulation so that there is a sense of acupuncture</td>
<td>Needle manipulation every 10 min</td>
<td>30 min</td>
<td>Disposal sterile acupuncture needle (Suzhou Tianxie acupuncture equipment Co., ltd.)</td>
<td>1-2</td>
<td>Once or twice a day (if there was no effect within 4 hours after the initial acupuncture, acupuncture was performed once more.)</td>
<td>1 day None</td>
<td></td>
</tr>
<tr>
<td>Chen et al. [23]</td>
<td>Transcutaneous electrical acupuncture stimulation</td>
<td>Not applicable</td>
<td>Bilateral LI4, LI20</td>
<td>Not applicable</td>
<td>Slight tingling sensation</td>
<td>2/100 Hz, intensity 4</td>
<td>30 min</td>
<td>A low-frequency electronic pulse therapy device (Wuxi Jiajian medical instrument Co., ltd.)</td>
<td>4</td>
<td>1, 13, 25, 37 hours after surgery</td>
<td>37 hours None</td>
<td></td>
</tr>
<tr>
<td>Guo et al. [25]</td>
<td>Moxibustion</td>
<td>Not applicable</td>
<td>Bilateral LI20, EX-HN3</td>
<td>Not applicable</td>
<td>Feel the local skin warm and slightly hot without burning pain, and the local skin is slightly red without blistering</td>
<td>Not applicable</td>
<td>30 min</td>
<td>Ginger-separated moxibustion</td>
<td>14</td>
<td>Once a day</td>
<td>14 days None</td>
<td></td>
</tr>
<tr>
<td>He et al. [26]</td>
<td>Electroacupuncture</td>
<td>2</td>
<td>ST7, SI18 (CRS affected side)</td>
<td>ST7: 45–60 mm SI18: 30–45 mm</td>
<td>Deqi (soreness, numbness, heaviness or distension)</td>
<td>Not reported</td>
<td>20 min</td>
<td>0.3 mm × 75 mm filiform acupuncture needle</td>
<td>10</td>
<td>5 times a week</td>
<td>2 weeks 1, 3 months</td>
<td></td>
</tr>
<tr>
<td>Huang et al. [27]</td>
<td>Moxibustion</td>
<td>Not applicable</td>
<td>EX-HN3, EX-HN8 (no data on side)</td>
<td>Not applicable</td>
<td>Feel the local skin warm and slightly hot without burning pain, and the local skin is slightly red without blistering</td>
<td>Not applicable</td>
<td>30–40 min</td>
<td>Ginger-separated moxibustion</td>
<td>14–70</td>
<td>Once or twice a day</td>
<td>14–70 days None</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Details of acupuncture methods.
<table>
<thead>
<tr>
<th>Study ID</th>
<th>Style of acupuncture</th>
<th>Number of needles</th>
<th>Acupuncture points</th>
<th>Depth of insertion</th>
<th>Response sought</th>
<th>Needle stimulation</th>
<th>Retention time</th>
<th>Needle type</th>
<th>Number of treatment sessions</th>
<th>Frequency</th>
<th>Treatment duration</th>
<th>Follow-up period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Li and Fu [28]</td>
<td>Manual acupuncture</td>
<td>Not reported</td>
<td>LI20, EX-HN3, GV20, LI4, GB20, LU5, LU7 (no data on side)</td>
<td>0.1–0.3 cun</td>
<td>LI20</td>
<td>Needle manipulation every 5 min</td>
<td>25 min</td>
<td>Not reported</td>
<td>15</td>
<td>Once a day</td>
<td>15 days</td>
<td>None</td>
</tr>
<tr>
<td>Ma et al. [29]</td>
<td>Manual acupuncture</td>
<td>Not reported</td>
<td>ST7 (no data on side)</td>
<td>2.5 cun</td>
<td>Deqi (soreness, numbness, heaviness or distension)</td>
<td>Strong twirling and trembling method</td>
<td>Not reported</td>
<td>3 cun filiform acupuncture needle</td>
<td>6</td>
<td>Once a week</td>
<td>6 weeks</td>
<td>6 months</td>
</tr>
<tr>
<td>Rossberg et al. [30]</td>
<td>Manual acupuncture</td>
<td>Not reported</td>
<td>According to the four TCM diagnosis-retention of damp in the yangming channel, damp combined with heat: (bilateral) LI4, LI11, ST40, ST44-retention of phlegm in the shaoyang channel, liver fire: (Bilateral) GB34, LR2, LI4, LR3</td>
<td>Facial/hand/foot: 0.5 cun arms/trunk: 1.3 cun</td>
<td>Deqi (soreness, numbness, heaviness or distension)</td>
<td>Stimulated manually using reducing or reinforcing methods</td>
<td>25 min</td>
<td>0.28 mm × 25–40 mm filiform acupuncture needle</td>
<td>10</td>
<td>Not reported</td>
<td>4 weeks</td>
<td>11 months</td>
</tr>
<tr>
<td>Sun [31]</td>
<td>Manual acupuncture</td>
<td>Not reported</td>
<td>LI20, BL2, EX-HN5, EX-HN3, GV20, GV24, LI4, ST36 (no data on side)</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Needle manipulation every 10 min</td>
<td>30 min</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Once or twice a day if there was no effect within 4 hours after the initial acupuncture, acupuncture was performed once more.</td>
<td>Not reported</td>
<td>None</td>
</tr>
<tr>
<td>Zhang et al. [32]</td>
<td>Electroacupuncture</td>
<td>4</td>
<td>Bilateral LI4, PC6</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Wave of condensation and rarefaction, 27 Hz 100 Hz, 8–12 mA, neutral supplementation and draining methods</td>
<td>30 min</td>
<td>Not reported</td>
<td>1</td>
<td>Once</td>
<td>1 day</td>
<td>6 hours</td>
</tr>
</tbody>
</table>
present pain intensity assessed using the short-form McGill pain questionnaire in the acupuncture group when compared with the ibuprofen group. Rossberg et al. [30] compared manual acupuncture to conventional treatment, including the use of a local vasoconstrictor agent and a 0.9% sodium chloride solution, oral corticosteroids, and antibiotics for patients with CRS without nasal polyps or pansinusitis. There were no significant differences in these outcomes after treatment between the two groups.

3.5. Acupuncture Plus Conventional Treatment versus Conventional Treatment Alone. The CRS severity measured by TER was significantly higher after treatment in the acupuncture plus conventional treatment group compared to the conventional treatment group (2 studies, RR 1.25, 95% CI 1.11–1.40, \(I^2 = 0\%\)), regardless of the type of acupuncture used. In addition, the VAS for pain was significantly reduced in the acupuncture plus conventional treatment group (2 studies, MD \(-1.07\), 95% CI \(-1.27 \text{ to } -0.87, I^2 = 98\%\)). Statistical significance was maintained when sensitivity analysis was performed by excluding studies without any details of the random sequence generation method. Zhang et al. [32] targeted CRS populations in whom conservative treatment was not effective and who had no contraindications to FESS. They compared electroacupuncture plus FESS under intravenous general anesthesia combined with endotracheal intubation to FESS alone. The results showed that the need for additional doses of propofol and fentanyl during surgery was significantly lower in the acupuncture group. However, there were no significant differences between the two groups in terms of heart rate, mean arterial pressure, bleeding during operation, and operation time. He et al. [26] compared electroacupuncture plus conventional treatment (amoxicillin and topical furosemide nasal drops) with conventional treatment alone. The authors found a significant improvement in CRS symptoms in the acupuncture group; however, there were no significant differences between the groups in recurrence rates after 1- and 3-month follow-up. The authors [26] reported that there was only 1 case of hematoma in the electroacupuncture group; there was no significant difference in AEs between the two groups (1 study, RR 3.09, 95% CI 0.13–73.19; Table 3).

3.6. Acupuncture versus Sham Acupuncture. Rossberg et al. [30] compared manual acupuncture and sham acupuncture (minimal acupuncture at non-acupoints) for patients with CRS without nasal polyps or pansinusitis. After treatment, there were no differences compared with baseline in both groups in sinus soft tissue swelling assessed by CT, quality of life, and EuroQol VAS; there were no statistical comparisons reported between the groups. The authors reported small bleeds at the needle insertion site, nerve pain, and dizziness as AEs; their incidence was similar between groups (1 study, RR 1.50, 95% CI 0.63–3.53; Table 3).

3.7. Quality of Evidence. The overall quality of evidence was generally "moderate" or "low," and high-quality evidence was lacking. The main reason for downgrading the quality of evidence was the risk of bias of the included RCTs and the imprecision of the meta-analyzed results due to small sample sizes and wide CIs (Table 3).

4. Discussion

4.1. Summary of Evidence. In this review of RCTs (n = 10), we evaluated the effect and safety of acupuncture for CRS. A meta-analysis showed that acupuncture as monotherapy or adjunctive therapy to conventional treatment was associated with significantly higher TER and lower VAS than conventional treatment alone. Interestingly, subgroup and sensitivity analyses showed that moxibustion as a monotherapy was associated with significantly greater TER than...
Heterogeneity: Chi2 = 2.90, df = 1 (P < 0.00001)

Z = 68.02 (P = 0.003).

Subtotal (95% CI) 60 60 50.0% –2.05 [–2.11, –1.99]

Total (95% CI) 124 129 100.0% –2.04 [–2.10, –1.98]

Test for subgroup differences: Chi2 = 15.12, df = 1 (P < 0.00001)

Z = 3.14 (P = 0.002)

Subtotal (95% CI) 64 69 50.0% 1.27 [1.18, 1.36]

Sun 2014 2.2 40 3.5 40 0.7% –1.30 [–2.02, –0.58]

Chen 2012 3.25 24 3.95 29 9.8% –1.28 [–1.11, 0.65]

Study or Subgroup Events Total

Conventional treatment

Acupuncture 1.1.2 Moxibustion

Guo 2019 56 60 42 60 18.2% 1.33 [1.11, 1.59]

Huang 2014 332 367 230 320 31.8% 1.26 [1.17, 1.36]

Subtotal (95% CI) 427 380 50.0% 1.27 [1.18, 1.36]

Total events 338 272

Heterogeneity: Tau2 = 0.00; Chi2 = 0.02, df = 2 (P = 0.99); I2 = 0%

Test for overall effect: Z = 1.31 (P = 0.19)

Total (95% CI) 541 499 100.0% 1.17 [1.05, 1.30]

Test for subgroup differences: Chi2 = 8.80, df = 1 (P = 0.004)

Sun 2014 32 40 30 40 13.0% 1.07 [0.84, 1.35]

Ma 2008 48 50 45 50 27.2% 1.07 [0.96, 1.19]

Chen 2012 19 60 3.95

1.2.1 Manual acupuncture

Study or Subgroup Events Total

Acupuncture

Conventional treatment

Total events 99 97

Heterogeneity: Tau2 = 0.00; Chi2 = 0.02, df = 2 (P = 0.99); I2 = 0%

Test for overall effect: Z = 1.31 (P = 0.19)

Total (95% CI) 60 60 50.0% –2.05 [–2.11, –1.99]

Test for overall effect: Z = 6.68 (P < 0.00001)

Subtotal (95% CI) 114 119 50.0% 1.06 [0.97, 1.17]

1.2.2 Moxibustion

Guo 2019 1.9 60 3.95

Huang 2014 0.5 0.7

0.16 60 98.9% –2.05 [–2.11, –1.99]

1.1.1 Manual acupuncture

Chen 2012 19 24 22 29 9.8% 1.04 [0.78, 1.40]

Ma 2008 48 50 45 50 27.2% 1.07 [0.96, 1.19]

Sun 2014 32 40 3.5 40 0.7% –1.30 [–2.02, –0.58]

Subtotal (95% CI) 114 119 50.0% 1.06 [0.97, 1.17]

Total events 99 97

Heterogeneity: Tau2 = 0.00; Chi2 = 0.34, df = 1 (P = 0.56); I2 = 0%

Test for over all effect: Z = 1.31 (P = 0.19)

Total (95% CI) 64 69 1.1% –0.91 [–1.48, –0.34]

Test for subgroup differences: Chi2 = 2.90, df = 2 (P = 0.99); I2 = 93%

Sun 2014 3.5 40 3.5 40 0.7% –1.30 [–2.02, –0.58]

Chen 2012 19 24 3.53 29 9.8% –1.28 [–1.11, 0.65]

Study or Subgroup Total

Acupuncture

Conventional treatment

Acupuncture Conventional treatment

1.2.1 Manual acupuncture

Chen 2012 3.25 14.68 24 2.3 1.684 2.35 1.785 29 9.8% –1.28 [–1.11, 0.65]

Sun 2014 2.2 1.6 40 3.5 1.6 40 1.7 40 0.7% –1.30 [–2.02, –0.58]

Subtotal (95% CI) 64 69 50.0% –0.91 [–1.48, –0.34]

Heterogeneity: Chi2 = 2.90, df = 1 (P = 0.09); I2 = 65%

Test for overall effect: Z = 3.14 (P = 0.002)

1.2.2 Moxibustion

Guo 2019 1.9 0.16 60 3.95 0.17 60 98.9% –2.05 [–2.11, –1.99]

Subtotal (95% CI) 0.17 60 50.0% –2.05 [–2.11, –1.99]

Heterogeneity: Not applicable

Total (95% CI) 124 129 100.0% –2.04 [–2.10, –1.98]

Heterogeneity: Chi2 = 18.01, df = 2 (P = 0.0001); I2 = 89%

Test for overall effect: Z = 67.98 (P < 0.00001)

Test for subgroup differences: Chi2 = 15.12, df = 1 (P = 0.0001), I2 = 93%

4.2. Implications of the Results. CRS is a chronic illness associated with a significant disease burden and poor quality of life [3]. Limitations of conventional treatments have led to a significant interest in CIM as an alternative treatment modality [7, 8]. In this evidence-based systematic review, we examined the role of acupuncture in the treatment of CRS. It was anticipated that this could help inform clinical decision-making. The findings of the review suggested that acupuncture is associated with better TER and VAS for the treatment of CRS. However, there were significant methodological limitations across these studies, and the quality of evidence was moderate-to-low. Nevertheless, there is little high-level evidence to support current treatment protocols for CRS [33]; therefore, acupuncture should be considered a promising treatment candidate.

The pathogenesis of CRS is not fully understood; however, it may involve chronic inflammation, alterations in mucociliary clearance, abnormalities in the sinonasal epithelial cell barrier, and tissue remodeling [34–36]. According to a preclinical animal study, manual acupuncture and moxibustion can reduce the inflammatory response by decreasing the expression of thymic stromal lymphopoietin (TSLP) protein in the nasal sinus mucosa [37]. TSLP, the master regulator of Th2-mediated inflammation, correlates...
### Table 3: Summary of findings.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Subgroup</th>
<th>No. of participants (RCTs)</th>
<th>Anticipated absolute effects (95% CI)</th>
<th>Relative effect (95% CI)</th>
<th>I² value (%)</th>
<th>Quality of evidence (grade)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Risk with control group</td>
<td>Risk with treatment group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture versus conventional treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TER</td>
<td>Total</td>
<td>1040 (5)</td>
<td>739 per 1000 (776 to 961)</td>
<td>865 per 1000 (845 to 973)</td>
<td>RR 1.17 (1.05, 1.30)</td>
<td>59 Moderate Risk of bias (−1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manual acupuncture</td>
<td>233 (3)</td>
<td>815 per 1000 (791 to 954)</td>
<td>909 per 1000 (845 to 973)</td>
<td>RR 1.06 (0.97, 1.17)</td>
<td>0 Moderate Risk of bias (−1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moxibustion</td>
<td>807 (2)</td>
<td>716 per 1000</td>
<td></td>
<td>RR 1.27 (1.18, 1.36)</td>
<td>0 Moderate Risk of bias (−1)</td>
<td></td>
</tr>
<tr>
<td>VAS</td>
<td>Total</td>
<td>253 (3)</td>
<td>—</td>
<td>2.04 lower (2.1 to 1.98 lower)</td>
<td>— 89 Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manual acupuncture</td>
<td>133 (2)</td>
<td>—</td>
<td>0.91 lower (1.48 to 0.34 lower)</td>
<td>— 65 Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moxibustion</td>
<td>120 (1)</td>
<td>—</td>
<td>2.05 lower (2.11 to 1.99 lower)</td>
<td>— NA Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNOT-20</td>
<td>Total (moxibustion)</td>
<td>120 (1)</td>
<td>—</td>
<td>3.48 lower (3.58 to 3.38 lower)</td>
<td>— NA Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lund-kennedy endoscopic score</td>
<td>Total (moxibustion)</td>
<td>120 (1)</td>
<td>—</td>
<td>1.25 lower (1.82 to 0.68 lower)</td>
<td>— NA Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lund-Mackay CT score</td>
<td>Total (moxibustion)</td>
<td>120 (1)</td>
<td>—</td>
<td>1.23 lower (1.8 to 0.66 lower)</td>
<td>— NA Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrence rate (after 6 months)</td>
<td>Total (manual acupuncture)</td>
<td>65 (1)</td>
<td>320 per 1000 (74 to 422)</td>
<td>176 per 1000</td>
<td>RR 0.55 (0.23, 1.32)</td>
<td>NA Low Risk of bias (−1) Imprecision (−1)</td>
<td></td>
</tr>
<tr>
<td>Adverse events</td>
<td>Total (manual acupuncture)</td>
<td>53 (1)</td>
<td>69 per 1000</td>
<td>41 per 1000 (4 to 432)</td>
<td>RR 0.60 (0.06, 6.26)</td>
<td>NA Low Risk of bias (−1) Imprecision (−1)</td>
<td></td>
</tr>
<tr>
<td>Acupuncture plus conventional treatment versus conventional treatment alone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TER</td>
<td>Total</td>
<td>165 (2)</td>
<td>783 per 1000 (869 to 1000)</td>
<td>979 per 1000 (848 to 1000)</td>
<td>RR 1.25 (1.11, 1.40)</td>
<td>0 Moderate Risk of bias (−1) Imprecision (−1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manual acupuncture</td>
<td>100 (1)</td>
<td>800 per 1000 (848 to 1000)</td>
<td>984 per 1000</td>
<td>RR 1.23 (1.06, 1.41)</td>
<td>NA Low Risk of bias (−1) Imprecision (−1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electroacupuncture</td>
<td>65 (1)</td>
<td>758 per 1000 (788 to 1000)</td>
<td>970 per 1000</td>
<td>RR 1.28 (1.04, 1.57)</td>
<td>NA Low Risk of bias (−1) Imprecision (−1)</td>
<td></td>
</tr>
<tr>
<td>VAS</td>
<td>Total</td>
<td>195 (2)</td>
<td>—</td>
<td>1.07 lower (1.27 to 0.87 lower)</td>
<td>— 98 Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electroacupuncture</td>
<td>120 (1)</td>
<td>—</td>
<td>0.19 lower (0.2 lower to 0.58 higher)</td>
<td>— NA Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TEAS</td>
<td>75 (1)</td>
<td>—</td>
<td>1.50 lower (1.73 to 1.27 lower)</td>
<td>— NA Moderate Risk of bias (−1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
with the inflammatory markers of Th2 inflammation in sinus tissue [38]. Moreover, adjuvant electrostimulation therapy can improve CRS symptoms by affecting inflammation [39], supporting the applicability of electroacupuncture found in this review.

In addition, the findings of this review highlight the frequent use of certain acupuncture points, including LI4, for the treatment of CRS. Interestingly, LI4 is a frequently used acupuncture point for the treatment of allergic rhinitis [40]. This point is linked to the activity of a specific brain region responsible for the orofacial area [41]; its stimulation is associated with an anti-inflammatory response [42]. In addition, although not used in the studies included in this review, another recent systematic review reported that acupuncture at the sphenopalatine ganglion acupoint may be an effective alternative therapy for patients with allergic rhinitis [43]. Hence, the impact of this strategy on CRS should be considered in further studies. As pointed out in a recent review, the current level of evidence is considered insufficient to routinely recommend acupuncture for CRS. However, it can be considered a useful and promising candidate for CRS treatment, especially as an adjunct to conventional therapy [12]. Nonetheless, rigorous research is needed to elucidate the clinical effects and underlying mechanisms of acupuncture treatment for CRS.

4.4. Limitations and Suggestions for Future Research. This study provided a comprehensive and critical review of acupuncture treatment for CRS and assessed the quality of evidence for key findings; however, the following limitations should be considered. First, because of the limited number of studies reviewed, most meta-analysis results were based on one to three studies. Moreover, since the methodological quality of the included studies was not high, future robust high-quality studies should be conducted. The results of those future studies may invalidate or validate our findings. Many patients with CRS are interested in CIM modalities [7, 8], including acupuncture; therefore, clinical trials on this topic should be encouraged to facilitate evidence-based decision-making in clinical settings. Second, it appears that there is no differentiated acupuncture strategy based on the classification of CRS. In general, CRS can be classified according to the presence or absence of nasal polyps and these types have different inflammatory characteristics [51]. In addition, recent findings suggest that CRS with nasal polyposis can be further classified as eosinophilic and non-eosinophilic [51]. The elucidation of the underlying mechanism of acupuncture for CRS could help establish an optimized treatment strategy based on the classification of CRS. Third, acupuncture, as defined in this review, included manual acupuncture, electroacupuncture, and moxibustion;
therefore, we performed a subanalysis to explore the effects of each acupuncture type. However, the observed heterogeneity could not be fully explained due to an insufficient study number. The findings of this review suggest that moxibustion may be a particularly useful monotherapy option for CRS. Since moxibustion is a noninvasive treatment, it might be useful in patients who are afraid of needles or pain caused by the insertion of acupuncture needles. Finally, a funnel plot could not be generated to evaluate publication bias due to the insufficient number of included studies. Additionally, most of the included studies were conducted in China; therefore, more studies should be conducted in different countries.

**Data Availability**

All data generated or analyzed during this study are included within the article.

**Disclosure**

Boram Lee and Chan-Young Kwon are co-first authors.

**Conflicts of Interest**

The authors declare that they have no conflicts of interest regarding the publication of this paper.

**Authors’ Contributions**

Boram Lee and Chan-Young Kwon contributed equally (co-first authors). B. L. conceptualized the study; B. L. and C. Y. K. developed the methodology; B. L. and C. Y. K. carried out formal analysis; B. L. and C. Y. K. investigated the study; B. L. and C. Y. K wrote and prepared the original draft; M. Y. P. reviewed the edited the study; M. Y. P. carried out funding acquisition.

**Acknowledgments**

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**Supplementary Materials**

*Supplement 1.* Search strategies used in each database and the results. *Supplement 2.* Excluded studies after full-text review. (Supplementary Materials)

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