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针灸临床实践指南
成人轻中度抑郁症

Clinical guideline on acupuncture and moxibustion—
Adult major depressive disorder（mild-moderate degree）

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Foreword

This guideline aims to provide a set of standardized recommendations and protocols for acupuncture and moxibustion interventions for the management of adult with mild-moderate major depressive disorder.

This guideline is developed in accordance with the technical procedures and rules established by the Standardization Working Committee of the World Federation of Acupuncture-Moxibustion Societies.

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Please note that some of the contents of this guideline may involve patents. The issuing organization of this guideline does not assume the responsibility for identifying patents.

Clinical guideline on acupuncture and moxibustion—Adult major depressive disorder（mild-moderate degree）

1 Introduction

1.1 Terminology

1.1.1
acupuncture therapy

We used the World Health Organization's definition："Acupuncture" is used in its broad sense to include traditional body needling，moxibustion，electro-acupuncture，laser acupuncture（photo-acupuncture），microsystem acupuncture such as ear（auricular），face，hand，and scalp acupuncture. This guideline did not include acupressure[1].

1.1.2
acupuncture

The insertion of needles into humans for remedial purposes or its methods. This guideline includes manual acupuncture，electro-acupuncture，and microsystem acupuncture，excluding moxibustion and laser acupuncture[1].

1.1.3
body acupuncture

It involves stimulating acupoints on the body or head through skin penetration with thin，solid，metallic needles manipulated by the hands. It can involve passing an electro current through acupuncture needles.

1.1.4
body acupuncture with Yinbai acupoints as the primary acupoints

Yinbai is a acupuncture prescription which is acupoints selection must include Yintang（EX-HN3）and Baihui（DU20），besides other body acupoints. Neither auricular nor scalp acupuncture should be excluded.

1.1.5
scalp acupuncture

It is one of the microsystem acupuncture therapies. The intervention involves stimulating anatomical points on the head through skin penetration with thin, solid, metallic needles manipulated by hands. It can involve passing an electro current through acupuncture needles[1].

1.1.6
auricular acupuncture

It is one of the microsystem acupuncture therapies in which points located on the auricle are stimulated[1].

1.1.7
moxibustion

A therapeutic method involving ignited material (usually moxa) to apply heat to certain points or areas of the body surface for curing disease[1].

1.1.8
electro-acupuncture

Electric stimulation of the needle following acupuncture points insertion[1].

1.1.9
laser acupuncture

It is a variant of body acupuncture. It uses laser irradiate on the acupuncture points[1].

1.1.10
psychotherapy

We referred to psychotherapy as psychological therapy or talking therapy[2].

1.1.11
exercise

We define exercise as any specified style of exercise or physical activity, such as one designed to improve strength, range of movement, aerobic capacity, or a combination of these. The exercise included physical activity interventions that could be initially taught by an exercise professional or involve periodical/ongoing supervision. We included aquatic exercise, range of motion and flexibility exercise, aerobic exercise, strength/resistance exercise, motor control exercise, balance training, Tai Chi, Yoga, and Pilates.

1.1.12
antidepressants

This guideline includes:①Selective Serotonin Reuptake Inhibitors (SSRIs): Fluoxetine, Norfluoxetine, Paroxetine, Sertraline, Fluvoxamine, Citalopram, Escitalopram; ② Serotonin-norepinephrine Reuptake Inhibitors (SNRIs): Venlafaxine, Desvenlafaxine, Duloxetine;③Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs): Mirtazapine; ④ Serotonin Antagonist and Reuptake Inhibitors (SARIs): Trazodone; ⑤ serotonin 5-HT_{1A} receptor agonists: Buspirone, Tandospirone; ⑥Tricyclic Antidepressants (TCAs): Clomipramine, Amitriptyline, Doxepin;⑦Monoamine Oxidase Inhibitors (MAOIs): Phenelzine, Moclobemide;⑧Tetracyclic Antidepressants (TeCAs): Maprotiline, Mianserin; ⑨ others: Agomelatine, Ketamine, and Deanxit[1-4]. Our panel considered including Deanxit (Melitracen/Flupentixol) for its relevance, considering:① Melitracen is a tricyclic antidepressant and flupentixol is antipsychotic and only adds some effects; ② Deanxit (Melitracen/Flupentixol) is the most prescribed compounds in China and licensed in Austria and Switzerland[4,5].

1.1.13
response of depression

We define the response of depression as a 50% or more reduction in the severity of depression scores measured using the Hamilton Depression Scale (HAMD) or other clinician-rated depression instruments[6].

1.2 Aims and objectives

The guideline aims to support clinicians, patients, and policymakers in optimizing mild and moderate Major Depressive Disorder (MDD)'s clinical or policy decision-making.

1.3 Scope

This guideline focuses on acupuncture treatment in adults with mild and moderate MDD.

1.4 Target audience

The target audience includes clinicians (acupuncturists, nurses, physicians, etc.), patients, and health policymakers.

1.5 Settings

The guideline is applicable to hospitals including hospitals specialized in acupuncture-moxibustion, primary hospitals or clinics.

1.6 Summary of recommendations

No.	Recommendations	Strength rating	Certainty of evidence
1	For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using psychotherapy over acupuncture therapy.	Conditional recommendation	Low
2	For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using either acupuncture therapies or antidepressants.	Conditional recommendation	Low
3	For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using acupuncture therapy plus antidepressants over acupuncture therapy alone.	Conditional recommendation	Low
4	For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using acupuncture plus antidepressants over antidepressants alone.	Conditional recommendation	Low
5	For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests using auricular or body acupuncture.	Conditional recommendation	Very Low
6	For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests using electro-acupuncture or manual acupuncture.	Conditional recommendation	Very Low
7	For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests using acupuncture ≥3 times over≤2 times a week.	Conditional recommendation	Very Low
8	For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests standard treatment duration (≤4 weeks) over extended treatment duration(>4 weeks).	Conditional recommendation	Very Low

1.7 Contacts

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2 Overview of the disease

2.1 Definition

Depression is an affective mental disorder characterized by persistent and pronounced depressed mood. The main clinical features are persistent low mood, reduced activity, delayed thinking and cognitive functioning, including agitation, lack of pleasure, sleep disturbances, feelings of guilt and recurrent suicidal thoughts. Each MDD depressive episode features a depressed mood and loss of interest or pleasure in nearly all activities for at least two weeks[7].

2.2 Epidemiology

Depressive disorder is among the most prevalent non-fatal diseases worldwide[8]. MDD is the most common depressive disorder[9]. MDD has a lifetime prevalence of 16.2% and a 12-month prevalence of 6.6% worldwide, affecting approximately 300 million people globally[10-12]. The age distribution of MDD onset indicates that depression might persist throughout the lifespan[10]. MDD can increase the onset risk of diabetes, heart disease, and stroke and lead to suicide[12]. The research identified low socioeconomic status[13], workdays lost[14], and cognitive impairments[15-16] as the most common MDD risk factors.

2.3 Symptoms and examinations

2.3.1 Symptoms

In the *Diagnostic and Statistical Manual of Mental Disorders*, *5th Revision*, developed by the American Psychiatric Association[17], the diagnostic criteria for depression include two main aspects, i.e., first-episode depressive disorders and relapsing depressive disorders, but do not include bipolar depression. Typical symptoms of depression include a low mood, loss of interest and pleasure, fatigue, or lack of energy. Other common symptoms include reduced ability to concentrate and focus, decreased self-esteem, feelings of guilt and worthlessness, a pessimistic outlook on the future, thoughts or behaviors of self-harm or suicide, sleep disturbances, and decreased appetite. The course of depressive disorder typically lasts for at least two weeks.

2.3.2 Degree of depression

2.3.2.1 Mild depression: with at least 2 typical symptoms and at least 2 other symptoms, and the patient has some difficulty with daily work and social activities, which has an impact on the patient's social functioning.

2.3.2.2 Moderate depression: at least 2 typical symptoms and at least 3 (preferably 4) other symptoms, and the patient has considerable difficulty with work, social or domestic activities.

2.3.2.3 Severe depression: the presence of all 3 typical symptoms and at least 4 other symptoms; the diagnosis can be made in less than 2 weeks when the symptoms are extremely severe or the onset of the disease is very acute; social, work or household activities are almost impossible except to a very limited extent.

2.3.3 Physical examinations

The diagnosis of depression relies mainly on clinical manifestations and does not require special tests.

2.4 Treatment of Western Medicine

Pharmacotherapy and psychotherapy are the main treatment options for MDD[18]. Despite several guidelines recommending second-generation antidepressants as the first-line treatment for MDD[17,19-20], antidepressants have not been successful in all MDD patients. Up to 30% of MDD patients had no improvement in their depressive symptoms after taking two or more antidepressants[21-22]. In addition, adverse reactions to antidepressants vary from 3.1% to 31%[23-24]. Common adverse reactions include nausea, insomnia, headache, diarrhea, and dizziness[25].

American Psychological Association (APA), Canadian Network for Mood and Anxiety (CANMAT), and Indian Clinical Practice Guidelines (CPG) recommended Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Behavioral Activation (BA) as the first-line treatment for MDD[17,26-27]. Moderate certainty evidence showed that psychotherapy is more effective than usual care and a waiting list in treatment response and remission rates[28]. Most psychotherapies still had significant effects on the response of depression at 12-month follow-ups[29]. Due to higher costs and lower accessibility, patients use psychotherapy less frequently than pharmacotherapy[28,30-31].

Acupuncture has thousands of years of history in treating psychological disorders. In the US, 8.9 million patients with severe depression use acupuncture treatment[3]. Low certainty evidence showed that acupuncture plus antidepressants could reduce the severity of depression[5,32].

3 Guideline development process

3.1 Development of clinical questions

3.1.1 Research on clinical issues

With panel members, we first brainstormed the most prevalent, clinically relevant questions related to MDD concerning acupuncture treatment. Then, using an online survey developed by Wenjuanxing (www.wjx.cn), we prioritized ten clinical questions with all panels (Figure 1). Initially, we prioritized 10 clinical questions. We addressed eight questions in the guidelines and dropped two without direct evidence supporting the recommendations(PICO 2,PICO 6).

3.1.2 Research on ending indicators

The panel selected and defined outcomes for each question a priori and rated their importance using a 9-point scale[33]. The panel rated the following outcomes as critically important for clinical decision-making across all questions: severity of depression, the total number of Severe Adverse Events (SAE), and the response of depression. Questions 3&4 have two additional critically important outcomes: drug-related adverse events and total numbers of adverse events. Question 4 also has quality of life as a critically important outcome. Important outcomes informed recommendations included quality of life, insomnia, fatigue, SAE, change in medication or use of other support systems, and drug-related adverse events.

3.1.3 Identification of clinical problems

The expert panel concluded five categories of clinical questions that have attracted the most attention:①How are acupuncture therapies compared to the most popular non-pharmacological treatment for MDD? ②How is acupuncture compared to anti-depressants? ③Would combining acupuncture and anti-depressants be better than using either intervention alone? ④Will the acupuncture points selection, and stimulation method impact the treatment effect and safety? ⑤What is the impact of the duration and frequency of acupuncture therapies? Within these five broad categories, we refined and identified ten clinical questions through panel experts' discussion (See Figure 1).

	Clinical Question(s)	PICO Question(s)
Nonpharmacological treatment	Are acupuncture therapies an optimal non-pharmacological treatment for major depressive disorder in adults?	**PICO 1:** For adults diagnosed with mild or moderate major depressive disorder (MDD), should we recommend acupuncture alone, acupuncture plus moxibustion, or psychotherapy? **PICO 2:** For adults diagnosed with mild or moderate MDD, should we recommend acupuncture alone, acupuncture plus moxibustion, or exercise? (Dropped and no recommendation)
Pharmacological treatment vs. Acupuncture therapies	Does acupuncture work better than anti-depressants?	**PICO 3:** For adults diagnosed with mild or moderate MDD, should we recommend acupuncture alone, acupuncture plus moxibustion, or antidepressants?
Add-on option option to Pharmacological or Acupuncture therapies	Would combining multiple interventions improve outcomes?	**PICO 4:** For adults diagnosed with mild or moderate MDD, should we recommend acupuncture therapies plus antidepressants or acupuncture therapies alone? **PICO 5:** For adults diagnosed with mild or moderate MDD, should we recommend acupuncture therapies plus antidepressants or antidepressants alone?
What is the impact of the points selection and types of acupuncture?	Would acupuncture therapies' effect differ when acupoints differ? Would electroacupuncture work better than manual acupuncture?	**PICO 6:** For adults diagnosed with mild or moderate MDD who will receive acupuncture therapies, should we recommend body acupuncture or scalp acupuncture? (Dropped and no recommendation) **PICO 7:** For adults diagnosed with mild or moderate MDD who will receive acupuncture therapies, should we recommend body acupuncture or auricular acupuncture? **PICO 8:** For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies, should we recommend electro-acupuncture or manual acupuncture?
What is the impact of the duration and frequency of acupuncture therapies?	What is the optimal duration and frequency of acupuncture therapies?	**PICO 9:** For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies, should we recommend treating patients twice (⩽ 2 times per week) or three times and more a week (⩾ 3 times a week)? **PICO 10:** For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies, should we recommend standard treatment duration (⩽ 4 weeks) or extended treatment duration (> 4 weeks)?

Figure1—PICO questions

3.2 Construction of evidence body

3.2.1 Literature search

A medical librarian, the methodology, and the clinical chairs developed the search strategy. A Cochrane review on acupuncture treating depression searched the literature before June 2016[1]. It does not include moxibustion treatment or the Chinese literature database. First, we updated searches from the Cochrane systematic reviews, including articles from June 2016 to May 2021. Second, we supplemented the English literature on moxibustion treatment for depression (from inception to May 2021). Then, we conducted a comprehensive search, including acupuncture and moxibustion, in the Chinese databases (from inception to May 2021). We searched the following electronic databases: Sino Med, China National Knowledge Infrastructure Database (CNKI), Wan Fang Database, VIP Database, PubMed, Embase, and Cochrane Library. We updated all searches in September 14, 2023.

3.2.2 Literature screening and evidence synthesis

Using a standardized form, three reviewers (HS. Yang, YX. Feng, and YQ. Xu) independently extracted data from original trial reports. Two reviewers (Q. Fan and S. Cui) checked the data to ensure accuracy. Disagreements were resolved by discussion and by a third reviewer (H. Zhao or YQ. Zhang) when needed. Data extracted included patient characteristics, diagnosis, intervention, control group details, duration of follow-up, and outcome indicators.

Information on the risk of bias was collected and assessed for each outcome in each included study using the Cochrane risk of bias tool for RCTs[34]. We assessed the risk of bias according to the following domains: random sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessment, incomplete outcome data, selective outcome reporting, and other biases. Each quality item was rated as low risk, high risk, or unclear risk. Two investigators (HS. Yang and YX. Feng) independently completed the assessments and resolved the discrepancies through discussion. If unresolved, the corresponding author (YQ. Zhang) arbitrated the conflicts.

We performed statistical analysis using Review Manager 5.4 software. We summarized dichotomous data using Risk Ratios (RRs) with corresponding 95% confidence intervals (95% CIs) and continuous data using Mean Differences (MDs) or Standardized Mean Differences (SMDs) with 95% CIs. The χ^2 test and I^2-statistic were calculated for heterogeneity. When $I^2 < 50\%$, the systematic review used a fixed-effect model; otherwise, the random-effect model.

The systematic review group summarized evidence using GRADEpro GDT software to generate evidence profiles, Summary of Findings (SoF) tables, and Evidence to Decision(EtD) tables[35]. All EtD tables contain sections on effectiveness and safety, patients' values and preferences, resources use, feasibility, acceptability, and equity.

3.3 Development of recommendations

The WFAS panel first reviewed EtDs and the summary of finding tables through emails before the online meetings and suggested corrections or additional evidence. Then, through nine online video conferences, all panels evaluated and discussed the benefits and harms, certainty in the effect estimate, underlining patients' values and preferences, resource use, feasibility, acceptability, and equity for alternative interventions. We used the GRADE approach to rate the strength of the recommendations. The panel reached a consensus on the strength and direction of the recommendations and their remarks through discussion. In rare instances, the panel used online voting to reach a consensus. We required an 80% majority for any strong recommendations. We also recorded additional comments and, upon the panels' request, dissenting opinions on EtDs. The panel reviewed and approved all recommendations and the guideline manuscript.

4 Recommendations

Question 1: For adults diagnosed with mild or moderate major depressive disorder (MDD), should we recommend acupuncture alone, acupuncture plus moxibustion, or psychotherapy?
(1) Recommendation
For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using psychotherapy over acupuncture therapy.(Conditional recommendation, low certainty in the estimated effects)
(2) Summary of findings
• Rationale for question When managing MDD, patients often choose between pharmacological and non-pharmacological interventions. Non-pharmacological interventions, such as psychotherapy, complementary and alternative medicine, exercise, are often considered first[36-38]. Acupuncture and psychotherapy are the most used non-pharmacologic therapies[32,39]. To identify the optimal non-pharmacological interventions, the panel assessed the relative effectiveness and safety of acupuncture and psychotherapy. • Summary of evidence The systematic review identified 1 RCT directly comparing acupuncture therapy with psychotherapy[39]. The RCT (n = 58) reported the severity of depression at the end of treatment (eight weeks), assessed by the Hamilton Depression Scale (HAMD-17), and evaluated the response of depression at eight weeks of treatment.

(*continued*)

- **Benefits, harms and burdens**

Compared with psychotherapy, acupuncture therapy may result in little to no difference in the severity of depression at the end of treatment (MD, −0.44; 95%CI, −2.05 to 1.17; low certainty in the estimated effects) and the response of depression at the end of treatment (RR, 1.14; 95%CI, 0.69 to 1.88; ARR, 68 more per 1 000 patients; 95% CI, 150 fewer to 425 more; low certainty in the estimated effects).

Relative impact on QoL, fatigue, insomnia, and change in medication or use of other support systems could not be evaluated because of the absence of data. The impact of acupuncture therapy on SAEs and AEs was not reported.

Considering the limited direct evidence, we also checked indirect evidence[40]. A systematic review summarized 453 RCTs ($n = 36\ 702$) comparing psychotherapies with minimal control (waiting list, usual care, placebo pill, or other control such as brochure or a general discussion group) and found an overall effect size of SMD −0.75 (95% CI, −0.67 to −0.82) in patients with MDD. The authors conducted a sensitivity analysis including only studies with a low risk of bias ($n = 120$) and yielded an SMD −0.51 (95% CI, 0.42 to 0.60). A Cochrane review compared acupuncture with minimal control (no treatment, waiting list, treatment as usual) and found acupuncture may reduce the severity of depression at the end of the treatment (SMD, −0.66, 95% CI, −1.06 to −0.25; low certainty in the estimated effects).

- **Certainty in the estimated effects**

Certainty in the estimated effects was low for both the severity of depression and the response of depression at the end of treatment because of the serious risk of bias and serious imprecision.

(3) Explanation

- **Panel discussion and conclusions**

The panel concluded: ① acupuncture therapy showed an unclear desirable effect in mild or moderate MMD compared with psychotherapy, with low-certainty evidence; ②the impact of acupuncture therapy on SAEs and AEs was unclear; ③indirect evidence shows that acupuncture therapy showed a trivial effect in mild or moderate MMD compared with psychotherapy with low-certainty evidence. The indirect evidence also shows that when compared with minimal control, psychotherapy likely results in a reduction of the severity of depression, and although the cost is similar, more countries cover psychotherapy compared to acupuncture therapy.

Above all, either acupuncture therapy or psychotherapy can be a good option for patients, but the latter might be more accessible and less costly in more settings.

(*continued*)

• Implementation considerations Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering: ① the various cost, coverage, and access, ② the low certainty of evidence on benefit, and ③ the lack of information on adverse events and other undesirable effects. • Other considerations The guideline panel considered acupuncture or psychotherapy's efficacy, accessibility, and cost were important factors in managing patients with MMD. Before reimbursement, a 6-week treatment for acupuncture (3 to 5 times a week) and psychotherapy (once a week) directly cost 2 340.0 to 3 900.0 RMB (345.0 to 574.0 USD) and 234.0 to 300.0/3 600.0 RMB (35.0 to 44.0/531.0 USD) (public/private) in Beijing, China. Considering that the insurance coverage of acupuncture and psychotherapy varies significantly in different countries and regions, the cost of acupuncture and psychotherapy also varies. Panels stated that compared to acupuncture, more countries (e.g., Germany, Australia) cover psychotherapy, and some cover both (e.g., China and South Korea).

Question 2: For adults diagnosed with mild or moderate MDD, should we recommend acupuncture alone, acupuncture plus moxibustion, or exercise?
(1) Recommendation
Dropped and no recommendation.
(2) Summary of findings
No direct and indirect evidence was found on this clinical question, so it could not be evaluated. Future studies directly comparing exercise and acupuncture therapies are needed.

Question 3: For adults diagnosed with mild or moderate MDD, should we recommend acupuncture alone, acupuncture plus moxibustion, or antidepressants?
(1) Recommendation
For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using either acupuncture therapies or antidepressants. (Conditional recommendation, low certainty in the estimated effects)

(*continued*)

(2) Summary of findings
• Rationale for question In primary care settings, some countries, such as the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines, suggest using antidepressants to manage depression[41]. The most used antidepressants include Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs), Tricyclic Antidepressants (TCAs), and Monoamine Oxidase Inhibitors (MAOIs)[42]. More patients have recently been seeking acupuncture treatment for depression[43]. To identify the optimal treatment options, the panel evaluated the efficacy and safety of acupuncture and antidepressant treatment for mild or moderate depression in clinical applications. • Summary of evidence The systematic review identified 43 RCTs [42,44-85] directly comparing acupuncture therapy with antidepressants to inform this recommendation. 40 RCTs ($n = 3\ 178$) reported severity of depression at the end of treatment (6.1 weeks), assessed by HAMD-17 or HAMD-24. Thirty-four trials ($n = 2\ 790$) evaluated the response of depression at the end of treatment (5.9 weeks). One RCT ($n = 60$) evaluated the response of depression at six months follow-up. Five RCTs ($n = 455$) evaluated the total number of AEs at the end of the treatment (6 weeks), and 10 RCTs ($n = 635$) reported the severity of side effects at the end of the treatment (5.6 weeks), assessed with the Asberg Rating Scale for Side Effects (SERS) or Treatment Emergent Symptom Scale (TESS). One RCT ($n = 60$) reported QoL at the end of the treatment (4 weeks), assessed with World Health Organization Quality Of Life (WHOQOL-BREEF). Five RCTs ($n = 330$) reported insomnia at the end of the treatment (8.4 weeks), four ($n = 215$) measured with HAMD-Sleep disturbance, and one with Pittsburgh Sleep Quality Index (PSQI). Out of a total of 43 studies, for the selection of compulsory acupoints, 10 selected scalp acupoints, 2 selected scalp acupoints and body acupoints, 14 selected GV20, EX-HN3 and body acupoints, 10 selected GV20 and body acupoints, 4 selected acupoints on the back (transport point) and 3 selected body acupoints. Out of 17 studies that used electro-acupuncture, 6 did not specify the type of electro-wave, 5 used continuous wave, 3 used anti-depressant wave, 2 used sparse-dense wave, and 1 used intermittent wave. Different types of acupuncture might have different magnitudes of effects. The overall certainty of the evidence is low. Acupuncture plus moxibustion (warm needling-adding moxibustion at the end of the needles or using acupuncture plus moxibustion independently) is better than manual or electro-acupuncture alone. The most common antidepressants included were SSRIs ($n = 32$), TCAs ($n = 6$), NaSSAs ($n = 2$), and other types of antidepressants ($n = 3$).

(*continued*)

- Benefits

The evidence suggests acupuncture therapy may reduce the severity of depression at the end of treatment (SMD, −0.53; 95%CI, −0.77 to −0.29; low certainty in the estimated effects) compared with antidepressants. When compared with antidepressants, either acupuncture therapy or manual acupuncture may slightly increase (RR, 1.18; 95%CI, 1.09 to 1.27; ARR, 107 more per 1 000 patients; 95% CI, 54 more to 161 more; low certainty in the estimated effects; RR, 1.23; 95%CI, 1.11 to 1.37; ARR, 127 more per 1 000 patients; 95% CI, 61 more to 204 more; low certainty in the estimated effects), electro-acupuncture may result in little to no difference (RR, 1.03; 95%CI, 0.99 to 1.11; ARR, 20 more per 1 000 patients; 95% CI, 7 fewer to 73 more; low certainty in the estimated effects), and acupuncture plus moxibustion may result in an increase in the response of depression at the end of treatment (RR, 1.36; 95%CI, 1.16 to 1.59; ARR, 220 more per 1 000 patients; 95% CI, 98 more to 360 more; low certainty in the estimated effects).

Regarding QoL at the end of treatment, when compared with antidepressants, acupuncture therapy may result in a large increase in the physiological domain (MD, 2.86; 95%CI, 1.76 to 3.96; low certainty in the estimated effects) and psychological domain (MD, 2.76; 95%CI, 2.12 to 3.40; low certainty in the estimated effects), and little to no difference in the social domain (MD, −0.34; 95%CI, −1.10 to 0.42; low certainty in the estimated effects) or the environmental domain (MD, −0.20; 95%CI, −0.71 to 0.31; low certainty in the estimated effects).

When compared with antidepressants, at the end of the treatment, acupuncture therapy may result in a large reduction in HAMD-Sleep disturbance (MD, −1.6; 95%CI, −2.00 to −1.21; low certainty in the estimated effects) and may reduce insomnia slightly when assessed with PSQI (MD, −1.37; 95%CI, −2.44 to −0.30; low certainty in the estimated effects). When compared with antidepressants, acupuncture therapy may result in a large reduction in the risk of AEs (RR, 0.11; 95% CI, 0.05 to 0.23; ARR, 246 fewer per 1 000 patients; 95% CI, 263 fewer to 213 fewer; low certainty in the estimated effects) and a large reduction on the severity of side effects (SMD, −2.15; 95%CI, −3.01 to −1.29; low certainty in the estimated effects). When compared with antidepressants, manual acupuncture and acupuncture plus moxibustion may result in a large reduction in the severity of side effects at the end of treatment (SMD, −2.31; 95%CI, −3.38 to −1.25; low certainty in the estimated effects; SMD, −3.34; 95%CI, −4.70 to −2.17; low certainty in the estimated effects), and electro-acupuncture may slightly reduce the severity of side effects (SMD, −0.41; 95%CI, −0.81 to −0.01; low certainty in the estimated effects). Relative impact on change in medication use or other support systems could not be evaluated because of a lack of data.

- Harms and burdens

The impact of acupuncture therapy on SAEs was not reported. The undesirable effects were judged as don't know.

(*continued*)

• Certainty in the estimated effects Certainty in the estimated effects was judged to be low for the severity of depression, response of depression, total numbers of AEs, and QoL at the end of treatment because of the serious risk of bias and serious imprecision. Certainty in the estimated effects was judged to be low for the severity of side effects and HAMD-Sleep disturbance at the end of the treatment because of the serious risk of bias and serious inconsistency. Certainty in the estimated effects was considered low for insomnia at the end of treatment because of the serious risk of bias and inconsistency.
(3) Explanation
• Panel discussion and conclusions The panel concluded: ①low certainty evidence showed that compared with antidepressants, acupuncture therapy moderately reduced the severity of depression, the improved response of depression in a small magnitude, the total number of AEs and HAMD-Sleep disturbance in a large magnitude at the end of treatment, and②that the undesirable effect of acupuncture therapy was unclear. We do have a large body of evidence on the effect of antidepressants. Among all the existing antidepressants, current evidence included only certain types of antidepressants. There is probably no important uncertainty or variability in patients' values and preferences. When considering feasibility and cost (direct and indirect), the choice between acupuncture and antidepressants might vary in different settings and among patients. On balance, the panel concluded that the clinical superiority of acupuncture therapy (balance of effect) outweighs its higher price. Above all, either acupuncture therapy or antidepressants can be a good option for patients. • Subgroup The treatment effect of interventions in patients who have initially diagnosed, relapsed, and therapy-resistant depression might differ, considering the different baseline risks. We have limited information on the included population in studies supporting this recommendation. Among 43 studies, one included patients having initially diagnosed depression, three included a mixed population of initially diagnosed and relapsed depression, and the remaining 39 did not specify the type of depression. When using this guideline to make treatment decisions, readers should consider these factors. • Implementation Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering: ①the various cost and access, ②the low certainty of evidence on benefits, and ③the lack of information on severe adverse events and other undesirable effects.

(*continued*)

• Other considerations Before reimbursement, a 6-week treatment for acupuncture (3 to 5 times a week) and antidepressants (once a day) directly cost 2 340 to 3 900 RMB (345 to 574 USD) and 76 to 941 RMB (11 to 86 USD) in Beijing, China. Varying insurance coverage for acupuncture and antidepressants leads to varying costs in different countries and regions. Patients need private insurance to access acupuncture in countries like Norway, Australia, and Germany. Recommending acupuncture might increase health equity as it will encourage insurance coverage. There is no impact on equity in China and South Korea, as both antidepressants and acupuncture are covered. Across countries, patients and clinicians (including acupuncturists, primary care physicians, etc.) accept acupuncture as a good treatment option. Acupuncture therapy is probably feasible, with some uncertainties regarding the capacity of the healthcare system and the availability and skills of acupuncturists/clinicians delivering care to MDD patients. • Monitoring and evaluation Clinicians and patients should monitor the symptoms and the severity of depression and suicidality. Clinicians should consider providing different or additional treatments if patients' depression worsens.

Question 4: For adults diagnosed with mild or moderate MDD, should we recommend acupuncture therapies plus antidepressants or acupuncture therapies alone?
(1) Recommendation
For adults diagnosed with mild or moderate MDD, the WFAS panel suggests using acupuncture therapy plus antidepressants over acupuncture therapy alone. (Conditional recommendation, with low certainty evidence)
(2) Summary of findings
• Rationale for question Acupuncture has the potential to be an effective, safe, and well-tolerated monotherapy for depression[5-6,86]. Patients often seek acupuncture therapies[86]. Sometimes, however, applying acupuncture therapy alone might not be sufficient. Therefore, the panel believes it is important to evaluate whether combining antidepressants would be better than acupuncture therapy alone.

(*continued*)

- Summary of evidence

The systematic review identified 5 RCTs[55,60,75,85,87] directly comparing acupuncture therapy plus antidepressants with acupuncture therapy alone to inform this recommendation. 4 RCTs ($n = 277$) reported severity of depression assessed by the Hamilton Depression Scale (HAMD-17 or HAMD-24) at the end of treatment (8 weeks), 5 ($n = 316$) response of depression at the end of treatment (7.6 weeks), 1 ($n = 39$) QoL assessed with Short-Form Health Survey (SF-36), and 2 ($n = 165$) total numbers of AEs at the end of the six weeks treatment.

Out of the five studies that informed the recommendation, four selected scalp acupoints and one selected body acupoints as the compulsory acupoints. Two of four electro-acupuncture studies used continuous waves, and two used sparse-dense electro waves. Our systematic review did not identify evidence of other types of acupuncture therapies (laser, acupressure, etc.).

Among all antidepressants, included studies only investigated SSRIs.

- Benefits

Compared with using acupuncture therapy alone, at the end of treatment, acupuncture therapy plus antidepressants may slightly reduce the severity of depression (SMD, −0.38; 95%CI, −0.61 to −0.14; low certainty in the estimated effects), slightly increase QoL (MD, 56.06; 95% CI, −52.85 to 164.97; low certainty in the estimated effects), and may increase the response of depression (RR, 1.54; 95%CI, 1.24 to 1.90; ARR, 215 more per 1 000 patients; 95%CI, 96 more to 359 more; low certainty in the estimated effects). Compared with using acupuncture therapy alone, acupuncture therapy plus antidepressants likely results in little to no difference in AEs at the end of the treatment (RR, 0.98; 95%CI, 0.30 to 3.17; ARR, 1 fewer per 1 000 patients; 95% CI, 42 fewer to 131 more; low certainty in the estimated effects).

The relative impact of fatigue, insomnia, and change in the medication or use of other support systems could not be evaluated because of a lack of data.

- Harms and burdens

The impact of acupuncture therapy plus antidepressants on SAEs was not reported. We did not identify other undesirable effects and therefore were judged as don't know.

- Certainty in the estimated effects

Certainty in the estimated effects was judged to be low for the severity of depression, response of depression, total numbers of AEs, and QoL at the end of treatment because of the serious risk of bias and serious imprecision.

(*continued*)

(3) Explanation
• Panel discussion and conclusions The panel concluded that: ① compared to acupuncture therapy alone, acupuncture therapy plus antidepressants showed a moderate desirable effect on the severity and response of depression and a small effect on the quality of life supported by low certainty evidence, and ② the undesirable effect is unclear. When considering the cost (both direct and indirect), the choice between acupuncture plus antidepressants and acupuncture might vary in different settings and among patients, and ③ there is probably no important uncertainty or variability in patients' values and preferences. The panel concluded that the clinical superiority of acupuncture therapy plus antidepressants (balance of effect) outweighs its slightly higher price. Above all, acupuncture therapy plus antidepressants can be a better option than acupuncture therapy alone for patients. A patient-clinician shared decision-making process is needed. • Subgroup None of the five included trials specified whether included patients have initially diagnosed or relapsed depression. • Other considerations Before reimbursement, a 6-week treatment for acupuncture (3 to 5 times a week) plus antidepressants (once a day) directly cost 2 416 to 4 841 RMB (361 to 723 USD) in Beijing, China. If antidepressants-related severe adverse events happen, the indirect cost could be substantial. Various insurances across countries and regions might impact patients' acceptability. For health equity, the panel agreed on little to no impact in most countries except the USA, where adding antidepressants might reduce equity considering the cost and access, since USA is not universal health care. Since across countries, patients and clinicians (including acupuncturists and other clinicians) probably accept acupuncture and antidepressants, which is probably feasible to implement. • Monitoring and evaluation Clinicians and patients should monitor the symptoms and the severity of depression, suicidality, etc. Clinicians should consider providing different or additional treatments if patients' depression worsens.

Question 5：For adults diagnosed with mild or moderate MDD，should we recommend acupuncture therapies plus antidepressants or antidepressants alone？
（1）Recommendation
For adults diagnosed with mild or moderate MDD，the WFAS panel suggests using acupuncture plus antidepressants over antidepressants alone.（Conditional recommendation，low certainty in the estimated effects）
（2）Summary of findings
• Rationale for question Antidepressants are the first-line treatment for depression. Despite continuous antidepressant treatment，nonresponse occurs in 19% to 34% of patients，and up to 50% fail to achieve and sustain full remission or have a recurrence of depression[88-93]。When patients fail to respond to a single modality，adding acupuncture to antidepressant medication can be a good option. The panel，therefore，decided to evaluate the efficacy and safety of combination therapy in patients with mild or moderate MDD. • Summary of evidence The systematic review identified 52 RCTs[59，74，85，87，93-140] directly comparing acupuncture therapy plus antidepressants with antidepressants to inform this recommendation. 45 RCTs（n = 3 475）reported the severity of depression assessed by HAMD-17 or HAMD-24，and 38 RCTs（n = 2 823）evaluated the response of depression at the end of the treatment（mean：6.5 weeks）. 3 RCTs（n = 647）reported QoL assessed with the World Health Organization Quality Of Life（WHOQOL-BREEF）scale. 8 RCTs（n = 621）reported insomnia assessed with PSQI. 5 RCTs（n = 733）reported HAMD-Sleep disturbance. 6 RCTs（n = 523）evaluated the total number of AEs，and 16 RCTs（n = 1 205）reported the severity of side effects assessed with SERS or TESS. One RCT（n = 128）reported a change in medication use and assessed whether additional treatments were provided. All trials reported the outcome measures at the end of the treatment. When selecting compulsory acupoints，of 52 studies，21 selected GV20，EX-HN3，and body acupoints，14 scalp acupoints，6 GV20 and body acupoints，4 body acupoints，3 auricular acupoints，2 scalp acupoints，and body acupoints，and one auricular acupoints and body acupoints. Out of 19 studies that used electro-acupuncture，one did not specify the type of electro-wave，six used continuous wave，and twelve used sparse-dense wave. The most common antidepressants included were SSRIs（n = 45），SNRIs（n = 2），5-HT_{1A} receptor agonists（n = 2），NaSSAs（n = 1），and other types of antidepressants（n = 2），and one study did not specify the type of antidepressants in the article.

(*continued*)

- Benefits

Compared with antidepressants, acupuncture therapy plus antidepressant may result in a large reduction in the severity of depression (SMD, −1.22; 95%CI, −1.43 to −1.00; low certainty in the estimated effects), and probably increase the response of depression slightly at the end of treatment (RR, 1.36; 95%CI, 1.25 to 1.46; ARR, 163 more per 1 000 patients; 95% CI, 113 more to 209 more; moderate certainty in the estimated effects). Compared with an antidepressant, acupuncture therapy plus antidepressant likely results in little to no difference in overall quality of life (MD, 0.26; 95%CI, 0.13 to 0.38; moderate certainty in the estimated effects), general health domain (MD, 0.25; 95%CI, 0.11 to 0.35; moderate certainty in the estimated effects), physiological health domain (MD, 1.22; 95%CI, 0.33 to 2.11; moderate certainty in the estimated effects), psychological health domain (MD, 1.11; 95%CI, 0.45 to 1.77; moderate certainty in the estimated effects), environmental domain (MD, 0.51; 95%CI, 0.17 to 0.84; moderate certainty in the estimated effects), or social domain (MD, 0.28; 95%CI, −0.10 to 0.67; low certainty in the estimated effects). Compared with antidepressants, the evidence is very uncertain about the effect of acupuncture therapy plus antidepressants on insomnia at the end of the treatment assessed with PSQI (MD, −2.28; 95%CI, −4.17 to −0.38; very low certainty in the estimated effects). Compared with antidepressants, acupuncture therapy plus antidepressants may reduce sleep disturbance measured with HAMD-Sleep disturbance (MD, −0.73; 95%CI, −1.40 to −0.06; low certainty in the estimated effects) and may slightly reduce the number of patients who increased their medication usage (RR, 0.32; 95%CI, 0.14 to 0.75; ARR, 156 fewer per 1 000 patients; 95% CI, 197 fewer to 57 fewer; low certainty in the estimated effects).

Compared with antidepressants, acupuncture therapy plus antidepressants may reduce medication usage slightly (Paroxetine, mg/day, doses taken) during the 6-week treatment (MD, −0.55; 95% CI, −1.97 to 0.87; low certainty in the estimated effects) and at 4-week follow-up (MD, −1.80; 95%CI, −4.09 to 0.49; low certainty in the estimated effects).

Compared with antidepressants, acupuncture therapy plus antidepressants likely reduced the risk of AEs (RR, 0.25; 95% CI, 0.14 to 0.44; ARR, 173 fewer per 1 000 patients; 95% CI, 193 fewer to 123 fewer; moderate certainty in the estimated effects) and may result in a large reduction in the severity of side effects (SMD, −1.41; 95%CI, −1.81 to −1.01; low certainty in the estimated effects).

- Harms and burdens

The impact of acupuncture therapy on SAEs was not reported. The undesirable effects were judged as trivial based on indirect evidence[5].

(*continued*)

- Certainty in the estimated effects

Certainty in the estimated effects was moderate for the response of depression, QoL, and total numbers of AEs because of the serious risk of bias, low for the severity of depression because of the serious risk of bias and inconsistency, low for the severity of side effects and change in use of medication because of serious risk of bias and imprecision, and very low for insomnia because of serious risk of bias, inconsistency, and imprecision.

(3) Explanation

- Panel discussion and conclusions

The panel concluded: ①acupuncture therapy plus antidepressants showed a large desirable effect on the severity of depression and severity of AE, moderate on the total number of AEs, and small on the response of depression, dosage, and the number of patients increased medication usage with low-certainty evidence, and ② trivial undesirable effect of acupuncture therapy. When considering cost, adding acupuncture to antidepressants may generate moderate costs and vary in settings and among patients.

Above all, adding acupuncture to antidepressants can be a good option for patients. The panel, therefore, suggests acupuncture plus antidepressants over antidepressants when treating patients with mild to moderate major depressive disorder.

- Subgroup

Considering the different baseline risks in patients who have initially diagnosed, relapsed, and therapy-resistant depression, the treatment effect of interventions might differ. The included studies reported limited information regarding the type of depression. Among all included studies, 11 included patients with initially diagnosed depression, two had relapsed depression, seven included a mixed population of initially diagnosed and relapsed depression, and the remaining 28 did not specify the type of MDD patients included. Guideline readers should consider these factors when using this recommendation.

- Implementation

Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering: ① the various cost and access, ② the low certainty of evidence on benefits, and ③ the lack of information on severe adverse events and other undesirable effects.

- Other considerations

The panel considers that adding acupuncture to antidepressants can generate a moderate cost, especially in countries where patients need to pay out of pocket. Implementing acupuncture plus antidepressants is probably acceptable and feasible among patients and clinicians despite the cost and access challenges.

(*continued*)

- Monitoring and evaluation

Clinicians and patients should monitor the symptoms and severity of depression, suicidality, etc. Clinicians should consider providing different or additional treatments if patients' depression worsens.

Question 6: For adults diagnosed with mild or moderate MDD who will receive acupuncture therapies, should we recommend body acupuncture or scalp acupuncture?

(1) Recommendation

Dropped and no recommendation.

(2) Summary of findings

No direct and indirect evidence was found on this clinical question, and therefore it could not be evaluated and a recommendation made. Randomized controlled studies directly comparing body and head needling could be considered in the future.

Question 7: For adults diagnosed with mild or moderate MDD who will receive acupuncture therapies, should we recommend body acupuncture or auricular acupuncture?

(1) Recommendation

For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests using auricular or body acupuncture. (Conditional recommendation, with very low certainty evidence)

(2) Summary of findings

- Rationale for question

Acupuncture involves the insertion of fine needles to correct the imbalance of energy within the body. Different styles of acupuncture, for instance, auricular and trigger point acupuncture, may differ in effectiveness [134, 135]. Auricular and body acupuncture are the most common acupuncture styles; therefore, the panel believes it is important to evaluate the net benefits of different styles of acupuncture for MDD.

(*continued*)

- Summary of evidence

Our systematic review did not identify direct evidence but indirect evidence of 3 RCT [112, 118, 136] comparing auricular therapy plus antidepressants versus antidepressants and 10 RCTs [59, 74, 93, 98, 100, 101, 109, 112, 113, 134] comparing body acupuncture plus antidepressants with antidepressants. The relative effects of auricular and body acupuncture were obtained through common controls. Out of the 13 RCTs, 10 ($n = 654$) reported the severity of depression assessed by HAMD (mean: 5.8 weeks), and 12 ($n = 727$) evaluated the response of depression at the end of treatment (mean: 6.3 weeks).

When selecting compulsory acupoints, eight out of 13 studies selected scalp acupoints, two auricular acupoints, two GV20, EX-HN3, and body acupoints, and one auricular acupoints and body acupoints. Ten studies used electro-acupuncture with sparse-dense wave ($n = 7$) and continuous wave ($n = 3$).

The most common antidepressants included were SSRIs ($n = 12$) and other antidepressants ($n = 1$).

- Benefits, harms and burdens

Indirect evidence shows that compared with body acupuncture, auricular acupuncture may reduce the severity of depression (SMD, −0.20; 95%CI, −1.18 to 0.78; very low certainty in the estimated effects), but the evidence is very uncertain. Auricular acupuncture may result in a large increase in the response of depression (RR, 1.88; 95%CI, 1.42 to 2.48; ARR, 525 more per 1 000 patients; 95% CI, 251 more to 884 more; low certainty in the estimated effects).

Relative impact on QoL, fatigue, insomnia, and change in medication or use of other support systems, SAEs, and AEs could not be evaluated because of the absence of data.

- Certainty in the estimated effects

Certainty in the estimated effects was judged to be low for the response of depression because of the serious risk of bias, indirectness and very low for the severity of depression due to additional serious imprecision.

(3) Explanation

- Panel discussion and conclusions

The panel concluded: ①the evidence is very uncertain about the effect of auricular acupuncture on the severity of depression at the end of treatment and low for the response of depression at the end of treatment in mild or moderate MMD; ② the impact of acupuncture therapy on SAEs and AEs was unclear; and when considering feasibility and cost (both direct and indirect), the choice between auricular and body acupuncture might vary in different settings and among patients.

(*continued*)

Therefore, auricular or body acupuncture can be a good option for patients with MDD. A patient-clinician shared decision-making process is needed.

- Subgroup

Considering the different baseline risks, the treatment effect in patients who have initially diagnosed, relapsed, and therapy-resistant depression might differ. We have limited information on the included population in this recommendation. Among 13 included studies, four included patients with initially diagnosed depression, three with a mixed population of initially diagnosed and relapsed depression, and the remaining six did not specify the type of MDD patients included. When using this recommendation, readers should consider these factors.

- Implementation

Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering: ① the various cost and access, ② the low and very low certainty of evidence on benefits, and ③ the lack of information on severe adverse events and other undesirable effects.

- Other considerations

Before reimbursement, a 6-week treatment for body acupuncture (3 to 5 times a week) costs 2 340 to 3 900 RMB (350 to 583 USD) and 936 to 2 808 RMB (140 to 420 USD) for auricular therapy (1 to 3 times a week) in Beijing, China.

In many countries, such as Germany, South Korea, the USA, and China, compared to body acupuncture, auricular acupuncture has lower treatment frequency, therefore saving patients direct and indirect costs. In other countries, such as Norway and Australia, auricular acupuncture is often used as an add-on to body acupuncture. The cost difference between body and auricular acupuncture is small.

For health equity, the panel agreed on a varied impact. In some countries, psychiatrists and acupuncturists offer auricular acupuncture; in others, only acupuncturists can offer both body and auricular acupuncture.

Across countries, patients and clinicians (including acupuncturists and other clinicians) probably accept auricular and body acupuncture, which is feasible to implement.

- Monitoring and evaluation

Clinicians and patients should monitor the symptoms and severity of depression, suicidality, etc. Clinicians should consider providing different or additional treatments if patients' depression worsens.

Question 8:For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies, should we recommend electro-acupuncture or manual acupuncture?
(1) Recommendation
For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests using electro-acupuncture or manual acupuncture. (Conditional recommendation, with very low certainty evidence)
(2) Summary of findings
• Rationale for question Clinicians use manual and electro-acupuncture acupuncture, most commonly worldwide[32]. To identify the optimal acupuncture approaches for MDD patients, the panel assessed the relative effectiveness and safety of electro- and manual acupuncture. • Summary of evidence The systematic review identified 7 RCTs[113, 125, 141-145] directly comparing electro- versus manual acupuncture to inform this recommendation. Four RCTs ($n=178$) evaluated the response of depression at the end of the treatment (mean: 6.5 weeks), and another 4 ($n=185$) reported the severity of depression at the end of the treatment (mean: 7.5 weeks), assessed by HAMD-17 or HAMD-24. One RCT ($n=45$) evaluated the severity of depression at three months follow-up after treatment. Three RCTs ($n=390$) reported insomnia, two ($n=330$) measured using HAMD-Sleep disturbance, and one ($n=60$) using PSQI. One RCT ($n=310$) reported QoL assessed with WHO-QOL-BREF. One RCT ($n=60$) reported the severity of side effects assessed with TESS. All RCTs measured insomnia, QoL, and side effects at the end of the treatment. We also analyzed indirect evidence in RCTs, including manual or electro-acupuncture, and compared acupuncture therapy vs. antidepressants or acupuncture therapy plus antidepressants vs. antidepressants. A total of 72 RCTs ($n=4\ 665$) reported the severity of depression, 59 RCTs ($n=4\ 931$) response of depression, 8 RCTs ($n=948$) insomnia using the HAMD-Sleep disturbance scale, 8 RCTs ($n=858$) the total numbers of adverse events and 22 RCTs ($n=1\ 570$) the severity of side effects. Two RCTs ($n=537$) reported QoL assessed with WHOQOL-BREF pooling acupuncture therapy plus antidepressants vs. antidepressants. Two RCTs ($n=128$) reported insomnia measured with PSQI pooling acupuncture therapy vs. antidepressants. Out of seven studies directly compared manual and electro-acupuncture, four selected GV20, EX-HN3, and body acupoints, two selected scalp acupoints, and one selected GV20 and body acupoints as their compulsory acupoints. Seven studies used electro-acupuncture, three with continuous waves, and four with sparse-dense waves.

(*continued*)

- Benefits

Compared with manual acupuncture, electro-acupuncture may have little to no effect on the response of depression at the end of the treatment (RR, 1.18; 95%CI, 0.87 to 1.61; ARR, 70 more per 1 000 patients; 95% CI, 51 fewer to 238 more; low certainty in the estimated effects), the severity of depression (SMD, −0.01; 95%CI, −0.52 to 0.51; very low certainty in the estimated effects) at the end of treatment, and at three months follow-up (MD, −3.6; 95%CI, −7.11 to 0.09; very low certainty in the estimated effects) but the evidence is very uncertain. When compared with manual acupuncture, electro-acupuncture may have little to no effect on Sleep disturbance measured as HAMD-Sleep disturbance (MD, −0.24; 95%CI, −0.51 to −0.03; low certainty in the estimated effects) and insomnia at the end of the treatment assessed with PSQI (MD, 0.86; 95%CI, −1.38 to 3.1; very low certainty in the estimated effects). Compared with manual acupuncture, electro-acupuncture may result in little to no difference in the overall quality of life (MD, 0.11; 95%CI, −0.05 to 0.27; low certainty in the estimated effects), and sub-domains of quality of life instrument: general health (MD, 0.02; 95%CI, −0.16 to 0.02; low certainty in the estimated effects), physiological domain (MD, 0.16; 95%CI, −0.33 to 0.65; low certainty in the estimated effects), psychological domain (MD, −0.33; 95%CI, −0.52 to 0.46; low certainty in the estimated effects), environmental domain (MD, −0.08; 95%CI, −0.53 to 0.37; low certainty in the estimated effects), and social domain (MD, −0.12; 95%CI, −0.63 to 0.39; low certainty in the estimated effects).

Compared with manual acupuncture, indirect evidence show that electro-acupuncture have little to no effect on the severity of depression (SMD, 0.09; 95%CI, −0.46 to 0.63; very low certainty in the estimated effects), the response of depression at the end of the treatment (RR, 1.03; 95%CI, 0.72 to 1.47; ARR, 18 more per 1 000 patients; 95% CI, 167 fewer to 280 more; very low certainty in the estimated effects), the overall quality of life (MD, 0.1; 95%CI, −0.25 to 0.45; very low certainty in the estimated effects), general health (MD, 0; 95%CI, −0.38 to 0.38; very low certainty in the estimated effects), and sub domains of quality of life instrument: physiological domain (MD, 0.01; 95%CI, −3.79 to 3.81; very low certainty in the estimated effects), psychological domain (MD, −0.36; 95%CI, −2.57 to 1.85; very low certainty in the estimated effects), environmental domain (MD, −0.09; 95%CI, −1.19 to 1.01; very low certainty in the estimated effects), social domain (MD, −0.09; 95%CI, −1.03 to 5.85; very low certainty in the estimated effects), insomnia (MD, 2.56; 95%CI, −0.73 to 5.85; very low certainty in the estimated effects), and HAMD-Sleep disturbance (SMD, 0.69; 95%CI, −0.37 to 1.75; very low certainty in the estimated effects).

The relative impact of change in medication or other support systems could not be evaluated because of the absence of data.

(*continued*)

- Harms and burdens

Electro-acupuncture may increase the severity of side effects at the end of treatment (MD, 0.04; 95%CI, −0.4 to 0.48; very low certainty in the estimated effects), but the evidence is very uncertain. Compared with manual acupuncture, indirect evidence show that electro-acupuncture has little to no effect on total numbers of AE (RR, 0.49; 95%CI, 0.10 to 2.36; ARR, 88 fewer per 1 000 patients; 95% CI, 155 fewer to 234 more; very low certainty in the estimated effects). Indirect evidence shows that electro-acupuncture may increase the severity of side effects at the end of treatment (SMD, 0.91; 95%CI, −1.42 to 3.23; very low certainty in the estimated effects), but the evidence is very uncertain.

- Certainty in the estimated effects

For direct evidence, certainty in the estimated effects was judged to be low for the response of depression, HAMD-Sleep disturbance, and QoL at the end of treatment because of the serious risk of bias and serious imprecision, very low for the severity of depression at the end of treatment, because of serious risk of bias, serious inconsistency, and serious imprecision. Certainty in the estimated effects was judged to be very low for insomnia, the severity of side effects at the end of treatment, and the severity of depression at three months follow-up due to serious risk of bias and very serious imprecision. For indirect evidence, certainty in the estimated effects was judged to be very low for all outcomes due to the serious risk of bias, indirectness, and imprecision.

(3) Explanation

- Panel discussion and conclusions

The panel concluded: ①compared to manual acupuncture, electro-acupuncture showed a trivial desirable effect on the response and severity of depression, sleep disturbance, insomnia, and quality of life outcomes at the end of the treatment with very low-certainty evidence, and ② a trivial increase of severity of side effect at the end of treatment.

There is probably no important uncertainty or variability in patients' preferences. The two types of acupuncture have similar costs. Patients probably accept acupuncture, and it is probably feasible to implement. Above all, either electro-acupuncture or manual acupuncture can be a good option for MDD patients.

- Subgroup

The treatment effect of interventions in patients who have initially diagnosed, relapsed, and therapy-resistant depression might differ, considering the different baseline risks. We have limited information on the included population in this recommendation. Among seven studies directly compared electro- vs. manual acupuncture, we have four studies that included initially diagnosed depression, and three studies did not specify the type of depression included. When using this recommendation, users should consider these factors for treatment decisions.

(*continued*)

- Implementation

Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering: ① the slight cost and access difference, ② the very low certainty of evidence from direct and indirect evidence, and ③ the lack of information on adverse events and other long-term outcomes.

- Other considerations

The guideline panel believes that the effectiveness, adverse effect, patients' values, preferences, feasibility, accessibility, and cost of electro-acupuncture or manual acupuncture are important factors to consider when managing MMD patients. The cost of electro-acupuncture and manual acupuncture is similar, and the former is slightly more expensive considering the cost of a machine that generates an electric current.

The guideline panel estimated the direct costs of 6 weeks treatment before medical insurance reimbursement. Electro-acupuncture (3 to 5 times a week) costs 2 790 to 4 650 RMB (417 to 695 USD), and manual acupuncture (3 to 5 times a week) costs 2 340 to 3 900 RMB (350 to 583 USD) in Beijing, China.

Electro-acupuncture or manual acupuncture should be selected based on patients' requirements and circumstances. Electro-acupuncture is selected for better efficacy, and manual acupuncture is selected for lower cost.

There is probably no important uncertainty or variability in patients' preferences. Patients probably accept acupuncture, and it is probably feasible to implement.

- Monitoring and evaluation

Clinicians and patients should monitor the symptoms and severity of depression, suicidality, etc. Clinicians should consider providing different or additional treatments if patients' depression worsens.

Question 9: For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies, should we recommend treating patients twice (≤2 times per week) or three times and more a week (≥3 times a week)? (The initial PICO question compared once versus two or more weekly acupuncture sessions. Since there is no evidence on the predefined treatment frequency, the panel made the recommendations based on identified evidence on the alternative frequencies instead.)

(*continued*)

(1) Recommendation
For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests using acupuncture ⩾3 times over⩽2 times a week. (Conditional recommendation, with very low certainty evidence)
(2) Summary of findings
• Rationale for question Acupuncture treatment frequency might impact the treatment effect [79,146]. In different countries, clinicians practice acupuncture with a different frequency depending on their experience, insurance policy, and feasibility. More frequent acupuncture generates higher direct and indirect costs (e.g., time, productivity, transportation, parking). Therefore, it is of great importance to determine the optimal acupuncture frequency. • Summary of evidence No direct evidence was identified for this question. We used indirect evidence of 48 RCTs comparing acupuncture therapy plus antidepressants versus antidepressants with different treatment frequencies (⩽2 times and ⩾3 times a week). We used the subgroup estimate to calculate the pooled effect estimates of the two frequencies and compared the differences and variances. 41 RCTs (n = 3 159) reported severity of depression assessed by HAMD at the end of treatment (mean: 6.4 weeks); 7 RCTs (n = 511) reported insomnia assessed with PSQI at the end of treatment (mean: 6.0 weeks); and 14 RCTs (n = 1 056) evaluated the severity of side effects at the end of treatment (mean: 6.4 weeks). When selecting compulsory acupoints, of 48 studies, 20 selected GV20, EX-HN3, and body acupoints, 14 scalp acupoints, six GV20 and body acupoints, four body acupoints, two auricular acupoints, one scalp acupoints, and body acupoints, and one auricular acupoints and body acupoints. Out of 19 studies that used electro-acupuncture, one did not specify the type of electro-wave, six used continuous wave, and twelve used sparse-dense wave. The most common antidepressants included were SSRIs (n = 42), 5-HT_{1A} receptor agonists (n = 2), NaSSAs (n = 1), and other types of antidepressants (n = 2), and one study did not specify the type of antidepressants in the article.

(*continued*)

- Benefits, harms and burdens

Compared with treating patients three times or more per week, indirect evidence shows that treating patients one to two times a week may increase the severity of depression (SMD, 0.75; 95% CI, 0.01 to 1.49; very low certainty in the estimated effects), and severity of AEs at the end of treatment (SMD, 0.48; 95%CI, −0.54 to 1.50; very low certainty in the estimated effects), but the evidence is very uncertain. Compared with treating patients three times or more per week, the indirect evidence is very uncertain about the effect of treating patients one to two times a week on insomnia (MD, −0.52; 95%CI, −3.83 to 2.79; very low certainty in the estimated effects), relative impact on the response of depression, QoL, fatigue, and change in use of medication or use of other support systems, the total number of SAEs and AEs could not be evaluated because of the absence of data.

- Certainty in the estimated effects

Certainty in the estimated effects was judged to be very low for the severity of depression and AEs, insomnia at the end of treatment because of the serious risk of bias, indirectness, and imprecision.

(3) Explanation

- Panel discussion and conclusions

The panel concluded that: ① comparing to treating MDD using acupuncture one to two times a week, three times or more treatment showed a desirable effect on insomnia, the severity of depression, and AEs at the end of treatment in mild or moderate MMD, with very low-certainty evidence, and ② the undesirable effect of more frequent treatment is mainly an at least moderate cost increase (both direct and indirect).

- Subgroup

The treatment effect of interventions in patients who have initially diagnosed, relapsed, and therapy-resistant depression might differ, considering the different baseline risks. We have limited information on the included population in this recommendation. Among all included studies, 11 included patients with initially diagnosed depression, two had relapsed depression, seven included a mixed population of initially diagnosed and relapsed depression, and the remaining 28 did not specify the type of MDD patients included. Guideline readers should consider these factors when using this recommendation.

(*continued*)

<table>
<tr><td>

- **Implementation**

Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering: ① the various cost and access, ② the very low certainty of evidence on outcomes, and ③ the lack of information on benefits and serious severe adverse events.

- **Other considerations**

The guideline panel estimated that before reimbursement, one to two times a week of 6 weeks of acupuncture therapies costs approximately 1 560 RMB (233 USD), and three times or more a week costs 2 340 RMB (350 USD) in Beijing, China.

Acupuncture treatment frequency differs in different settings. More frequent treatment will generate at least a moderate cost (e.g., in Australia, China, and South Korea) and sometimes a large cost, such as in Norway and Germany.

Patients probably accept acupuncture, and it is probably feasible to implement.

- **Monitoring and evaluation**

Clinicians and patients should monitor the symptoms and severity of depression, suicidality, etc. Clinicians should consider providing different or additional treatments if patients' depression worsens.

</td></tr>
</table>

<table>
<tr><td>Question 10: For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies, should we recommend standard treatment duration (≤4 weeks) or extended treatment duration (>4 weeks)?</td></tr>
<tr><td>(1) Recommendation</td></tr>
<tr><td>For adults diagnosed with mild or moderate MDD, when using acupuncture therapies, the WFAS panel suggests standard treatment duration (≤4 weeks) over extended treatment duration (>4 weeks). (Conditional recommendation, with very low certainty evidence)</td></tr>
<tr><td>(2) Summary of findings</td></tr>
<tr><td>

- **Rationale for question**

The course of acupuncture treatment might impact acupuncture's treatment effect. Prolonged treatment, however, is more costly for patients and might not necessarily improve patient-important outcomes[147]. The panel, therefore, feels it is important to determine the optimal course of acupuncture treatment for MDD.

</td></tr>
</table>

(*continued*)

- Summary of evidence

Our systematic review did not identify direct evidence on this question. We used indirect evidence of 87 RCTs comparing a) acupuncture therapy versus antidepressants and b) acupuncture therapy plus antidepressants versus antidepressants with standard or extended treatment durations (≤4 weeks vs. >4 weeks). We used the subgroup estimate to calculate the pooled effect estimates of the two treatment durations and compared the differences and their variances first in each comparison [a) or b)] then pooled across two comparisons [a) and b)].78 RCTs (n = 6 337) reported severity of depression assessed by HAMD at the end of treatment (mean: 6.3 weeks); 64 RCTs (n = 5 297) reported a response of depression at the end of treatment (mean: 6.2 weeks), and 10 RCTs (n = 635) evaluated the severity of side effects at the end of treatment (mean: 5.6 weeks).

When selecting compulsory acupoints, out of 87 included studies, 33 studies selected GV20, EX-HN3, and body acupoints, 22 selected scalp acupoints, 15 studies selected GV20 and body acupoints, six selected body acupoints, five selected acupoints on the back, three selected scalp acupoints and body acupoints, three selected auricular acupoints. Out of 34 studies that used electro-acupuncture, 12 used continuous wave, 11 used sparse-dense wave, three used anti-depression waves, one used Intermittent wave, and seven did not specify the type of electro wave.

The most common antidepressants included were SSRIs (n = 71), TCAs (n = 5), 5-HT_{1A} receptor agonists (n = 2), NaSSAs (n = 2), TeCAs (n = 1), other types of antidepressants (n = 5), and one study did not specify the type of antidepressants.

- Benefits, harms and burdens

Compared to extended treatment duration (>4 weeks), the standard duration of acupuncture treatment may have little to no effect on the response of depression (RR, 1.08; 95%CI, 0.81 to 1.45; ARR, 49 more per 1 000 patients; 95% CI, 116 fewer to 276 more; low certainty in the estimated effects); the severity of depression (SMD, 0.02; 95%CI, −0.49 to 0.53; very low certainty in the estimated effects), and the severity of side effects at the end of the treatment (SMD, 0.09; 95%CI, −1.98 to 2.16; very low certainty in the estimated effects) but the evidence is very uncertain for the last two outcomes.

Relative impact on the QoL, fatigue, insomnia, changes in medication use or other support systems, and the total number of SAEs and AEs could not be evaluated because of the absence of data.

- Certainty in the estimated effects

Certainty in the estimated effects was judged to be low for the response of depression due to serious risk of bias and imprecision and very low for the severity of depression and side effects at the end of treatment due to additional serious indirectness.

(*continued*)

(3) Explanation
● Panel discussion and conclusions The panel concluded that: ① low and very low certainty evidence showed trivial differences between standard and extended treatment on the severity and response of depression and the severity of side effects at the end of the treatment. ② Long-term outcomes were lacking.When considering feasibility and cost (direct and indirect), the difference between standard and extended duration varies in different settings and among patients. Still, standard treatment brings at least moderate savings. If patients place a higher value on cost and resource use, standard treatment duration can be slightly better. ● Subgroup The treatment effect of interventions in patients who have initially diagnosed, relapsed, and therapy-resistant depression might differ, considering the different baseline risks. We have limited information on the included population in this recommendation. Among 87 studies, 12 included patients with initially diagnosed depression, two with relapsed depression, 10 with a mixed population of initially diagnosed and relapsed depression, and the remaining 63 did not specify the type of depression. When using this recommendation to make treatment decisions, readers should consider these factors. ● Implementation Shared decision-making between patients and clinicians is needed when implementing this recommendation especially considering:① the various cost and access, ② the very low certainty of evidence on benefits and harms, and ③ the lack of information on long-term outcomes. ● Other considerations The guideline panel estimated that four weeks of acupuncture therapies cost approximately 520 RMB (78 USD) in Beijing, China, before reimbursement. Extended treatment will generate at least a moderate additional cost (e.g., in Australia, China, and South Korea) and sometimes a large additional cost, such as in Norway and Germany. It poses challenges to patients on both direct costs (of the intervention), indirect costs (time and other expenses), and accessibility. Patients probably accept acupuncture, and it is probably feasible to implement. ● Monitoring and evaluation Clinicians and patients should monitor the symptoms and severity of depression, suicidality, etc. Clinicians should consider providing different or additional treatments if patients' depression worsens

5 Access to the guideline

The guidelines are published on the website of the World Federation of Acupuncture-Moxibustion Societies (WFAS) and the paper version is published by Standards Press of China. In addition, the core content of the guide will be published in English journals. Users can access this guide through the above mentioned channels.

6 Implication for future research

6.1 How this guideline compares to other clinical practice guidelines for the treatment of a major depressive disorder

In the past ten years, the United States, Canada, and China developed six clinical practice guidelines for MDD, including acupuncture therapy as an intervention.

APA [17], American College of Physicians (ACP) [6], CANMAT [26], The Management of Major Depressive Disorder Working Group[148] focused on: ① whether to use acupuncture as a monotherapy; ② whether to use acupuncture as an adjunct intervention with antidepressants and ③ whether to use acupuncture as an adjunct intervention with other non-pharmacologic treatment. A 2014 *China Acupuncture-Moxibustion Society Guideline*[4] addressed acupuncture treatment plans and technique-specific questions, such as acupoints selection and the optimal types of acupuncture.

This guideline covers clinical questions that compare acupuncture and the most frequently used non-pharmacological intervention (recommendations 1 to 2), acupuncture versus or add-on to antidepressants (recommendations 3 to 5), and acupuncture technique and treatment dosage-specific questions: the optimal types of acupuncture (recommendations 6 to 8), treatment frequency and duration (recommendation 9 to 10).

6.2 Strength of this guideline

Our guideline has several strengths. First, we clearly defined the PICO questions and transparently reported the patients, intervention, comparator, and outcomes corresponding to each recommendation. Clearly defined PICO questions help guideline readers compare and evaluate their patients and better apply the recommendations. Second, this guideline conducted systematic reviews, used the GRADE approach to assess the certainty of the evidence, rated the strength of the recommendation, and used the evidence to decision framework for formulating recommendations[33,35]. Besides comprehensively searching English databases, we included major Chinese databases publishing many acupuncture literature. The comprehensive evidence synthesis and transparent recommendation formulation process increased the credibility of the guideline. Third, a global multidisciplinary expert panel including physiatrists, psychiatrists, psychologists, frontline acupuncturists, patients, and a guideline methodologist increased the representativeness and usability of the guideline. Fourth, including two patient representatives in the guideline panel enables our guideline to incorporate patients' perspectives into the recommendations. Finally, implementing a standard conflict of interest management process minimized the biases derived from the guideline. All the above features ensure this guideline adheres to the Institute of Medicine standard for trustworthy guidelines.

6.3 Research gaps

This guideline identified areas in which head-to-head RCTs were absent. Investigators can conduct RCTs acupuncture therapy with non-pharmacological therapies (such as psychotherapy or exercise, body versus scalp acupuncture). In addition, considering patients' concerns about pharmacological interventions' adverse effects[149], comparing non-pharmacological therapies (such as acupuncture, psychotherapy, and exercise) over pharmacological therapy can be another area for future research. To identify the optimal acupuncture therapies to treat MDD, conducting RCTs comparing acupuncture therapies (scalp vs. body acupuncture), optimal acupuncture points prescription (e.g., RCTs comparing GV20, EX-HN3 versus complex acupoints regimen), different acupuncture frequency (once a week versus two times or more), or different acupuncture duration (standard vs. extended duration) can inform optimal clinical practice.

Most of the included trials were at high risk of bias. Future trials can improve their design and execution, especially using appropriate allocation concealment and randomization methods, blind outcome assessors, analysts, and patients (when possible) [150]. Well-designed and conducted randomized controlled trials are needed. Future studies need to design and report safety outcomes, such as severe adverse events, outcomes at longer follow-up times (6 months or longer), and report baseline risk of the included patients.

7 Limitations

Patients and clinicians face many challenges when choosing MDD treatment options. The main limitation of our guideline includes the limited number of questions. The panel only chose the most common and challenging clinical questions in daily practice. In addition, although our guideline has a global scope, including panels from North America, Europe, East Asia, and Australia, the resources, feasibility, and acceptability might vary in different countries and settings. We also dropped two questions (PICO 2 and 6) due to the lack of evidence of head-to-head RCTs. The population baseline risk and medical insurance policy are various among countries, thus, guideline performer should make modifications according to local conditions.

Annex A
Members of guideline working group

The guideline was drafted by the Institute of Acupuncture and Moxibustion of China Academy of Chinese Medical Sciences，Department of Health Research Methods，Evidence，and Impact，McMaster University，Luohu Hospital of Traditional Chinese Medicine，Shenzhen.

A.1 The guidelines development group members

Expert name	Country	Role/Expertise	Organization
Hong Zhao	China	Acupuncturist	Luohu District Hospital of Traditional Chinese Medicine；Institute of Acupuncture and Moxibustion，China Academy of Chinese Medical Sciences
Yu-Qing Zhang	Canada	Guideline methodologist；Traditional Chinese medicine expert	Department of Health Research Methods，Evidence，and Impact，McMaster University；Institute of Acupuncture and Moxibustion，China Academy of Chinese Medical Sciences；CEBIM（Center for Evidence Based Integrative Medicine）-Clarity Collaboration，Guang'anmen Hospital，China Academy of Chinese Medical Sciences；Nottingham Ningbo GRADE Centre，University of Nottingham Ningbo
Richard Musil	Germany	Psychiatrist	Psychiatric Clinic of University Munich（LMU）；Oberberg Fachklinik Bad Tölz
Amir Qaseem	United States of America	Internal medicine physician；Guideline methodologist	American College of Physicians
Yong-Suk Kim	Republic of Korea	Medicine doctor（acupuncture specialist）	Kyung Hee University

(*continued*)

Expert name	Country	Role/Expertise	Organization
Chris Zaslawski	Australia	Acupuncturist	University of Technology Sydney
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Hedi Luxenburger	Germany	Physician, specialized in anesthesia, pain and acupuncture	The International Council of Medical Acupuncture and Related Techniques
Anette Sorensen	Norway	Acupuncturist	Kristiania University College
Hilde Skjerve	Norway	Acupuncturist	Kristiania University College
Zhuo-xin Yang	China	Acupuncturist	Shenzhen Traditional Chinese Medicine Hospital
Hai-bo Yu	China	Acupuncturist	Shenzhen Traditional Chinese Medicine Hospital
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Zhi-qing Wang	China	Psychologist	Guang'anmen Hospital, China Academy of Chinese Medical Sciences
Wei-na Peng	China	Acupuncturist	Guang'anmen Hospital, China Academy of Chinese Medical Sciences
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Xiao-wei Liu	China	Obstetrician	Beijing Obstetrics and Gynecology Hospital, Capital Medical University

(*continued*)

Expert name	Country	Role/Expertise	Organization
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Jun Liu	China	Acupuncturist	Guang'anmen Hospital, China Academy of Chinese Medical Sciences
Yu-jie Zhong	China	Psychologist	Guang'anmen Hospital, China Academy of Chinese Medical Sciences

A.2 The guideline grafting group members

Expert name	Country	Role/Expertise	Organization
Hong Zhao	China	Organize experts, solicit expert opinions, and draft guideline	Luohu District Hospital of Traditional Chinese Medicine; Institute of Acupuncture and Moxibustion, China Academy of Chinese Medical Sciences
Yu-Qing Zhang	Canada	Organize group meetings, organize experts and solicit expert opinions, and draft guideline	Department of Health Research Methods, Evidence, and Impact, McMaster University; Institute of Acupuncture and Moxibustion, China Academy of Chinese Medical Sciences; CEBIM (Center for Evidence Based Integrative Medicine)-Clarity Collaboration, Guang'anmen Hospital, China Academy of Chinese Medical Sciences; Nottingham Ningbo GRADE Centre, University of Nottingham Ningbo
Hui-sheng Yang	China	Solicit expert opinions and text writing	Institute of Acupuncture and Moxibustion, China Academy of Chinese Medical Sciences; Shenzhen Maternity & Child Healthcare Hospital

(*continued*)

Expert name	Country	Role/Expertise	Organization
Yi-xuan Feng	China	Solicit expert opinions and literature evaluation	Institute of Acupuncture and Moxibustion, China Academy of Chinese Medical Sciences; Beijing College of Social Administration
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Han Tang	China	Literature search and sorting	Luohu District Hospital of Traditional Chinese Medicine

Annex B
Abbreviations

Full name	Abbreviation
American College of Physicians	ACP
American Psychiatric Association	APA
Behavioral Activation	BA
Canadian Network for Mood and Anxiety Treatments	CANMAT
Cognitive-Behavioral Therapy	CBT
Clinical Practice Guidelines	CPG
Diagnostic and Statistical Manual of Mental Disorders-5	DSM-5
Evidence to Decision	EtD
Grade of Recommendations Assessment，Development，and Evaluation	GRADE
The Hamilton Depression Scale	HAMD
Interpersonal Therapy	IPT
Monoamine Oxidase Inhibitors	MAOIs
Major Depressive Disorder	MDD
Mean Differences	MDs
Noradrenergic and Specific Serotonergic Antidepressants	NaSSAs
Pittsburgh Sleep Quality Index	PSQI
Randomized Controlled Trial	RCT
Risk Ratios	RRs
Severe Adverse Events	SAE
Serotonin Antagonist and Reuptake Inhibitors	SARIs
Rating Scale for Side Effects	SERS
Standardized Mean Differences	SMDs

(*continued*)

Full name	Abbreviation
Serotonin-norepinephrine Reuptake Inhibitors	SNRIs
Summary of Findings	SoF
Selective Serotonin Reuptake Inhibitors	SSRIs
Tricyclic Antidepressants	TCAs
Tetracyclic Antidepressants	TeCAs
Treatment Emergent Symptom Scale	TESS
The World Federation of Acupuncture-Moxibustion Societies	WFAS
World Health Organization	WHO
World Health Organization Quality of Life	WHOQOL-BREEF

Annex C
Summary of clinical questions

NO.	Clinical questions
1	For adults diagnosed with mild or moderate major depressive disorder（MDD），should we recommend acupuncture alone，acupuncture plus moxibustion，or psychotherapy？
2	For adults diagnosed with mild or moderate MDD，should we recommend acupuncture alone，acupuncture plus moxibustion，or exercise？
3	For adults diagnosed with mild or moderate MDD，should we recommend acupuncture alone，acupuncture plus moxibustion，or antidepressants？
4	For adults diagnosed with mild or moderate MDD，should we recommend acupuncture therapies plus antidepressants or acupuncture therapies alone？
5	For adults diagnosed with mild or moderate MDD，should we recommend acupuncture therapies plus antidepressants or antidepressants alone？
6	For adults diagnosed with mild or moderate MDD who will receive acupuncture therapies，should we recommend body acupuncture or scalp acupuncture？
7	For adults diagnosed with mild or moderate MDD who will receive acupuncture therapies，should we recommend body acupuncture or auricular acupuncture？
8	For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies，should we recommend electro-acupuncture or manual acupuncture？
9	For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies，should we recommend treating patients twice（≤2 times per week）or three times and more a week（≥3 times a week）？
10	For adults diagnosed with mild or moderate MDD and who will receive acupuncture therapies，should we recommend standard treatment duration（≤4 weeks）or extended treatment duration（>4 weeks）？

前　言

本指南的制定旨在为成人轻中度抑郁症的针灸干预提供标准化的推荐方案。

本指南依据世界针灸学会联合会标准工作委员会制定的技术流程和规则研制。

本指南由世界针灸学会联合会(World Federation of Acupuncture-Moxibustion Societies，WFAS)归口并发布。

本指南起草单位：中国中医科学院针灸研究所、深圳市罗湖区中医院(上海中医药大学深圳医院)。

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本指南的制定得到了中华人民共和国科技部-国家重点研发计划中医药现代化研究重点专项针灸优势病种疗效评价国际合作研究项目中针灸治疗优势病种的效应机制研究课题(课题编号：2017YFC1703606)的基金支持。同时也由WFAS(课题编号：WFASRP202001-SC03)资助。

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请注意本指南的某些内容可能涉及专利。本指南的发布机构不承担识别专利的责任。

针灸临床实践指南
成人轻中度抑郁症

1 指南概要

1.1 名词术语

1.1.1

针灸疗法

本指南采用的是世界卫生组织(World Health Organization,WHO)关于针灸疗法的定义。在本指南中,"针灸疗法"广义含义包括传统的体针、艾灸、电针、激光针灸(光针)、微针系统(如耳、面、手和头针),但不包括穴位按压[1]。

1.1.2

针灸

以治疗为目的的针刺或用针刺入人体的方法。本指南包括手针、电针和微针系统,不包括艾灸和激光针灸[1]。

1.1.3

体针

在操作中将针灸针刺入身体或头部的特定穴位,用手进行手法操作,或者配合使用电针。

1.1.4

以印百穴为主穴的体针

以印堂穴(EX-HN3)、百会穴(DU20)为主穴,可以配合其他腧穴的针灸方法。不包括头针和耳针。

1.1.5

头针

头针是微针系统中的一种,在操作中将针灸针刺入头部的特定部位,用手进行手法操作,或者配合使用电针[1]。

1.1.6

耳针

耳针是微针系统中的一种,选取的穴位在耳朵上,以治疗疾病为目的的一种方法[1]。

1.1.7

艾灸

艾灸是一种用点燃的材料(通常是艾草)在身体表面温灼穴位以治疗疾病的治疗方法[1]。

1.1.8

电针

在毫针针刺的基础上,针刺得气后连接电针仪,利用不同波形的脉冲电流,以加强对穴位的刺激,从而达到治疗疾病的一种治疗方法[1]。

1.1.9

激光针灸

激光针灸是体针的一种,是利用激光束照射穴位以防治疾病的方法[1]。

1.1.10

心理疗法

心理疗法指心理治疗或谈话治疗[2]，是一种通过非物质或精神心理手段应对疾病、压力或痛苦的方式。

1.1.11

锻炼

任何特定的陆上运动或体力活动，例如旨在提高力量、运动范围、有氧能力的运动或这些运动的组合。它包括体育锻炼干预，指由运动专业人士教授，或进行定期/持续监督的体育活动，具体包括水上运动、柔韧性运动、有氧运动、力量/阻力运动、运动控制运动、平衡训练、太极拳、瑜伽和普拉提等。

1.1.12

抗抑郁药

本指南中的抗抑郁药包括以下几类：①选择性5-羟色胺再摄取抑制剂（Selective Serotonin Reuptake Inhibitors，SSRIs）：氟西汀、诺氟西汀、帕罗西汀、舍曲林、氟伏沙明、西酞普兰、艾司西酞普兰；②5-羟色胺及去甲肾上腺素再摄取抑制剂（Serotonin-Norepinephrine Reuptake Inhibitors，SNRIs）：文拉法辛、德文拉法辛、度洛西汀；③去甲肾上腺素及特异性5-羟色胺能抗抑郁药（Noradrenergic and Specific Serotonergic Antidepressants，NaSSAs）：米氮平；④5-羟色胺受体拮抗剂和再摄取抑制剂（Serotonin Antagonist and Reuptake Inhibitors，SARIs）：曲唑酮；⑤选择性5-HT_{1A}受体激动剂：丁螺环酮、坦度螺酮；⑥三环类抗抑郁药（Tricyclic Antidepressants，TCAs）：氯咪帕明、阿米替林、多塞平；⑦单胺氧化酶抑制剂（Monoamine Oxidase Inhibitors，MAOIs）：苯乙肼、吗氯贝胺；⑧四环类抗抑郁药物（Tetracyclic Antidepressants，TeCAs）：马普替林、莫氯贝胺；⑨其他：阿戈美拉汀、氯胺酮和黛力新[1-4]。专家小组将黛力新(美利曲辛/氟哌噻吨)纳入的考虑：①美利曲辛是一种三环类抗抑郁药，而氟哌噻吨是抗精神病药，只增加了一些作用；②黛力新(美利曲辛/氟苯噻醇)是中国处方量最大的药物，在奥地利和瑞士也获得了许可[4,5]。

1.1.13

抑郁好转率

基于汉密尔顿抑郁症量表（Hamilton Depression Scale，HAMD）或其他临床医生评定的量表减分率超过50％计算[6]。

1.2 目的

WFAS《针灸临床实践指南　成人轻中度抑郁症》(以下简称本指南)的编写目的在于根据现有临床证据，针对目前针灸治疗成人轻中度抑郁症的国际需求及关注的临床问题，在充分考虑国际适用性的基础上，结合抑郁症患者价值观和意愿，系统研制出帮助临床医生、患者和决策者优化轻中度抑郁症针灸治疗方案的指导性意见。本指南将致力于提高成人轻中度抑郁症针灸治疗技术的有效性、安全性与规范性，促进针灸治疗抑郁症在国际范围内的临床应用推广。

1.3 范围

本指南的适用疾病范围为轻中度抑郁症，不同程度的抑郁症均可以酌情采用针灸治疗。本指南的适用患者为成人轻中度抑郁症患者。

1.4 适用人群

本指南的适用人群为全球范围内与成人轻中度抑郁症临床、教学和科研相关的专业人员，包括：①针灸医师；②中医医师；③精神科、心身医学科或内科医师；④护士；⑤患者和卫生政策制定者；⑥中医药科研机构相关人员；⑦医学院或中医教育培训机构的教师和学生。

1.5 适用场所

本指南的适用环境为全球范围内包含针灸专科的医院、从事针灸学临床工作的基层医院或诊所、包含针灸学专业的医学院校、针灸学相关的科研及评价机构。

1.6 推荐意见汇总

编号	推荐意见	推荐级别	证据质量
1	对于成人轻中度抑郁症患者，如果采用非药物疗法，WFAS 专家组建议使用心理疗法，而不是针灸疗法。	条件性推荐	低
2	对于成人轻中度抑郁症患者，WFAS 专家组建议使用针灸疗法或者抗抑郁药物。	条件性推荐	低
3	对于成人轻中度抑郁症患者，WFAS 专家组建议使用针灸疗法联合抗抑郁药物，而不是单独使用针灸疗法。	条件性推荐	低
4	对于成人轻中度抑郁症患者，WFAS 专家组建议使用针灸疗法联合抗抑郁药物，而不是单独使用抗抑郁药物。	条件性推荐	低
5	对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS 专家组建议使用耳针或者体针疗法。	条件性推荐	极低
6	对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS 专家组建议使用电针或者手针疗法。	条件性推荐	极低
7	对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS 专家组建议使用每周治疗≥3 次，而不是每周治疗≤2 次。	条件性推荐	极低
8	对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS 专家组建议疗程≤4 周，而不是疗程>4 周。	条件性推荐	极低

1.7 联系人

赵宏，深圳市罗湖区中医院，中国中医科学院针灸研究所，电子邮箱：hongzhao2005@aliyun.com。

2 疾病概述

2.1 现代医学定义

抑郁症（Major Depressive Disorder，MDD）是一种以持久而明显的心境低落为特征的情感性精神障碍。临床主要特征为持续情绪低落、活动能力减退、思维与认知功能迟缓，包括焦躁情绪、快感缺失、睡眠障碍、负罪感和反复自杀念头等。抑郁发作持续至少 2 周，既往不存在轻躁狂或躁狂发作且除外精神活性物质或器质性精神障碍[7]。

2.2 流行病学特征

抑郁障碍是2017年全球最常见的非致命疾病之一[8]，而抑郁症是最常见的抑郁障碍[9]。研究报道全球抑郁症的终生患病率为16.2%，12个月患病率为6.6%，影响了全球约3亿人[10-12]。抑郁症发病的年龄分布表明其可能会持续整个生命周期[10]，并且抑郁症会增加糖尿病、心脏病、中风的患病风险，甚至可能导致自杀[12]。研究发现，低下的社会经济地位[13]、工作日损失[14]和认知障碍[15-16]是抑郁症的常见风险因素。

2.3 症状、体征和检查

2.3.1 临床症状

美国精神病学会（American Psychiatric Association，APA）制定的《精神疾病的诊断和统计手册》第5次修订本（Diagnostic and Statistical Manual of Mental Disorders-5，DSM-5）[17]中抑郁症的诊断标准主要包括首次发作的抑郁障碍和复发的抑郁障碍两个方面，不包括双相抑郁。抑郁症典型症状包括心境低落、兴趣和愉快感丧失、精力不济或疲劳感等；其他常见症状包括集中注意和注意的能力降低、自我评价降低、自罪观念和无价值感、认为前途暗淡、悲观、自伤或自杀的观念或行为、睡眠障碍、食欲下降。抑郁障碍的病程持续至少2周。

2.3.2 病情程度

2.3.2.1 轻度抑郁：具有至少2条典型症状和至少2条其他症状，且患者的日常工作和社交活动有一定困难，对患者的社会功能有影响。

2.3.2.2 中度抑郁：具有至少2条典型症状和至少3条（最好4条）其他症状，且患者的工作、社交或家务活动有相当困难。

2.3.2.3 重度抑郁：3条典型症状都存在，并且有至少4条其他症状；症状极为严重或起病非常急骤时，不足2周的病程也可作出诊断；除了在极有限的范围内，患者几乎不可能进行社交、工作或家务活动。

2.3.3 检查

抑郁症的诊断主要依赖临床表现，不需要进行特殊的检查。

2.4 现代医学治疗

目前，药物疗法和心理疗法是临床常用的治疗方法[18]，第二代抗抑郁药通常是中度至重度抑郁症的一线用药，相关系统评价证明了其疗效[17,19-20]，尽管抗抑郁药使用范围广，但其并不对所有抑郁症患者都有效，多达30%的抑郁症患者在服用两种或两种以上类型的抗抑郁药后，其抑郁症状没有改善[21-22]，这被定义为难治性抑郁症。此外，服用抗抑郁药而导致的不良反应发生率从3.1%到31%不等[23-24]，常见不良反应包括恶心、失眠、头痛、腹泻以及眩晕[25]。

APA、加拿大心境障碍与焦虑障碍治疗协作组（Canadian Network for Mood and Anxiety，CANMAT）和印度临床实践指南（Clinical Practice Guidelines，CPG）推荐认知行为疗法（Cognitive-Behavioral Therapy，CBT）、人际治疗（Interpersonal Therapy，IPT））和行为激活（Behavioral Activation，BA）疗法作为治疗抑郁症的一线疗法[17,26-27]。中等质量的证据表明，心理疗法在治疗应答率和缓解率上比常规疗法和等待治疗更有效[28]，大多数心理疗法在12个月随访时仍有显著效果[29]。

但由于成本较高并且可及性较低，心理疗法的普及程度低于药物疗法。抑郁症的严重程度、专业背景、距离和初诊的便利性等诸多因素也是可能导致抑郁症患者的心理治疗转诊率较低，依从性较差的原因[28,30-31]。

针灸治疗心理疾病已有数千年的历史。在美国，890 万重度抑郁症患者使用针灸治疗[3]。低质量的证据显示针灸联合抗抑郁药物可以减轻抑郁症的严重程度[5,32]。

3 指南制定过程

3.1 临床问题的确定

3.1.1 临床问题的调研

指南起草小组和专家组共同讨论整理了与针灸治疗抑郁症相关的临床普遍关注的问题。利用问卷星(www.wjx.cn)开发的在线调查问卷，对 10 个临床问题进行了优先性排序。见图 1。指南解决了 8 个临床问题，放弃了没有直接或间接证据支持的 2 个问题(PICO 2、PICO 6)。

3.1.2 结局指标的调研

专家组对每个临床问题的结局指标以及重要性进行了选择和定义，并使用 9 分制对结局指标的重要性进行了评级[33]。专家小组将以下结局指标评为对所有临床问题都至关重要的结局：抑郁严重程度、严重不良反应发生总数、抑郁好转率。临床问题 3 和临床问题 4 有两个额外的至关重要结局：与药物相关的不良反应发生总数和不良事件总数。临床问题 4 中生活质量也是至关重要的结局指标。重要结局指标包括生活质量、失眠、疲劳、严重不良事件总数、药物使用或其他干预措施的使用变化、药物相关不良事件。

3.1.3 临床问题的确定

专家组总结了 5 类最受关注的临床问题：①针灸疗法与最常用的治疗抑郁症的非药物疗法相比如何？②针灸与抗抑郁药相比如何？③针灸联合抗抑郁药使用是否比单独使用针灸或者抗抑郁药更好？④不同穴位选择和刺激方法是否会影响针灸治疗效果和安全性？⑤针灸疗法的疗程和治疗频率对疗效和安全性有什么影响？在这 5 大类问题层次上，专家组通过讨论提炼并确定了 10 个临床问题(见图 1)。

	临床问题	PICO 问题
非药物疗法	针刺疗法是成人抑郁症的最佳非药物疗法吗？	**PICO 1:** 对于成人轻中度抑郁症，如果采用非药物疗法，应该推荐单纯针刺、针刺加灸法，还是心理疗法？ **PICO 2:** 对于成人轻中度抑郁症，如果采用非药物疗法，应该推荐单纯针刺、针刺加灸法，还是锻炼？（放弃，未作出推荐）
药物疗法 vs 针灸疗法	针灸和抗抑郁药效果更好吗？	**PICO 3:** 对于成人轻中度抑郁症，应该推荐单纯针刺、针刺加灸法，还是抗抑郁药物？
联合疗法 vs 药物疗法或针灸疗法	将多种疗法联合运用会改善结局吗？	**PICO 4:** 对于成人轻中度抑郁症，应该推荐针灸联合抗抑郁药物，还是针灸疗法？ **PICO 5:** 对于成人轻中度抑郁症，应该推荐针灸疗法联合抗抑郁药物，还是单纯使用抗抑郁药物？
不同穴位选择和针灸种类影响如何	当穴位选择不同时针灸的疗效会不同吗？ 电针疗效比手针好吗？	**PICO 6:** 对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐体针还是头针疗法？（放弃，未作出推荐） **PICO 7:** 对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐耳针还是体针疗法？ **PICO 8:** 对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐电针还是手针疗法？
不同针灸疗法的疗程和治疗频率影响如何	最佳针灸治疗频率和疗程是？	**PICO 9:** 对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐每周治疗≤2 次，还是每周≥3 次的治疗频次？ **PICO 10:** 对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐≤4 周，还是>4 周的疗程？

图 1　**PICO 问题**

3.2 证据体的检索、评价与综合

3.2.1 文献检索策略

检索策略由医学检索专业人员、方法学家以及专家组主席共同制定。一篇关于针灸治疗抑郁症的 Cochrane 系统评价检索了 2016 年 6 月之前的相关文献[1]，但没有纳入艾灸相关文献，并且没有检索中文数据库。因此，首先对 Cochrane 系统评价中的文献进行了更新，检索了 2016 年 7 月至 2021 年 5 月之间的文献，其次增加检索了关于艾灸治疗抑郁症的英文文献（从建库至 2021 年 5 月），最后系统检索了中文数据库中关于针刺和艾灸治疗抑郁症的相关文献（从建库至 2021 年 5 月）。检索的数据库包括：中国生物医学文献数据库、中国知网、国家知识基础设施数据库、中国学术期刊数据库、中文科技期刊数据库、PubMed、Embase、和 Cochrane Library。2023 年 9 月 14 日，再一次更新了文献。

3.2.2 文献筛选和证据合成

3 名研究者（杨会生、丰逸轩、徐玉芹）使用标准化的数据提取表从原始文献中独立提取数据，2 名研究者（范琦、崔硕）进行数据核查以保证数据提取的准确性。分歧通过讨论协商解决，如未能解决，则由另外一名研究者进行判定（赵宏或者张誉清）。提取患者特征、诊断、干预、对照、随访疗程以及结局指标等信息。

采用 Cochrane ROB 工具对纳入的随机对照试验（Randomized Controlled Trial，RCT）进行偏倚风险评估[34]。我们根据以下领域对偏倚风险进行评估：随机序列生成、分配隐藏、患者和研究人员盲法、结局评估者盲法、结局数据完整性、选择报告和其他偏倚，每项条目可被评价为低风险、高风险、不清楚。2 名研究者（杨会生、丰逸轩）独立进行偏倚风险评估，分歧通过与另外一名研究者（张誉清）讨论解决。

采用 Review Manager 5.4 软件进行统计分析，二分类变量采用相对危险度（Risk Ratios，RRs）和相应的 95％置信区间表示；连续型变量采用均数差（Mean Differences，MDs）和相应的 95％置信区间表示，但若采用不同的测量工具对结局指标进行测量，则采用标准化均数差（Standardized Mean Differences，SMDs）和相应的 95％置信区间表示。采用 χ^2 检验和 I^2 进行异质性检验。如果 $I^2<50\%$，则采用固定效应模型进行统计分析，否则采用随机效应模型。同时，根据不同的针灸疗法（如手针、电针、针刺联合艾灸、耳针）以及不同种类的抗抑郁药进行了亚组分析，并对每个亚组分析进行显著性检验。

系统评价小组使用 GRADEpro GDT 软件生成证据概要（Summary of Findings，SoF）表和证据决策（Evidence to Decision，EtD）表框架，以总结系统评价的所有证据[35]。所有 EtD 表包含关于有效性和安全性、患者价值观和偏好、资源花费、可行性、可接受性和公平性的证据。

3.3 推荐意见的形成

①起草组在线上会议开会之前将临床问题的 EtD 框架和证据概要表通过电子邮件发送给专家组成员进行审查；②通过 9 次在线视频会议，专家组评估和讨论了干预的利弊、证据质量、患者的价值观和偏好、资源使用、可行性、可接受性和公平性，采用推荐分级的评估、制定和评价（Grade of Recommendations Assessment，Development，and Evaluation，GRADE）方法对推荐意见强度进行评级；③通过讨论，专家组就推荐意见的强度和方向及意见达成了共识，在极少数情况下，专家组使用在线投票的方式达成共识，对于强推荐，要求 80％的多数票支持，同时记录其他意见，并应专家组的要求记录了对 EtD 的任何异议意见；④所有专家组成员审查并同意了所有推荐意见和指南手稿。

4 推荐意见

临床问题 1:对于成人轻中度抑郁症,如果采用非药物疗法,应该推荐单纯针刺、针刺加灸法,还是心理疗法?

(1) 推荐意见

对于成人轻中度抑郁症患者,如果采用非药物疗法,WFAS 专家组建议使用心理疗法,而不是针灸疗法。(有条件地推荐,低质量证据)

(2) 证据概述

- **选择该临床问题的理由**

药物疗法和非药物疗法是临床常用治疗抑郁症的疗法。非药物疗法中的心理疗法、补充替代疗法、锻炼是治疗抑郁症的一线疗法[36-38]。针灸疗法和心理疗法也是常用治疗抑郁症的非药物疗法[32,39]。为了确定最佳的非药物疗法,专家组评估了针灸和心理治疗的相对有效性和安全性。

- **证据总结**

本临床问题共纳入了 1 篇直接比较针灸疗法和心理疗法的 RCT[39]。该 RCT(n=58)报告了治疗结束时的抑郁症严重程度,采用汉密尔顿抑郁量表进行评估;并评估了治疗 8 周时抑郁好转率。

- **有利效果、不利效果和负担**

与心理疗法相比,针灸疗法对改善治疗结束时抑郁的严重程度(MD,−0.44;95%CI,−2.05～1.17;低质量)和抑郁好转率(RR,1.14;95%CI,0.69～ 1.88;ARR,68 more per 1 000 patients;95% CI,150 fewer～ 425 more;低质量)上几乎没有影响。

由于缺乏相关数据,生活质量、疲劳、失眠、药物使用或其他干预措施的使用变化这 4 个结局指标未能进行评估。关于针灸疗法的严重不良事件及不良事件未见报道。

一篇系统评价[40]的间接证据总结了 453 项随机对照试验(n=36 702),比较了心理疗法与最低限度控制组(等待名单、常规护理、安慰剂药物或其他控制手段,如宣传册或一般讨论小组)在 MDD 患者中的总体效应大小(SMD, −0.75, 95% CI,−0.67～−0.82)。敏感性分析只包括风险低的研究(n=120),SMD 为−0.51(95% CI,0.42～0.60)。一项 Cochrane 综述比较了针灸与最低限度控制组(无治疗、等待名单、常规治疗),发现针灸可能会在治疗结束时减轻抑郁症的严重程度(SMD,−0.66,95% CI,−1.06～−0.25;低质量)。

- **证据质量**

由于存在严重的偏倚风险和严重的不精确性,治疗结束时抑郁的严重程度和抑郁好转率的证据质量被判断为低。

(3) 推荐说明

- **专家讨论和结论**

①与心理治疗相比,针灸治疗在轻度或中度抑郁症中显示出不明确的理想效果,证据质量较低。

②由于缺乏证据,针灸疗法在治疗抑郁症时的严重不良事件和不良事件尚不清楚。

③间接证据显示,与心理治疗相比,针灸治疗在轻度或中度抑郁症中显示出微弱的效果,证据的质量较低。间接证据还显示,与最低程度的控制相比,心理治疗可能会减轻抑郁症的严重程度。虽然费用相似,但与针灸治疗相比,更多国家的医疗保险覆盖了心理治疗。

（续）

总之，无论是针灸治疗还是心理治疗，对病人来说都是一个很好的选择，但后者在更多的场合可能更容易获得，而且费用更低。

- **实施考虑**

在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①成本、可及性的不同；②有利效果证据质量低；③缺乏严重不良事件和其他不良影响的信息。

- **其他考虑**

本指南专家组认为针灸和心理疗法的疗效、可及性以及成本是影响其治疗抑郁症患者的重要因素。在中国北京，医保报销前的 6 周针灸治疗（3 次/周～5 次/周）和心理疗法（1 次/周）的直接花费分别为 2 340 人民币～3 900 人民币（345 美金～574 美金）和 234 人民币～300 人民币/3 600 人民币（35 美元～44 美元/531 美元）（公立/私立）。考虑到不同国家和地区医疗保险对针灸疗法和心理疗法的覆盖程度差异较大，其成本差异也较大。专家小组指出，与针灸相比，更多国家（如德国、澳大利亚）的医疗保险覆盖心理疗法，而一些国家（如中国和韩国）的医疗保险同时覆盖这两种治疗方法。

临床问题 2：对于成人轻中度抑郁症，如果采用非药物疗法，应该推荐单纯针刺、针刺加灸法，还是锻炼？
（1）推荐意见
未作出推荐。
（2）证据概述
在这个临床问题上没有发现直接和间接的证据，因此无法进行评估。未来需要直接比较锻炼和针灸疗法的研究。

临床问题 3：对于成人轻中度抑郁症，应该推荐单纯针刺、针刺加灸法，还是抗抑郁药物？
（1）推荐意见
对于成人轻中度抑郁症患者，WFAS 专家组建议使用针灸疗法或者抗抑郁药物。（有条件地推荐，低质量证据）
（2）证据概述
• **选择该临床问题的理由** 在基层医疗环境中，一些国家（如澳大利亚和新西兰皇家精神病学院临床实践指南）建议主要使用抗抑郁药治疗抑郁症[41]。最常用的抗抑郁药包括选择性 5-HT 再摄取抑制剂、选择性 5-HT 及 NE 再摄取抑制剂、三环类抗抑郁药和单胺氧化酶抑制剂[42]。近年来，越来越多的抑郁症患者寻求针灸治疗[43]。为了确定最佳的抑郁症治疗方案，专家组评估了针灸和抗抑郁药治疗轻中度抑郁症的有效性和安全性。

（续）

- **证据总结**

本临床问题共纳入了 43 篇直接比较针灸疗法和抗抑郁药的 RCT [42,44-85]。其中 40 篇 RCT（n=3 178）报告了治疗结束时抑郁的严重程度（6.1 周），由 HAMD-17 或 HAMD-24 量表评估；34 篇 RCT（n=2 790）报告了治疗结束时抑郁好转率（5.9 周）；1 篇 RCT（n=60）报告了随访 6 个月时抑郁好转率；5 篇 RCT（n=455）报告了治疗结束时不良反应发生总数（6 周）；10 篇 RCT（n=635）报告了治疗结束时不良反应的严重程度（5.6 周），由 Asberg 氏抗抑郁剂副反应量表（Tating Scale for Side Effects，SERS）或副反应量表（Treatment Emergent Symptom Scale，TESS）评估；1 篇 RCT（n=60）报告了治疗结束时生活质量（4 周），采用世界卫生组织生活质量（World Health Organization Quality Of Life，WHOQOL-BREEF）量表评估；5 篇 RCT（n=330）报告了治疗结束时失眠情况（8.4 周），其中的 4 篇 RCT（n=215）采用 HAMD 睡眠障碍量表评估，1 篇 RCT 采用匹兹堡睡眠质量指数（Pittsburgh Sleep Quality Index，PSQI）量表评估。

在纳入的 43 篇研究中，关于主穴的选择，10 篇选择了头部穴位，2 篇选择了头部穴位和体穴，14 篇选择了百会、印堂和体穴，10 篇选择了百会和体穴，4 篇选择了背俞穴，3 篇选择了体穴。17 篇研究采用了电针，其中 5 篇采用了连续波，3 篇采用了抗抑郁波，2 篇采用了疏密波，1 篇采用了间歇波，剩下 6 篇未具体描述所采用的抑郁波型。不同类型的电针波型可能对疗效有不同程度的影响。针刺联合艾灸（温针灸或单独使用针刺加艾灸）优于单独使用手针或电针。

纳入的 43 篇研究中，包括以下几种抗抑郁药：SSRIs（n=32），TCAs（n=6），NaSSAs（n=2），和其他种类抗抑郁药（n=3）。

- **有利效果**

证据显示，与抗抑郁药相比，针灸可能可以改善治疗结束时抑郁的严重程度（SMD，－0.53；95％CI，－0.77～－0.29；低质量）。与抗抑郁药相比，无论单纯针刺还是手针（RR，1.18；95％CI，1.09～1.27；ARR，107 more per 1 000 patients；95％ CI，54 more～161 more；低质量；RR，1.23；95％CI，1.11～1.37；ARR，127 more per 1 000 patients；95％ CI，61 more～204 more；低质量）均可较小程度地提高抑郁好转率。与抗抑郁药相比，电针在改善抑郁好转率上几乎无影响（RR，1.03；95％CI，0.99～1.11；ARR，20 more per 1 000 patients；95％ CI，7 fewer～73 more；低质量）。针刺联合艾灸在治疗结束时能提高抑郁好转率（RR，1.36；95％CI，1.16～1.59；ARR，220 more per 1 000 patients；95％ CI，98 more～360 more；低质量）。

关于治疗结束时生活质量情况，与抗抑郁药相比，针灸疗法可能不会增加生理领域得分（MD，2.86；95％CI，1.76～3.96；低质量）、心理领域得分（MD，2.76；95％CI，2.12～3.40；低质量），可能不会降低社会领域得分（MD，－0.34；95％CI，－1.10～0.42；低质量），也不会降低环境领域得分（MD，－0.20；95％CI，－0.71～0.31；低质量）。

与抗抑郁药相比，在治疗结束时，针灸疗法可以大幅降低汉密尔顿睡眠障碍评分（MD，－1.6；95％CI，－2.00～－1.21；低质量），可能改善失眠（使用 PSQI 量表评估时）（MD，－1.37；95％CI，－2.44～0.30；低质量），但是证据非常不确定。针灸疗法在降低不良事件的风险（RR，0.11；95％ CI，0.05～0.23；ARR，246 fewer per 1 000 patients；95％ CI，263 fewer～213 fewer；低质量）和降低不良事件的严重程度（SMD，－2.15；95％CI，－3.01～－1.29；低质量）上呈现出大效应。与抗抑郁药相比，手针、电针和针刺联合艾灸疗法均能大幅降低治疗结束时不良事件的严重程度（SMD，－2.31；95％CI，－3.38～－1.25；低质量；SMD，－0.41；95％CI，－0.81～－0.01；低质量；SMD，－3.34；95％CI，－4.70～－2.17；低质量）。由于缺乏数据，无法评估药物使用或其他干预措施的使用变化。

- **不利效果和负担**

针灸疗法对严重不良事件的影响未见报道，不利效果被评估为不清楚。

（续）

● **证据质量** 由于存在严重的偏倚风险和严重的不精确性，治疗结束时抑郁的严重程度、抑郁好转率、不良反应总数和生活质量的证据质量被判断为低。由于严重的偏倚风险和严重的不一致性，治疗结束时，不良反应严重程度和 HAMD 睡眠障碍评分的证据质量被判断为低。由于存在严重的偏倚风险、严重的不精确性和严重的不一致性，治疗结束时失眠的证据质量被判断为低。
（3）**推荐说明**
● **专家讨论和结论** ①低质量证据表明，与抗抑郁药相比，针灸疗法中等程度地降低了抑郁的严重程度，小程度地改善了治疗结束时抑郁好转率，在很大程度上减少了治疗结束时不良事件发生总数和 HAMD 睡眠障碍评分。 ②针灸疗法的不利效果尚不清楚，但确有大量证据证明抗抑郁药的作用。在所有现有的抗抑郁药中，目前的证据仅包括某些类型的抗抑郁药。在考虑可行性和成本（直接和间接证据）时，针灸和抗抑郁药之间的选择可能因不同环境和患者而异。 基于此，专家组认为针灸疗法的临床优势（利弊平衡）超过了其更高的价格以及患者价值观和偏好的可能重要的不确定性或可变性，针灸疗法或抗抑郁药都是治疗抑郁症患者较好的临床疗法，需要医患共同决策。因此，专家组建议在治疗成人轻中度抑郁症患者时可以采用任意两种方法之一。 ● **亚组考虑** 原发性、复发和难治性抑郁症患者基线风险不同，本推荐中包含的人员诊断信息有限。在所有纳入的研究中，我们有 1 项研究包括原发性抑郁症的患者，3 项研究包括原发性和复发抑郁症的混合人群，其余 39 项研究未明确说明包括的抑郁症类型。指南读者在使用本指南推荐意见作出治疗决定时应考虑这些因素。 ● **实施考虑** 在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①成本、可及性的不同；②有利效果证据质量低；③缺乏严重不良事件和其他不良影响的信息。 ● **其他考虑** 在中国北京，医保报销前的 6 周针灸治疗（3 次/周～5 次/周）和抗抑郁药（1 次/天）的直接花费分别为 2 340 人民币～3 900 人民币（345 美金～574 美金）和 76 人民币～941 人民币（11 美金～86 美金）。考虑到不同国家和地区医疗保险对针灸疗法和抗抑郁药的覆盖范围差异较大，其成本差异也较大。 在挪威、澳大利亚和德国等国家，患者需要私人保险才能接受针灸治疗，推荐针灸治疗抑郁症可能会增加健康公平性，因为它将鼓励针灸的保险覆盖率。在中国和韩国，由于医保均覆盖抗抑郁药和针灸，因此对公平性没有影响。 在各国，患者、临床医生（包括针灸医生和其他临床医生）都认为针灸是一种较好的治疗选择。考虑到医疗系统的能力、针灸医生/临床医生向抑郁症患者提供针灸治疗的可用性和技能，针灸疗法的可及性仍存在一些不确定性。 ● **监察与评估** 临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

临床问题 4:对于成人轻中度抑郁症,应该推荐针灸联合抗抑郁药物,还是针灸疗法?
(1) 推荐意见
对于成人轻中度抑郁症患者,WFAS专家组建议使用针灸疗法联合抗抑郁药物,而不是单独使用针灸疗法。(有条件地推荐,低质量证据)
(2) 证据概述
• 选择该临床问题的理由 针灸有可能成为治疗抑郁症有效、安全和耐受性良好的单一疗法[5-6,86]。抑郁症患者经常会寻求针灸治疗[86]。然而,有时单独应用针灸治疗可能不够,因此,专家组认为评估针灸联合抗抑郁药治疗是否比单独使用针灸治疗更好是重要的。 • 证据总结 本临床问题共纳入了5篇直接比较针灸联合抗抑郁药疗法和单独使用针灸疗法的RCT[55,60,75,85,87]。其中4篇RCT(n=277)报告了抑郁的严重程度,由HAMD-17或HAMD-24量表评估;5篇RCT(n=316)报告了抑郁好转率,1篇RCT(n=39)报告了生活质量,由SF-36量表评估;2篇RCT(n=165)报告了治疗结束时不良反应发生总数。 在纳入的5项研究中,关于主穴的选择,4篇选择了头部穴位,1篇选择了体穴。4篇研究采用了电针,其中2篇使用连续波,2篇使用疏密波。 涉及的抗抑郁药只有SSRIs。 • 有利效果 与单用针灸疗法相比,在治疗结束时,针灸联合抗抑郁药在改善抑郁的严重程度(SMD,−0.38;95%CI,−0.61～−0.14;低质量)和生活质量(MD,56.06;95%CI,−52.85～164.97;低质量)上呈现小效应,在改善抑郁好转率上呈现中等效应(RR,1.54;95%CI,1.24～1.90;ARR,215 more per 1 000 patients;95% CI,96 more～359 more;低质量),在减少不良事件发生总数上呈现微小效应(RR,0.98;95% CI,0.30～3.17;ARR,1 fewer per 1 000 patients;95% CI,42 fewer～131 more;低质量)。 由于缺乏数据,无法评估疲乏、失眠和药物使用或其他干预措施的使用变化。 • 不利效果和负担 针灸联合抗抑郁药物疗法对严重不良事件的影响未见报道,也没发现其他不利效果的证据,因此不利效果被评估为不清楚。 • 证据质量 由于存在严重的偏倚风险和严重的不精确性,抑郁的严重程度、抑郁好转率、不良反应总数和生活质量的证据质量被判断为低。
(3) 推荐说明
• 专家讨论和结论 ①低质量证据表明,与单纯使用针灸疗法相比,针灸联合抗抑郁药物疗法小程度地降低了抑郁的严重程度和生活质量,中等程度地改善了治疗结束时抑郁好转率。 ②针灸联合抗抑郁药物疗法的不利效果尚不清楚。在所有针灸疗法中,目前收集的证据中仅包括电针。在考虑可行性和成本(直接和间接证据)时,针灸联合抗抑郁药和单用针灸疗法之间的选择可能因不同环境和患者而异。

（续）

总之，专家组认为针灸联合抗抑郁药物疗法的临床优势（利弊平衡）超过了其更高的价格以及患者价值观和偏好的可能重要的不确定性或可变性。相较于单用针灸疗法而言，针灸联合抗抑郁药治疗可能对抑郁症患者来说是更好的选择。需要医患共同决策。

- **亚组考虑**

纳入的5项研究均未明确其纳入的患者为原发性抑郁症还是复发性抑郁症。

- **其他考虑**

在中国北京，医保报销前的6周针灸（3次/周～5次/周）联合抗抑郁药（1次/天）的直接花费为2 416人民币～4 841人民币（361美金～723美金）。如果有与抗抑郁药相关的严重不良事件发生，间接成本可能相当大。不同国家和地区的各种保险可能会影响患者的可接受性。

对于健康公平性，专家组一致认为，除美国外，对大多数国家几乎没有影响，在美国，考虑到成本和可获得性，增加抗抑郁药治疗可能会降低公平性。在各国，患者、临床医生（包括针灸医生和其他临床医生）均可能能够接受针灸和抗抑郁药治疗，并且疗法可行。

- **监察与评估**

临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

临床问题5：对于成人轻中度抑郁症，应该推荐针灸疗法联合抗抑郁药物，还是单纯使用抗抑郁药物？

（1）推荐意见

对于成人轻中度抑郁症患者，WFAS专家组建议使用针灸疗法联合抗抑郁药物，而不是单独使用抗抑郁药物。（有条件地推荐，低质量证据）

（2）证据概述

- **选择该临床问题的理由**

抗抑郁药是治疗抑郁症的一线药物疗法。尽管药物干预缓解了50%完成治疗的抑郁症患者的抑郁症状，但还有47%的患者没能起效。对抗抑郁药无反应的发生率在19%～34%，高达约50%的患者在持续抗抑郁药治疗后仍未能实现并维持完全缓解或出现抑郁复发[88-93]。当患者对单一疗法没有反应时，在抗抑郁药物治疗的基础上增加针灸治疗可能是不错的选择。因此，专家组决定评估联合治疗对轻中度抑郁症的有效性和安全性。

- **证据总结**

本临床问题共纳入了52篇直接比较针灸联合抗抑郁药物疗法和抗抑郁药的RCT[59, 74, 85, 87, 93-140]。其中45篇RCT（n=3 475）报告了抑郁的严重程度，由HAMD-17或HAMD-24量表评估；38篇RCT（n=2 823）报告了抑郁好转率（平均：6.5周）；3篇RCT（n=647）报告了生活质量，采用WHOQOL-BREEF量表评估；8篇RCT（n=621）报告了采用PSQI量表评估失眠情况，5篇RCT（n=733）报告了采用HAMD睡眠障碍量表评估失眠情况，6篇RCT（n=523）报告了不良反应发生总数；16篇RCT（n=1 205）报告了不良反应的严重程度，由SERS或TESS量表评估；1篇RCT（n=128）报告了药物使用或其他干预措施的使用变化，评估方法是看是否提供了额外治疗。

在纳入的52篇研究中，关于主穴的选择，21篇选择了百会、印堂和体穴，14篇选择了头部穴位，6篇选择了百会和体穴，4篇选择了体穴，3篇选择了耳穴，2篇选择了头部穴位和体穴。19篇研究采用了电针，其中6篇采用了连续波，12篇采用了疏密波，剩下1篇未具体描述所采用的抑郁波型。

（续）

纳入的52篇研究中，包括以下几种抗抑郁药：SSRIs（$n=45$），SNRIs（$n=2$），5-HT_{1A}（$n=2$），NaSSAs（$n=1$），和其他种类抗抑郁药（$n=2$），还有1篇未明确报告所用何种抗抑郁药。

- **有利效果**

与抗抑郁药相比，针灸联合抗抑郁药物在改善抑郁的严重程度上呈现大效应（SMD，－1.22；95％CI，－1.43～－1.00；低质量）。在改善抑郁好转率上呈现中等效应（RR，1.36；95％CI，1.25～1.46；ARR，163 more per 1 000 patients；95％CI，113 more～209 more；中等质量）。与抗抑郁药相比，针灸联合抗抑郁药物对改善生活总体质量（MD，0.26；95％CI，0.13～0.38；中等质量）、一般健康领域（MD，0.25；95％CI，0.11～0.35；中等质量）、生理健康领域（MD，1.22；95％CI，0.33～2.11；中等质量）、心理健康领域（MD，1.11；95％CI，0.45～1.77；中等质量）、环境领域（MD，0.51；95％CI，0.17～0.84；中等质量）、社会领域（MD，0.28；95％CI，－0.10～0.67；低质量）几乎没有影响。与抗抑郁药相比，针灸联合抗抑郁药物对治疗结束时采用PSQI评估的失眠的改善作用不明确（MD，－2.28；95％CI，－4.17～－0.38；极低质量），对采用HAMD睡眠障碍评估的失眠几乎没有影响（MD，－0.73；95％CI，－1.40～－0.06；低质量），但可能会减少增加抗抑郁药物使用的人数（RR，0.32；95％CI，0.14～0.75；ARR，156 fewer per 1 000 patients；95％ CI，197 fewer～57 fewer；低质量）。

与抗抑郁药相比，针灸联合抗抑郁药物在治疗6周时（MD，－0.55；95％ CI，－1.97～0.87；低质量）和随访4周时（MD，－1.80；95％CI，－4.09～0.49；低质量）可能会导致药物使用的轻微变化（帕罗西汀，mg/天，服用剂量）。

与抗抑郁药相比，针灸联合抗抑郁药物可能降低不良事件的风险（RR，0.25；95％ CI，0.14～0.44；ARR，173 fewer per 1 000 patients；95％ CI，193 fewer～123 fewer；中等质量），在改善不良事件的严重程度上呈现大效应（SMD，－1.41；95％CI，－1.81～－1.01；低质量）。

- **不利效果和负担**

针灸疗法对严重不良事件的影响未见报道，根据间接证据最后不利效果被评估为微小[5]。

- **证据质量**

由于存在严重的偏倚风险，治疗结束时抑郁好转率、不良反应总数和生活质量的证据质量被判断为中等。由于严重的偏倚风险和严重的不一致性，抑郁的严重程度证据质量被判断为低。由于严重的偏倚风险和严重的不精确性，不良反应严重程度和药物使用或其他干预措施的使用变化的证据质量被判断为低。由于存在严重的偏倚风险、严重的不精确性和严重的不一致性，失眠的证据质量被判断为极低。

（3）推荐说明

- **专家讨论和结论**

①低质量证据显示，针灸联合抗抑郁药物疗法在改善抑郁的严重程度和不良事件的严重程度上呈现大效应，在改善不良事件发生总数上呈现中等效应，在提高抑郁好转率、改善药物使用剂量和减少增加抗抑郁药物使用的人数呈现小效应。

②针灸疗法在不利效果上呈现微小效应。在考虑成本时，在抗抑郁药中加入针灸治疗可以增加中等程度的成本，并且在不同国家差异较大。

总而言之，针灸联合抗抑郁药治疗可能对抑郁症患者来说是较好的选择。专家组建议在治疗轻中度抑郁症时可以选择针灸联合抗抑郁药治疗而不是单独使用抗抑郁药。

（续）

- **亚组考虑**

原发性、复发和难治性抑郁症患者基线风险不同，本推荐中包含的人员诊断信息有限。在所有纳入的研究中，我们有11项研究包括原发性抑郁症的患者，2项研究包括复发性抑郁症的患者，7项研究包括原发性和复发抑郁症的混合人群，其余28项研究未明确说明包括的抑郁症类型。指南读者在使用本指南推荐意见作出治疗决定时应考虑这些因素。

- **实施考虑**

在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①成本、可及性的不同；②有利效果证据质量低；③缺乏严重不良事件和其他不良影响的信息。

- **其他考虑**

专家组认为，在抗抑郁药中加入针灸治疗可以增加中等程度的成本，特别是在患者需要自付针灸费用的国家。尽管存在成本和可及性的挑战，但在患者和临床医生中实施针灸联合抗抑郁药疗法可能是可接受和可行的。

- **监察与评估**

临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

临床问题6：对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐体针还是头针疗法？
（1）推荐意见
未作出推荐。
（2）证据概述
在这个临床问题上没有发现直接和间接的证据，因此无法进行评估并作出推荐。未来可以考虑进行直接比较体针和头针的随机对照研究。

临床问题7：对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐耳针还是体针疗法？
（1）推荐意见
对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS专家组建议使用耳针或者体针疗法。（有条件地推荐，极低质量证据）
（2）证据概述
● **选择该临床问题的理由** 不同类型的针灸，如耳针、激痛点针灸，疗效可能会不同[134,135]。耳针和体针是最常见的针灸类型，因此专家组认为评估哪种针灸方式更适合治疗抑郁症非常重要。 ● **证据总结** 在这个临床问题上没有找到直接证据，但是找到一些间接证据，共13篇文献，其中3篇[112,118,136]是耳针联合抗抑郁药和抗抑郁药比较，10篇[59,74,93,98,100,101,109,112,113,134]是体针联合抗抑郁药和抗抑郁药比较。在纳入的13篇研究中，10篇（$n=654$）报告了用HAMD量表评估的抑郁症的严重程度（平均：5.8周），12篇（$n=727$）报告了治疗结束时抑郁好转率（平均：6.3周）。

（续）

在 13 篇研究中，关于主穴的选择，8 项选择了头皮穴位，2 篇选择了耳穴，2 篇选择了百会、印堂和体穴，1 篇选择了耳穴和体穴。10 篇研究采用了电针的疏密波（$n=7$）和连续波（$n=3$）。

最常见的抗抑郁药包括 SSRIs（$n=12$）和其他抗抑郁药（$n=1$）。

- **有利效果、不利效果和负担**

间接证据结果显示：与体针相比，耳针可能可以降低抑郁的严重程度（SMD，−0.20；95%CI，−1.18～0.78；极低质量），但是证据对此非常不确定，在改善抑郁好转率上呈现大效应（RR，1.88；95%CI，1.42～2.48；ARR，525 more per 1 000 patients；95% CI，251 more～884 more；低质量）。

由于缺乏数据，无法评估生活质量、疲乏、失眠、药物使用或其他干预措施的使用变化、严重不良事件和不良事件。

- **证据质量**

由于存在严重的偏倚风险和间接性，抑郁好转率证据质量被判断为低。由于严重的偏倚风险、间接性和不精确性，抑郁的严重程度证据质量被判断为极低。

（3）推荐说明

- **专家讨论和结论**

①极低质量证据显示，关于耳针对治疗结束时抑郁症严重程度的影响以及治疗结束时抑郁症好转率的影响，证据非常不确定。

②针灸对严重不良事件和不良事件的影响尚不清楚。在考虑可行性和成本（直接和间接证据）时，耳针和体针之间的选择可能因不同环境和患者而异。

然而，耳针疗法的成本低于体针，两者都有极低质量的证据，耳针对抑郁好转率表现出更大的影响。需要医患共同决策。

- **亚组考虑**

原发性、复发和难治性抑郁症患者基线风险不同，本推荐中包含的人员诊断信息有限。在所有纳入的研究中，有 4 项研究包括原发性抑郁症的患者，3 项研究包括原发性和复发抑郁症的混合人群，其余 6 项研究未明确说明包括的抑郁症类型。指南读者在使用本指南推荐意见作出治疗决定时应考虑这些因素。

- **实施考虑**

在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①成本、可及性的不同；②有利效果证据质量低；③缺乏严重不良事件和其他不良影响的信息。

- **其他考虑**

在中国北京，医保报销前的 6 周体针（3 次/周～5 次/周）治疗和耳针（1 次/周～3 次/周）治疗的直接花费分别为 2 340 人民币～3 900 人民币（350 美金～583 美金）和 936 人民币～2 808 人民币（140 美金～420 美金）。

在德国、韩国、美国和中国等许多国家，考虑到治疗频率较低，与体针相比，耳针为患者节省了直接和间接的费用。在其他国家，耳针通常作为体针的附加疗法，因此对成本的影响可能很小。

对于健康公平性，专家组认为对不同国家影响不同，因为在一些国家，精神科医生和针灸医生都能提供耳针疗法，而在其他国家，只有针灸医生可以提供体针和耳针治疗。

在不同的国家，患者、临床医生（包括针灸医生和其他临床医生）可能都能接受耳针和体针疗法，并且它是可行的。

- **监察与评估**

临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

临床问题8:对于成人轻中度抑郁症,如果采用针灸疗法,应该推荐电针还是手针疗法?

(1) 推荐意见

对于成人轻中度抑郁症患者,如果采用针灸疗法,WFAS专家组建议使用电针或者手针疗法。(有条件地推荐,极低质量证据)

(2) 证据概述

- **选择该临床问题的理由**

临床医生在临床上最常用的是手针和电针[32],为了评估哪种针灸方法更适合抑郁症患者,专家组比较了这两种针灸疗法的有效性和安全性。

- **证据总结**

本临床问题共纳入7篇直接比较电针和手针的RCT[113,125,141-145]。其中4篇RCT(n=178)报告了抑郁好转率(平均:6.5周),4篇RCT(n=185)报告了治疗结束时抑郁的严重程度(平均:7.5周),由HAMD-17或HAMD-24量表评估,1篇RCT(n=45)报告了随访3个月时抑郁的严重程度。3篇RCT(n=390)报告了失眠情况,其中2篇研究(n=330)采用HAMD睡眠障碍量表,1篇研究(n=60)采用PSQI量表。1篇研究(n=310)报告了生活质量,采用WHOQOL-BREEF量表评估。1篇研究(n=60)报告了不良反应的严重程度,采用TESS量表评估。所有研究均报告了治疗结束时失眠、生活质量和不良反应。

同时,也分析了相关的间接证据,其中72篇研究(n=4 665)报告了抑郁的严重程度,59篇研究(n=4 931)报告了抑郁好转率,8篇研究(n=948)报告了失眠情况,8篇研究(n=858)报告了不良反应发生总数,22篇研究(n=1 570)报告了不良反应的严重程度(整合针灸疗法vs抗抑郁药和针灸联合抗抑郁药vs抗抑郁药的数据,其对照均为抗抑郁药)。2篇研究(n=537)报告了生活质量(整合针灸联合抗抑郁药vs抗抑郁药的数据),采用WHOQOL-BREEF量表评估。2篇研究(n=128)报告了失眠情况,采用PSQI量表评估(整合针灸vs抗抑郁药的数据)。

在纳入的7篇研究中,针对主穴的选择,2篇选择头部穴位,4篇选择百会、印堂和体穴,1篇选择百会和体穴。7篇研究均使用了电针,其中3篇采用连续波,4篇采用疏密波。

- **有利效果**

与手针相比,电针对治疗结束时的抑郁好转率上几乎无影响(RR,1.18;95%CI,0.87～1.61;ARR,70 more per 1 000 patients;95% CI,51 fewer～238 more;低质量),对治疗结束时抑郁严重程度(SMD,－0.01;95%CI,－0.52～0.51;极低质量)和随访3个月时抑郁严重程度(MD,－3.6;95%CI,－7.11～0.09;极低质量)也几乎无影响,但是证据非常不确定。与手针相比,电针在改善治疗结束时由HAMD睡眠障碍量表评估的失眠(MD,－0.24;95%CI,－0.51～－0.03;低质量)和由PSQI量表评估的失眠(MD,0.86;95%CI,－1.38～3.1;极低质量)上影响非常不确定。与手针相比,电针对治疗结束时的总体生活质量(MD,0.11;95%CI,－0.05～0.27;低质量)、一般健康(MD,0.02;95%CI,－0.16～0.02;低质量)、生理领域得分(MD,0.16;95%CI,－0.33～0.65;低质量)、心理领域得分(MD,－0.33;95%CI,－0.52～0.46;低质量)、环境领域得分(MD,－0.08;95%CI,－0.53～0.37;低质量)和社会领域得分(MD,－0.12;95%CI,－0.63～0.39;低质量)上几乎无影响。

（续）

与手针相比，间接证据显示电针对以下结局几乎无影响：治疗结束时抑郁的严重程度（SMD，0.09；95%CI，−0.46～0.63；极低质量）、抑郁好转率（RR，1.03；95%CI，0.72～1.47；ARR，18 more per 1 000 patients；95% CI，167 fewer～280 more；极低质量）、总体生活质量（MD，0.1；95%CI，−0.25～0.45；极低质量）、一般健康（MD，0；95%CI，−0.38～0.38；极低质量）、生理领域得分（MD，0.01；95%CI，−3.79～3.81；极低质量）、心理领域得分（MD，−0.36；95% CI，−2.57～1.85；极低质量）、环境领域得分（MD，−0.09；95%CI，−1.19～1.01；极低质量）、社会领域得分（MD，−0.09；95%CI，−1.03～5.85；极低质量）、失眠（MD，2.56；95%CI，−0.73～5.85；极低质量）、睡眠障碍（SMD，0.69；95%CI，−0.37～1.75；极低质量）。 由于缺乏数据，无法评估药物使用或其他干预措施的使用变化。 ● 不利效果和负担 在治疗结束时，电针可能会增加副作用用的严重程度（MD，0.04；95%CI，−0.4～0.48；极低质量）以及不良事件的严重程度（SMD，0.73；95%CI，−0.35～ 1.81；极低质量），但证据非常不确定。与手针相比，间接证据显示电针对不良反应发生总数几乎无影响（RR，0.49；95%CI，0.10～2.36；ARR，88 fewer per 1 000 patients；95%CI，155 fewer ～234 more；极低质量）。间接证据显示，电针可能会增加治疗结束时副作用用的严重程度（SMD，0.91；95%CI，−1.42～3.23；极低质量），但证据非常不确定。 ● 证据质量 由于存在严重的偏倚风险和不精确性，治疗结束时抑郁好转率、HAMD 睡眠障碍评分、生活质量证据质量被判断为低。由于严重的偏倚风险、不一致性和不精确性，治疗结束时抑郁的严重程度证据质量被判断为极低。由于严重的偏倚风险和极其严重的不精确性，治疗结束时失眠、不良反应严重程度和随访 3 个月时抑郁的严重程度证据质量被判断为极低。
（3）推荐说明
● 专家讨论和结论 ①极低质量证据显示，与手针相比，电针在改善抑郁好转率、抑郁的严重程度、睡眠障碍、失眠以及生活质量上呈现微小效应。 ②微小地增加治疗结束时不良事件的严重程度。 总而言之，患者的偏好可能没有重要的不确定性或可变性。这两种针灸疗法的成本相似。患者可能会接受针灸疗法，并且实施起来可能是可行的。电针和手针均为治疗抑郁症的良好治疗方案。 ● 亚组考虑 原发性、复发和难治性抑郁症患者基线风险不同，本推荐中包含的人员诊断信息有限。在所有纳入的研究中，有 4 项研究包括原发性抑郁症的患者，其余 3 项研究未明确说明包括的抑郁症类型。指南读者在使用本指南推荐意见作出治疗决定时应考虑这些因素。 ● 实施考虑 在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①轻微的费用差异和可及性的不同；②有利效果直接和间接证据质量极低；③缺乏严重不良事件和其他长期随访结局的信息。 ● 其他考虑 专家组认为，电针或手针的有效性、不良反应、患者的价值观和偏好、可行性、可及性和成本是影响针灸治疗抑郁症的重要因素。 在中国北京，医保报销前的 6 周手针治疗（3 次/周～5 次/周）和电针治疗（3 次/周～5 次/周）的直接花费分别为 2 340 人民币～3 900 人民币（350 美金～583 美金）和 2 790 人民币～4 650 人民币（417 美金～695 美金）。

（续）

如果有与抗抑郁药相关的严重不良事件发生，间接成本可能相当大。不同国家和地区的各种保险可能会影响患者的可接受性。手针和电针的花费相似。

患者的偏好可能没有重要的不确定性或可变性。患者可能可以接受针灸，实施起来可能是可行的。

- **监察与评估**

临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

临床问题9：对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐每周治疗≤2次，还是每周≥3次的治疗频次？（最初的PICO问题是比较每周1次与每周治疗≥2次，由于缺乏证据，因此专家组根据现在的PICO问题的频率的证据作出了推荐）

（1）推荐意见

对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS专家组建议使用每周治疗≥3次，而不是每周治疗≤2次。（有条件地推荐，极低质量证据）

（2）证据概述

- **选择该临床问题的理由**

针灸治疗频次可能会影响治疗效果[79,146]。在不同的国家，临床医生根据他们的经验、保险政策和可行性以不同频次的针灸治疗。针灸频次越高，直接成本和间接成本（例如，时间、生产力、交通、停车）也会更高。因此，确定最佳的针刺频次非常重要。

- **证据总结**

在本临床问题上没有找到直接证据。采用了相关的间接证据，包括48篇有着不同针刺频次（≤2次/周和≥3次/周）比较针灸和抗抑郁药的研究。使用亚组分析估计来计算差异及其方差。41篇RCT（n=3 159）报告了HAMD抑郁量表评估的抑郁严重程度（平均：6.4周），7篇RCT（n=511）报告了PSQI评估的失眠（平均：6.0周），14篇RCT（n=1 056）评估了不良反应的严重程度（平均：6.4周），评估时点均在治疗结束时。

在纳入的48篇研究中，关于主穴的选择，20篇选择了百会、印堂和体穴，14篇选择了头部穴位，6篇选择了百会和体穴，4篇选择了体穴，2篇选择了耳穴，1篇选择了头部穴位和体穴。19篇研究采用了电针，其中6篇采用了连续波，12篇采用了疏密波，剩下1篇未具体描述所采用的抑郁波型。

纳入的48篇研究中，包括以下几种抗抑郁药：SSRIs（n=42），5-HT_{1A}（n=2），NaSSAs（n=1），和其他种类抗抑郁药（n=2），还有1篇未明确报告所用何种抗抑郁药。

- **有利效果、不利效果和负担**

与每周治疗≥3次相比，间接证据显示每周治疗≤2次可能增加治疗结束时抑郁严重程度（SMD，0.75；95%CI，0.01～1.49；极低质量）和不良反应严重程度（SMD，0.48；95%CI，−0.54～1.50；极低质量），但是证据非常不确定。与每周治疗≥3次相比，每周治疗≤2次对失眠的影响非常不确定（MD，−0.52；95%CI，−3.83～2.79；极低质量）。

由于缺乏数据，无法评估抑郁好转率、生活质量、疲乏、药物使用或其他干预措施的使用变化、严重不良事件发生总数和不良事件发生总数。

（续）

- **证据质量**

由于存在严重的偏倚风险、间接性和不精确性，治疗结束时抑郁的严重程度、失眠和严重程度被判断为极低。

（3）推荐说明

- **专家讨论和结论**

①极低质量证据显示，与每周治疗≤2 次相比，每周治疗≥3 次会一定程度增加治疗结束时抑郁严重程度、失眠和不良事件严重程度。

②直接和间接证据均显示更频繁治疗的不良影响主要在于至少会增加中等程度的成本。

- **亚组考虑**

原发性、复发和难治性抑郁症患者基线风险的不同，本推荐中包含的人员诊断信息有限。在所有纳入的研究中，有 11 项研究包括原发性抑郁症的患者，2 项研究包括复发性抑郁症的患者，7 项研究包括原发性和复发抑郁症的混合人群，其余 28 项研究未明确说明包括的抑郁症类型。指南读者在使用本指南推荐意见作出治疗决定时应考虑这些因素。

- **实施考虑**

在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①成本、可及性的不同；②有利效果证据质量极低；③缺乏严重不良事件和其他不良影响的信息。

- **其他考虑**

在中国北京，医保报销前的每周 1 次～2 次共 6 周的针灸治疗约花费 1 560 人民币（233 美金），每周≥3 次共 6 周的针灸治疗约花费 2 340 人民币（350 美金）。

针灸治疗频率因环境而异，更频繁的治疗将增加至少中等程度的成本（例如在澳大利亚、中国和韩国），有时则会产生高额的成本（例如在挪威和德国）。

患者可能可以接受针灸，实施起来可能是可行的。

- **监察与评估**

临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

临床问题 10：对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐≤4 周，还是＞4 周的疗程？

（1）推荐意见

对于成人轻中度抑郁症患者，如果采用针灸疗法，WFAS 专家组建议疗程≤4 周，而不是疗程＞4 周。（有条件地推荐，极低质量证据）

（2）证据概述

- **选择该临床问题的理由**

针灸治疗时间长短可能与针灸治疗效果有关。长期治疗对患者来说成本更高，并且不一定能改善患者的重要结局[147]。因此，专家组认为确定抑郁症的针灸治疗的最佳疗程很重要。

（续）

- **证据总结**

在本临床问题上没有找到直接证据。采用了相关的间接证据，包括87篇有着不同针刺疗程（≤4周和>4周）比较针灸或针灸联合抗抑郁药和抗抑郁药的研究。使用亚组分析估计来计算差异及其方差。78篇RCT（n=6 337）报告了抑郁的严重程度，由HAMD抑郁量表评估（平均：6.3周），64篇RCT（n=5 297）报告了抑郁好转率（平均：6.2周），10篇RCT（n=635）评估了不良反应的严重程度（平均：5.6周），评估时点均在治疗结束时。

在纳入的87篇研究中，针对主穴的选择，33篇选择百会、印堂和体穴，22篇选择头部的穴位，15篇选择百会和体穴，5篇选择背部的穴位，6篇选择体穴，3篇选择头部的穴位和体穴，3篇选择耳穴。34篇研究采用了电针，其中12篇采用了连续波，3篇采用了抗抑郁波，11篇采用了疏密波，1篇采用了间歇波，剩下7篇未具体描述所采用的抑郁波型。

纳入的87篇研究中，包括以下几种抗抑郁药：SSRIs（n=71），TCAs（n=5），5-HT_{1A}（n=2），TeCAs（n=1），NaSSAs（n=2），和其他种类抗抑郁药（n=5），还有1篇研究未报告使用抗抑郁药的种类。

- **有利效果、不利效果和负担**

与治疗>4周相比，治疗≤4周对治疗结束时抑郁好转率（RR，1.08；95% CI，0.81～1.45；ARR，49 more per 1 000 patients；95%CI，116 fewer～276 more；极低质量）几乎无影响，对治疗结束时抑郁的严重程度（SMD，0.02；95%CI，−0.49～0.53；极低质量）和不良反应的严重程度（SMD，0.09；95% CI，−1.98～2.16；极低质量）几乎无影响，但是证据非常不确定。

由于缺乏数据，无法评估生活质量、疲乏、失眠、药物使用或其他干预措施的使用变化、严重不良事件和不良事件。

- **证据质量**

由于存在严重的偏倚风险和不精确性，治疗结束时抑郁好转率证据质量被判断为低。由于严重的偏倚风险、间接性和不精确性，治疗结束时抑郁的严重程度、不良反应的严重程度证据质量被判断为极低。

（3）推荐说明

- **专家讨论和结论**

①低和极低质量证据显示，治疗≤4周和>4周在改善抑郁的严重程度、抑郁好转率和不良事件的严重程度上的差异微小，并且缺乏长期随访的结局。

②在考虑可行性和成本（直接和间接证据）时，治疗≤4周和>4周之间的选择可能因不同环境和患者而异，但是治疗≤4周可以至少中等程度地节约成本。

- **亚组考虑**

原发性、复发和难治性抑郁症患者基线风险的不同，本推荐中包含的人员诊断信息有限。在所有纳入的研究中，有12项研究包括原发性抑郁症的患者，2项研究包括复发性抑郁症的患者，10项研究包括原发性和复发抑郁症的混合人群，其余63项研究未明确说明包括的抑郁症类型。指南读者在使用本指南推荐意见作出治疗决定时应考虑这些因素。

- **实施考虑**

在实施本建议时，需要医患共同决策，特别是考虑到以下因素：①成本、可及性的不同；②有利效果证据质量极低；③缺乏长随随访结局信息。

（续）

● **其他考虑** 在中国北京，医保报销前的 4 周针灸治疗的直接花费为 520 人民币（78 美金）。 大于 4 周的针灸治疗至少会增加中等程度的成本（例如在澳大利亚、中国和韩国），有时会产生巨大的成本（例如在挪威和德国）。这对患者的直接成本（干预）、间接成本（时间和其他费用）和可及性提出了挑战。 患者可能可以接受针灸，实施起来可能是可行的。 ● **监察与评估** 临床医生和患者应监测抑郁症患者的症状、严重程度和自杀企图。如果患者的抑郁症恶化，临床医生应考虑提供不同或额外的治疗。

5 获取途径

本指南在世界针灸学会联合会网站发布，纸质版由中国标准出版社出版。此外，指南的核心内容将于英文期刊发布。用户可通过上述途径获取本指南。

6 未来可开展的研究

6.1 本指南与其他治疗抑郁症的临床实践指南的比较

在过去 10 年中，美国、加拿大和中国制定了 6 项抑郁症临床实践指南，其中包括针灸治疗作为干预措施的指南。

由 APA[17]、美国医师学会（American College of Physicians，ACP）[6]、CANMAT[26]、重性抑郁障碍管理工作组[148]制定的指南侧重于：①是否将针灸作为单一疗法进行使用；②是否将针灸作为抗抑郁药的辅助疗法进行运用；③是否将针灸作为其他非药物治疗的辅助疗法进行运用。2014 年，由中国针灸学会发布的针灸治疗抑郁症指南[4]则解决了针灸治疗方案和治疗技术问题，如穴位选择和不同刺激方法的选择。

本指南涵盖的临床问题包括比较针灸和其他最常用的非药物疗法（推荐意见 1 和推荐意见 2）、比较针灸和抗抑郁药（推荐意见 3～推荐意见 5）以及针灸技术和治疗特定问题。例如，最佳针灸治疗类型（推荐意见 6～推荐意见 8）、治疗频率和疗程（推荐意见 9 和推荐意见 10）。这是迄今为止最全面和实用的针灸治疗抑郁症的指南。

6.2 本指南的优势

第一，本指南明确定义了 PICO 问题，并透明清楚地报告了每个推荐意见对应的人群、干预措施、对照和结局。这有助于指南读者比较和评估他们的患者，从而更好地应用相关推荐意见。第二，本指南进行了系统评价，采用 GRADE 方法评估证据的质量，对推荐意见的强度进行评级，并使用 EtD 框架形成推荐意见[33,35]。这种透明度提高了指南的可信度。第三，本指南专家组是一个全球性的由理疗师、心理学家、一线针灸医生、患者、指南方法学家组成的多学科专家组，这提高了指南的代表性和可用性。第四，在本指南专家组中包括两名患者代表，这使本指南能够将患者的观点纳入推荐意见中。第五，本指南实施了标准的利益冲突管理流程，这最大限度地减少了产生的偏倚。所有上述特征确保本指南符合医学研究所可信指南的标准。

6.3 研究空白

本指南发现了缺乏直接证据的领域。在非药物疗法中(例如,针灸疗法、心理疗法、锻炼),没有直接比较针灸和心理疗法或者锻炼的随机对照研究。此外,考虑患者对药物疗法引起的不良事件的担忧[149],将非药物疗法(例如,针灸疗法、心理疗法、锻炼)的联合运用与药物疗法的组合进行比较可能是未来研究的另一个领域。为了确定治疗抑郁症的最佳针灸疗法,可进行直接比较不同针灸疗法(头针与体针)、最佳穴位处方(例如,比较百会、印堂与复合穴位方案)、不同的针灸频率(例如,每周2次与每周超过3次)、不同的疗程(例如,疗程大于4周和小于或等于4周)的随机对照试验。

系统评价中纳入的大部分研究均存在高偏倚风险。因此,在今后的临床研究中需更加关注试验设计和实施过程,特别是改进分配隐藏和随机过程、结局评估者盲法、统计分析和患者盲法(如可能)[150]。未来需要设计和实施良好的随机对照试验。未来的临床研究也需要设计和报告安全性结局,如严重不良事件、较长随访时间(6个月或更长)的结果,并报告纳入患者的基线风险。

7 局限和不足

在选择抑郁症的治疗方案时,患者和临床医生通常会面临很多挑战。本指南主要的局限性在于所纳入的临床问题数量有限。专家组仅选取了临床上最常见且最具挑战性的问题。此外,尽管本指南具备一定的国际视野,指南专家组包括了来自北美、欧洲、东亚和澳大利亚的成员,但是资源、可行性和可接受性在不同国家和情境下可能有所不同。另外,本指南因缺乏直接对比的随机对照试验的证据而放弃了两个问题(PICO 2、PICO 6)。各国的人群基线风险和医疗保险政策各不相同。因此,指南执行者应根据当地情况进行相应修改。

附 录 A
指南工作组成员

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附　录　B
缩略语表

中文全称	英文全称	缩略词
美国医师学会	American College of Physicians	ACP
美国精神病学会	American Psychiatric Association	APA
行为激活	Behavioral Activation	BA
加拿大心境障碍与焦虑障碍治疗协作组	Canadian Network for Mood and Anxiety Treatments	CANMAT
认知行为疗法	Cognitive-Behavioral Therapy	CBT
临床实践指南	Clinical Practice Guidelines	CPG
《精神疾病的诊断和统计手册》第 5 次修订本	Diagnostic and Statistical Manual of Mental Disorders-5	DSM-5
证据决策	Evidence to Decision	EtD
推荐分级的评估、制定和评价	Grade of Recommendations Assessment，Development，and Evaluation	GRADE
汉密尔顿抑郁量表	The Hamilton Depression Scale	HAMD
人际疗法	Interpersonal Therapy	IPT
单胺氧化酶抑制剂	Monoamine Oxidase Inhibitors	MAOIs
抑郁症	Major Depressive Disorder	MDD
均数差	Mean Differences	MDs
去甲肾上腺素能和特异性5-羟色胺能抗抑郁剂	Noradrenergic and Specific Serotonergic Antidepressants	NaSSAs
匹兹堡睡眠质量指数	Pittsburgh Sleep Quality Index	PSQI
随机对照试验	Randomized Controlled Trial	RCT
相对危险度	Risk Ratios	RRs
严重不良事件	Severe Adverse Events	SAE
5-羟色胺受体拮抗剂和再摄取抑制剂	Serotonin Antagonist and Reuptake Inhibitors	SARIs

（续）

中文全称	英文全称	缩略词
Asberg 氏抗抑郁剂副反应量表	Rating Scale for Side Effects	SERS
标准化均数差	Standardized Mean Differences	SMDs
5-羟色胺及去甲肾上腺素再摄取抑制剂	Serotonin-Norepinephrine Reuptake Inhibitors	SNRIs
证据概要	Summary of Findings	SoF
选择性 5-羟色胺再摄取抑制剂	Selective Serotonin Reuptake Inhibitors	SSRIs
三环类抗抑郁剂	Tricyclic Antidepressants	TCAs
四环类抗抑郁药	Tetracyclic Antidepressants	TeCAs
副反应量表	Treatment Emergent Symptom Scale	TESS
世界针灸学会联合会	The World Federation of Acupuncture-Moxibustion Societies	WFAS
世界卫生组织	World Health Organization	WHO
世界卫生组织生活质量	World Health Organization Quality of Life	WHOQOL-BREEF

附　录　C
临床问题汇总

编号	临床问题
1	对于成人轻中度抑郁症，如果采用非药物疗法，应该推荐单纯针刺、针刺加灸法，还是心理疗法？
2	对于成人轻中度抑郁症，如果采用非药物疗法，应该推荐单纯针刺、针刺加灸法，还是锻炼？（放弃，未作出推荐）
3	对于成人轻中度抑郁症，应该推荐单纯针刺、针刺加灸法，还是抗抑郁药物？
4	对于成人轻中度抑郁症，应该推荐针灸联合抗抑郁药物，还是针灸疗法？
5	对于成人轻中度抑郁症，应该推荐针灸疗法联合抗抑郁药物，还是单纯使用抗抑郁药物？
6	对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐体针还是头针疗法？（放弃，未作出推荐）
7	对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐耳针还是体针疗法？
8	对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐电针还是手针疗法？
9	对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐每周治疗≤2 次，还是每周≥3 次的治疗频次？
10	对于成人轻中度抑郁症，如果采用针灸疗法，应该推荐≤4 周，还是＞4 周的疗程？

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