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Reflexology for Relaxation

By Dónal P. O'Mathúna, PhD

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ANXIETY ACCOMPANIES MANY ILLNESSES AND THEIR TREATMENTS. Complementary therapies are seen as playing a valuable role in helping people relax. Reflexology is one such therapy, based on ancient approaches to foot massage.¹ The therapy has been growing in popularity, such as in the United Kingdom where reflexology is believed to be the complementary therapy most frequently practiced by nurses.² This popularity has led to questions about its potential role in clinical settings, especially as a non-invasive, non-pharmacological method of inducing relaxation.³

Reflexology looks very much like a foot massage. However, it is based on the view that specific regions called reflex zones (or reflex points) in the feet are connected to particular organs, glands, and regions of the body (*see Figure*).⁴ Thus, one definition of reflexology is that it is a "system of massage of the feet based on the idea that there are invisible zones running vertically through the body, so that each organ has a corresponding location in the foot."³ The same principles are applied to reflexology of the hands and ears, but the focus here will be on foot reflexology.⁵ Understanding the foundations of reflexology, and the results of research exploring its effectiveness, will help guide health care professionals responding to patients' questions about reflexology.

Background

Ancient Chinese and Egyptian diagrams of foot massage are said to depict earlier forms of reflexology, although the modern approach was proposed in 1913 by William Fitzgerald, MD, a laryngologist at Boston City Hospital.⁶ Fitzgerald noticed that pressure applied to specific parts of the hands or feet induced anesthesia in other parts of the body. From this developed the idea of zone therapy, whereby the body was envisioned as having 10 vertical zones running from the feet to the head and down each arm. Pressure applied to the area on a foot where a zone ends is believed to elicit a response within

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the internal organs falling within that same zone. Eunice Ingham, a massage therapist, further developed the therapy in the 1930s, reporting improvements in patients with illnesses as varied as asthma, angina, and arthritis.⁶ From these beginnings several schools of reflexology have developed that differ somewhat in the precise locations of various reflex zones and in the treatment methodology.⁷

Mechanism of Action

Broadly speaking, three different mechanisms of action have been proposed for reflexology. One is that massaging of the reflex points stimulates specific nerves, thus improving blood flow around related organs and leading to healing or improved health in those organs.⁸ A second explanation is that tension or illness in any organ will lead to the accumulation of tiny crystalline deposits of calcium and uric acid in the reflex zones of the feet.⁵ The pressure applied to the feet during reflexology then breaks up these deposits allowing them to be eliminated in a process called detoxification. The third proposed mechanism of action is based on the nonphysical life energy (chi, Qi, or prana) and meridian system that underlies other alternative therapies like acupuncture, shiatsu, and therapeutic touch.⁵ Reflexology employing this latter approach is therefore much more than a physical treatment, but also involves spiritual and emotional aspects.⁴

Regardless of how the reflex zones are believed to interconnect the body, all approaches to reflexology develop maps of the feet showing these connections. The maps are very specific, as exemplified by the following description. “On both feet, the spine runs along the medial aspects of the foot, the coccyx area is represented at the level of the heel, and the seventh cervical vertebra lies at the juncture of the great toe and foot. Many additional glands, organs, and body part reflex areas also are located in specific zones on the various areas of the feet (and hands).”⁴

The practice of reflexology emphasizes the importance of the “evolving therapeutic relationship” between the patient and practitioner.⁹ Within this context, a variety of foot massaging techniques are used. Palpation of the feet is used to gather information on the patient’s overall health. Areas of the feet that are sensitive, painful, or “gritty” are noted.⁴ Changes in the skin are taken to indicate areas of energy stagnation in the corresponding zone. Denser areas suggest the need for deeper massage of those regions to decongest the energy. Several reflexology sessions will normally be suggested for maximum benefit.

Clinical Studies

Although many anecdotal reports claim successful outcomes after reflexology, very little controlled research has been carried out.² An early randomized controlled study involved 83 women with premenstrual syndrome (PMS) complaining of 38 different symptoms.¹⁰ Participants were randomly assigned to true reflexology or a sham reflexology. The latter involved pressuring participants’ feet, hands, and ears on acupuncture-related points believed to have no association with PMS symptoms. Many participants dropped out of the study, with only 35 completing. The results found significantly greater reduction in PMS symptoms for those receiving true reflexology, including reduced symptoms of anxiety and irritability ($P < 0.01$). Others have pointed out that the reflex points used in this study are classic acupuncture points, claiming this study supports the efficacy of acupressure, not reflexology.⁷

A pilot study with 18 patients given a number of reflexology treatments found statistically significant reductions in pre- and post-treatment heart rate and systolic blood pressure ($P < 0.003$).¹¹ Diastolic blood pressure and respiratory rate were lower, but not with statistical significance. A control group was not used.

Another small study found some favorable results with 23 patients with breast or lung cancer.¹² In a crossover design, subjects’ anxiety and pain levels were measured before and after 30 minutes of reflexology or

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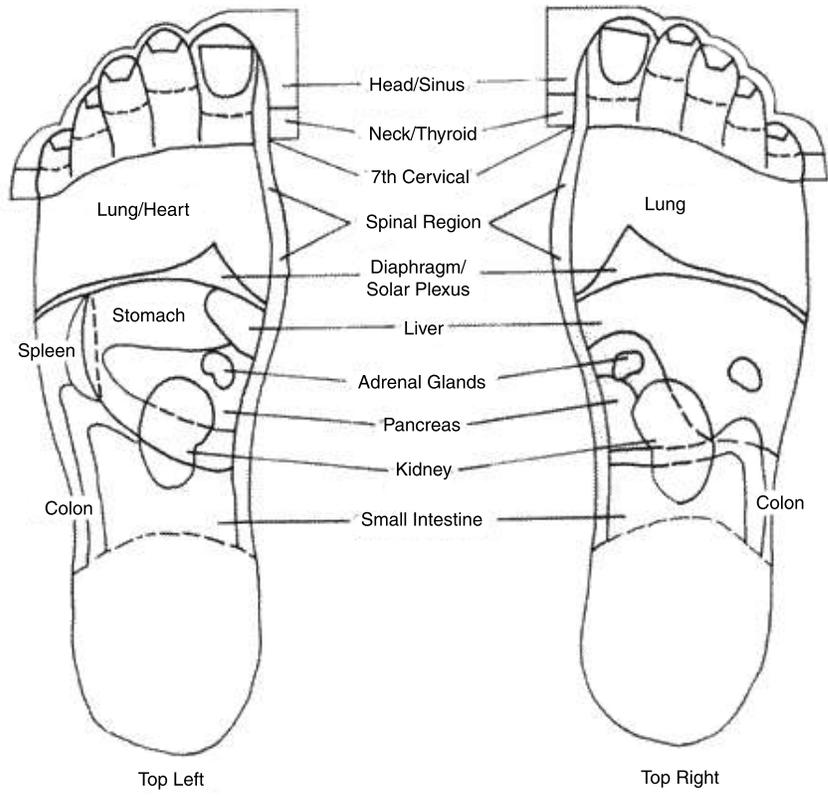
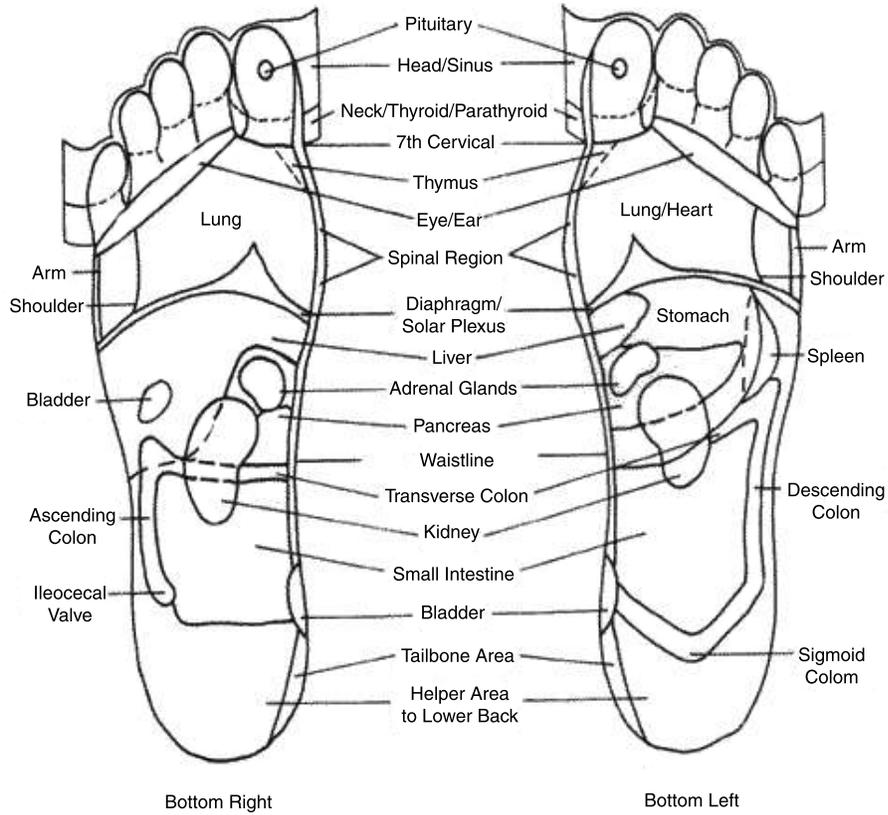
Questions & Comments

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Figure

Reflexology map of the feet



Reprinted with permission from: Dr Foot. Available at: www.drfoot.co.uk/flex.htm.

a no-intervention control. Post-reflexology anxiety levels were significantly lower when compared both to pre-reflexology levels and to control ($P = 0.000$). Pain levels were also significantly reduced after reflexology.

Thirty cancer patients, upon hospitalization, were randomly assigned to receive reflexology or no intervention.¹³ State-anxiety was measured before, immediately after, and 24 hours after intervention. Anxiety was reduced after reflexology, with the average score being significantly lower than in the control group ($P < 0.05$). One day later, the score in the reflexology group had not changed significantly.

Seventeen patients with chronic obstructive pulmonary disease (COPD) were randomly assigned to reflexology or control.³ Therapy sessions occurred weekly for four consecutive weeks, with participants either receiving reflexology or discussing the stresses in their lives (a much shorter meeting). Outcomes were assessed using quality-of-life questionnaires, lung function tests, and physiological measures of relaxation. The only measurement showing statistically significant differences was a short-term reduction in heart rate following reflexology ($P < 0.05$). None of the other physiological or psychological measures of relaxation differed significantly between the two groups.

A pilot study was conducted with 17 patients with advanced cancer.¹⁴ They were randomly assigned to receive either reflexology or foot massage weekly for six weeks. On average, the scores for anxiety and depression did not change over the course of the study, nor did they vary between the two groups. A number of other mood levels and symptoms were measured, with no statistical differences between the two groups.

Another randomized study compared reflexology to foot massage in 76 women with menopausal symptoms.¹⁵ Each woman received nine therapy sessions over 19 weeks. Scores for anxiety and for depression decreased significantly in both groups over the first six weeks of the study ($P < 0.001$), but not from week six to week 19. No significant differences were found between the two groups at any point.

Adverse Effects

Serious adverse effects have not been reported after reflexology. A number of authors state that reflexology can elicit catharsis or a "healing crisis."¹⁶ This normally lasts only a couple of days. The symptoms can be physical, such as headache, nausea, diarrhea, or coldness, and emotional, such as periods of unexplained crying or depression. No controlled evidence is available to document the prevalence or cause of these symptoms, which usually are explained as resulting from the breakdown of

crystalline products in the body as it detoxifies.⁵

What distinguishes reflexology from foot massage is the importance given to the zone maps of the feet. These maps are particularly important if reflexology is used to treat a specific condition or diagnose an illness. Reflexology organizations usually discourage such practices, yet they continue to occur. Reflexology maps vary sufficiently between one another to raise serious questions about their reliability and validity in guiding treatment or diagnosis.⁹ One study examined the reliability of two reflexologists' diagnostic skills.¹⁷ Both were blinded to the conditions present in 18 adults with between one and six previously specified medical conditions. Reflexologists were unable to accurately diagnose which patients had which conditions, and there was little agreement between the two therapists. The little evidence available suggests that using reflexology foot maps to guide treatment or diagnosis could lead to misdiagnoses and inaccurate decisions. The latter could be serious.

Conclusion

A small number of controlled studies support the effectiveness of reflexology in inducing relaxation. Reflexology has induced significantly more relaxation in controlled studies comparing it with placebo interventions. However, in the two studies comparing reflexology and foot massage, the relaxation effect was not significantly different. This suggests that reflexology does not offer additional benefits over foot massage. No studies have found evidence to support the existence of the zones that underlie reflexology theory, nor to support the use of reflexology to diagnose illnesses. A review of more than 8,000 cases in China found no evidence of reflexology's effectiveness for acute conditions.⁶ Reflexology, like other forms of massage, may be an effective means of promoting relaxation, which in turn may be of benefit to patients with chronic, painful conditions. However, the evidence suggests that an ordinary foot massage is as effective as reflexology in inducing relaxation. ❖

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CME Objectives

After reading *Alternative Therapies in Women's Health*, the health care professional will be able to:

1. evaluate alternative medicine and complementary therapies for women's health concerns;
2. identify risks and interactions associated with alternative therapies;
3. discuss alternative medicine options with patients;
4. offer guidance to patients based on latest science and clinical studies regarding alternative and complementary therapies.

CME Instructions

Physicians participate in this continuing medical education program by reading the article, using the provided references for further research, and studying the questions at the end of the article. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity, you must complete the evaluation form provided and return it in the reply envelope provided at the end of the semester to receive a certificate of completion. Upon receipt of your evaluation, a certificate will be mailed.

CME Questions

8. Reflexology looks similar in many ways to:
 - a. conventional reflex testing.
 - b. critical reflection on evidence.
 - c. foot massage.
 - d. acupuncture.
9. According to reflexology theory, the feet are connection to the rest of the body via:
 - a. nerves.
 - b. 10 vertical zones.
 - c. the limbic system.
 - d. 12 horizontal zones.
10. Evidence from controlled trials suggests that reflexology is:
 - a. as effective as foot massage in inducing relaxation.
 - b. more effective than placebo in inducing relaxation.
 - c. not effective in diagnosing illnesses.
 - d. All of the above
11. Baseline 25(OH)D levels can vary with:
 - a. latitude.
 - b. degree of food fortification.
 - c. season of the year.
 - d. All of the above

Answers: 8. c, 9. b, 10. d, 11. d.

“B” Wary: Folate and Cardiovascular Disease

By Russell H. Greenfield, MD

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Source: Bazzano LA, et al. Effect of folic acid supplementation on risk of cardiovascular diseases: A meta-analysis of randomized controlled trials. *JAMA* 2006;296:2720-2726.

Abstract: A meta-analysis of randomized, controlled trials (RCTs) was performed to evaluate the effects of folic acid supplementation on risk of cardiovascular diseases and all-cause mortality among persons with pre-existing cardiovascular or renal disease. The researchers performed a Medline search of articles from 1966 to 2006 without language restrictions, as well as a manual search of references cited in specific articles, and contacted experts who might know of trials near completion. Of 165 identified reports, 12 RCTs comparing folate with placebo or usual care for a minimum of six months, and with clinical cardiovascular disease events reported as endpoint, were analyzed. The data set included information on close to 17,000 people, with the majority of articles (eight) coming out of European countries. Trials were primarily parallel in design, with seven using placebo, and five employing usual care as a control. The dosage of folate used ranged from 0.5 mg/d to 15 mg/d, and duration of intervention ranged from six months to five years. Data were independently reviewed by two of the investigators, and in the case of a discrepancy a third reviewer was called in to offer an opinion.

All trials showed a decrease in serum homocysteine levels, but no statistically significant relationship was identified between net change in homocysteine level and relative risk (RR) for examined clinical outcomes. The overall RR for people with pre-existing cardiovascular or renal disease using folate supplementation compared with placebo was 0.95 for cardiovascular disease, 1.04 for coronary heart disease, 0.86 for stroke, and 0.96 for all-cause mortality. The data suggest that folic acid supplementation is not effective for secondary prevention of cardiovascular disease or all-cause mortality in people with pre-existing cardiovascular or renal disease.

Comments: Meta-analyses are frequently rife with limitations. Although interpretation of the results of this article likewise has its limitations, the authors are quick to point out those limitations themselves. Perhaps the biggest limitation has to do with duration of follow-up (the longest follow-up was only five years). It should

also be noted that the study focused on secondary, not primary, prevention. All this aside, as meta-analyses go this one is quite strong. There was almost no heterogeneity identified. RCTs were examined, thereby lessening the potential for bias and confounders often problematic in observational trials (examples of which might include sudden adoption of healthy lifestyles, additional folate supplementation, and dietary changes). Since the homocysteine hypothesis of arteriosclerosis first came to prominence with McCully's early work on people with inherited cystathione synthase deficiency, the promise of folic acid and vitamin B₁₂ supplementation for lessening the incidence of cardiovascular disease has garnered worldwide interest. Most observational trials suggest a cardiovascular benefit with lowering of serum homocysteine levels with folic acid, but clinical data have been mixed at best. Perhaps it has been naïve to believe that a single nutrient could significantly alter the incidence of what remains the leading cause of death in the world; primary prevention of cardiovascular disease may still be enhanced using appropriate folate supplementation, but support for its use for secondary prevention has faded to a considerable extent. ❖

The Sunshine Vitamin and Health: Optimal Vitamin D Levels

By Russell H. Greenfield, MD

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Source: Bischoff-Ferrari HA, et al. Estimation of optimal serum concentrations of 25-hydroxyvitamin D for multiple health outcomes. *Am J Clin Nutr* 2006;84:18-28. Erratum in: *Am J Clin Nutr* 2006;84:1253; dosage error in abstract.

Abstract: In an attempt to quantify the optimal level of 25-hydroxyvitamin D [25-(OH)D] needed to enhance health, a rigorous literature review was performed. The common definition of an optimal 25(OH)D serum concentration is generally regarded as that which maximally suppresses parathyroid hormone (PTH, which promotes bone loss), but estimates in this regard vary widely as PTH levels fluctuate with time of day, diet, physical activity, and renal function. In this paper, results from randomized controlled studies, dose-response trials, and

prospective and epidemiologic data were summarized for the effect of a given level of 25(OH)D on multiple health endpoints other than PTH suppression or optimal calcium absorption, including bone mineral density, anti-fracture efficacy, lower extremity function, falls, dental health, and prevention of colorectal cancer. For all examined endpoints, optimal 25(OH)D serum concentrations started at 75 nmol/L (30 ng/mL), but the best outcomes were found with serum levels that ranged from 90 to 100 nmol/L (36-40 ng/mL). The current recommended daily intake of vitamin D depends upon age and ranges from 200 to 600 IU/d; unfortunately, optimal 25(OH)D levels cannot be attained in most people with the present suggested levels of intake. Thus, an increase in the currently recommended daily intake of vitamin D to more than 1,000 IU (40 µg) seems warranted for all ethnic and racial groups.

Comments: Results of literature reviews do not typically merit a change in therapy, but this well-done paper does just that. A seeming explosion in the amount of data pointing toward a previously under-recognized importance of optimal vitamin D levels for health has been taking place. Potential benefits have been identified with the endpoints used in the article, but study results also suggest benefits of optimal 25(OH)D levels in the setting of other maladies such as multiple sclerosis, hypertension, tuberculosis, insulin resistance, osteoarthritis, and for chemoprevention against additional cancers. The majority of people in the United States have 25(OH)D serum levels significantly below the 90-100 nmol/L (36-40 ng/mL) optimum established by this review, especially the elderly. Baseline 25(OH)D levels can vary with latitude and degree of food fortification, but most all people will be relatively vitamin D-deficient

during the cold winter months. Concerns continue to exist with respect to sun exposure and skin cancer risk, but data on proper dietary intake and use of supplemental vitamin D are strongly suggestive of health benefit. With regard to supplemental vitamin D, cholecalciferol (D3) is a more efficient agent than is ergocalciferol (D2), though the latter is not harmful. The results summarized in this article consistently point to the need for a vitamin D intake of more than 700-800 IU/d. Many experts now point to a safe maximal daily intake of 2,000 IU vitamin D. Of note are data showing that intakes of 4,000-10,000 IU/d are safe for young adults, and that hypercalcemia develops in most people only with serum 25(OH)D concentrations higher than 220 nmol/L. This literature review did not address optimal vitamin D intake for children.

Conclusion: Our conservative nature as practitioners typically gives us pause when considering a significant increase in the recommended dosage for any agent, let alone a fat-soluble vitamin like vitamin D; however, the sheer volume of data suggesting benefit of optimal 25(OH)D levels for the prevention and, in some instances, treatment of disease is compelling. Considering that the vast majority of people do not have adequate intake of vitamin D to attain levels of 25(OH)D that appear to enhance health, and with a gradually expanding safe therapeutic range, it appears clear that practitioners should be recommending higher levels of vitamin D intake. This is a paper you might consider making hard copies of and sharing with your colleagues. ❖

News Briefs

Many Older Americans Not Discussing CAM With Their Physicians

Sixty-nine percent of people age 50 or older who use complementary and alternative medicine (CAM) do not talk to their doctors about it, according to a new survey conducted by AARP and the National Center for Complementary and Alternative Medicine (NCCAM) at the National Institutes of Health. The survey examined conversations between patients and their physicians regarding CAM use.

Differences in communication practices across demographic groups were also found. Women were more likely than men to have discussed CAM use (26% vs. 16%) and what types of therapies to use (70% vs. 51%). In addition, people with incomes of \$75,000 or more (31%) or \$25,000-\$49,999 (25%) frequently discussed CAM use with doctors.

This telephone survey, administered to a nationally representative group of 1,559 people age 50 or older, revealed some reasons why patients did not discuss CAM use with their physicians. Respondents most often did not discuss it because the physicians never asked (42%), they did not know that they should (30%), or there was not enough time during the office visit (19%). Interestingly, men who had seen a doctor were more likely than women not to have discussed CAM because their doctors never asked (46% vs. 38%).

Other highlights from the survey report include:

- The topics most often discussed with doctors were the effectiveness of a CAM therapy (67%), what to use (64%), how a CAM therapy might interact with other medications or treatments received (60%), advice on whether to pursue a CAM therapy (60%), and safety of a CAM therapy (57%).

- Nearly three-fourths of respondents said they take one or more prescription medications; in addition, 59% of respondents said they take one or more over-the-counter medications. Twenty percent of respondents reported taking more than five prescription medications.

To see the full survey report, visit: www.aarp.org/research/health/prevention/cam_2007.html.

Asian-Americans More Likely to Use CAM, Study Says

Nearly three-quarters of Asian-Americans used at least one type of complementary and alternative medicine (CAM) in the past 12 months, says a study published in the December 2006 issue of the *Journal of Alternative and Complementary Medicine*.

This was significantly higher than the national prevalence rate, according to the researchers, who did a cross-sectional survey of a sample of 9,187 adults representative of the California population. The researchers hypothesized that because of differences in health and cultural beliefs, patterns and predictors of CAM use would vary among Asian-American subgroups. They found that Chinese-Americans had the highest prevalence of any CAM use, whereas South Asians had the lowest prevalence (86% vs. 67%, respectively).

Acculturation and access to conventional medical care was unrelated to any CAM use for most Asian-American subgroups. Spirituality was the strongest predictor of any CAM use for most Asian-American subgroups.

FDA Updates Health Claim for Calcium and Osteoporosis

The Food and Drug Administration (FDA) is proposing to allow new claims on foods and dietary supplements containing calcium and vitamin D to show their potential to reduce the risk of osteoporosis. This action responds to a health claim petition submitted by the Beverage Institute for Health and Wellness, The Coca-Cola Co.

The proposed rule would amend one of the first health claims authorized in 1993 through the Nutrition Labeling and Education Act of 1990 for the relationship between calcium intake and osteoporosis. The proposal would amend this existing health claim by allowing for claims of a reduced risk of osteoporosis with the consumption of both calcium and vitamin D.

The proposed rule also would eliminate certain requirements that were a part of the required claim language in the existing calcium and osteoporosis health claim. However, FDA is not changing its conclusion that there is still significant scientific agreement to support claims for calcium intake and reduced risk of osteoporosis.

FDA's decision to amend the existing health claim is based on the agency's review of the publicly available scientific evidence, which included the 2004 Surgeon General's report on Bone Health and Osteoporosis and the 2000 NIH Consensus Statement on Osteoporosis, Prevention, Diagnosis, and Therapy.

Specifically, FDA is proposing to change the calcium and osteoporosis health claim to:

- Add a claim for calcium and vitamin D together and a reduced risk of osteoporosis.
Shorten the claim language by:
- Dropping the reference to sex, race, and age since the benefits apply to both sexes at all ages and race categories.
- Dropping the need to identify the mechanism by which calcium reduces the risk of osteoporosis.
- Dropping the requirement that the claim state that there are limits to benefit of calcium intakes above 200% of the Daily Value.

Comments may be submitted electronically to www.accessdata.fda.gov/scripts/oc/dockets/comments/commentdocket.cfm?AGENCY=FDA (click on the Docket Search link on the left side and put in the docket number 2004P-0464) or in writing to the Division of Dockets Management, 5630 Fishers Lane, room 1061, Rockville, MD 20852. Please reference the docket number when submitting comments. ❖

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Pomegranate Juice and Cardiovascular Disease

Vitamin D and Immunity

Horse Chestnut for Venous Insufficiency

DHEA for Menopause