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Al-Hijama in the UK

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Abstract

Hijama is a traditional form of therapy which is becoming increasingly popular in the United Kingdom, as well as USA, Canada and Australia. It is generally practiced by people with limited clinical training and clinicians will need to discuss this form of therapy with their patients when advice is sought. This brief review discusses issues that are likely to arise during such a consultation.

Introduction

Hijama is a form of preventive medicine and clinical treatment with a long history. Its use by the Muslim community was recommended by the angels during the Night Journey. It was already an established practice at the time and its origins may well be linked to that of acupuncture. Both forms of treatment are applied at comparable points on the body and there is a form of acupuncture where cutting needles are used. Outside of the Muslim community the procedure is known as wet cupping. It consists of raising an area of skin using suction, making multiple small superficial scratches on the skin with a blade and then reapplying suction so as to draw blood over a period of 15 to 30 minutes. Nowadays, the cups used are usually plastic and disposable and suction is obtained using a small pump. Traditional therapy used glass cups or horns and suction was obtained through heating the inside.

Support for use of hijama includes a report by Bukhari which states: *"There is healing in cupping."* (Book No. 71 Hadith No. 600)

During the last 10 years its use in the United Kingdom has become widespread. It is often referred to as "the lost Sunnah" and advertisements appear on the Internet and in many small shop windows. An increasing number of Muslims have sought such treatment. It is likely that both patients and acquaintances will be considering this approach to care, but unlikely that they will readily mention it during a clinical consultation. For patients with chronic disease many of the advertisements advocate its use in preference to allopathic treatments and quote dramatic responses in the form of patient histories.

The questions facing clinicians include:

1. What is the evidence base for this form of treatment and how effective is it?
2. What advice should be given to patients considering its use?
3. Is this a form of therapy which I should consider practicing?

What is the evidence base for this form of treatment and how effective is it?

In 2010 Cao et al (1) published a systematic review of 550 studies of cupping between 1959 and 2008. It included 73 randomised controlled trials, although their standard was poor according to Cochrane criteria. (2)

Amongst the conditions in which cupping was commonly employed were pain (70 studies), herpes zoster (59 studies), cough or asthma (39 studies), acne (29 studies),

cervical spondylosis (19 studies), lumbar sprain (19 studies), mastitis (14 studies), facial paralysis (13 studies), headache (13 studies), soft tissue injury (10 studies), arthritis (10 studies), neurodermatitis (10 studies) and sciatica (7 studies). In this period only 2 additional RCTs were conducted outside of China. (1) During the last forty years I have been unable to identify any published studies concerned with treatment of major conditions such as cancer, cardiovascular disease or dementia. (3). Nevertheless, its use has been promoted for such conditions in a number of advertisements on the internet.

There have been a limited number of studies which consider the mechanisms by which hijama could work, but, in general, they do not meet the rigorous standards required for laboratory-based studies. In contrast, in the comparable area of acupuncture there is a growing body of work using dynamic imaging techniques which demonstrate potential modes of action. A major issue for studies on both the physiological mechanisms by which hijama works and its clinical effectiveness is the absence of adequate independent external funding for such research. Such funding could be provided by many philanthropic Muslim institutions and is particularly needed at this time.

What advice should be given to patients considering its use?

In any discussion with patients concerning the use of hijama serious attention needs to be given to who will perform the procedure. Within the United Kingdom there are clinics in Birmingham, Sheffield, Leicester, London, Cardiff and Glasgow amongst other towns and cities. (3 and Table). In addition, there are many individual practitioners who offer mobile services or practice in their homes or even their garages. The central issue concerns the ability of practitioners to make a diagnosis. Hijama is a form of treatment and it is critical that a practitioner should know what he or she is treating. This knowledge cannot be achieved through an online course or during a day's training. Traditionally hijama was one form treatment offered by doctors or by therapists who had undergone a long training and been licenced by their mentor in the form of an ijazzah. Today in Saudi Arabia, United Arab Emirates and Oman, practitioners who are not medically qualified must practice under the direct supervision of qualified doctors.(4)

The need for such an approach in the United Kingdom is underlined by the fact that, on occasions, hijama is linked with ruqyah. Criminal prosecutions of such therapists have now happened in Leeds UK and Sydney Australia. Such cases have involved the need for appropriate psychiatric assessments and diagnoses as well as vulnerable adult and child protection issues. Whilst hijama remains a totally unregulated therapy more and more such cases are likely to occur. In general, self-regulation of complementary therapies has proven ineffective, and there is a reluctance amongst hijama therapists to come together and set up such a register. In contrast those who are registered with the General Medical Council (or any other statutory regulatory body dealing with health care practitioners) need to include their hijama practice within their annual appraisal and their practice is regulated by the same rigorous standards applied to other aspects of their work.

Is this a form of therapy which I should consider practicing?

Any clinician planning to take up hijama should:

1. Obtain appropriate training and supervision as in any other form of clinical practice.
2. Include their practice within their annual appraisal.
3. Keep careful records and use detailed consent procedures.
4. Give comprehensive and adequate explanations of the technique, its potential benefits, risks and limitations.
5. Consider setting up regional studies and trials

Conclusions

Hijama is an old and recognised form of clinical treatment. In the UK it is now being promoted as "the lost Sunnah" and is generally practiced by people with no recognised clinical training. There is an urgent need to ensure that patients who wish to have this form of therapy are treated by qualified and competent clinicians with a contemporary knowledge of disease processes and mechanisms.

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