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RESPONSE TO LETTER

Effects of Hip Joint Motion-Style Acupuncture Treatment in Patients with Acute Radiating Leg Symptoms After Traffic Accidents: A Pilot Pragmatic Randomized Controlled Trial [Response to Letter]

Doori Kim[1], Jin Hyun Kim[2], Yoon Jae Lee[1], In-Hyuk Ha[1]

[1]Jaseng Spine and Joint Research Institute, Jaseng Medical Foundation, Seoul, Republic of Korea; [2]Department of Korean Medicine Neuropsychiatry, Bucheon Jaseng Hospital of Korean Medicine, Bucheon, Republic of Korea

Correspondence: In-Hyuk Ha, Jaseng Spine and Joint Research Institute, Jaseng Medical Foundation, 540, Gangnam-daero, Seoul, 06110, Republic of Korea, Tel +82-2-2222-2740, Fax +82-2-2222-2737, Email hanihata@gmail.com

Dear editor

We sincerely thank Shen et al for their interest in our study,[1] their favorable evaluation, and for taking the time to provide meaningful and valuable comments. We also appreciate the opportunity to address the limitations of our study, and we would like to respond to the four issues raised, as follows.

On Acupuncture in the Control Group and Confounding Factors

First, we would like to emphasize again that our study was designed as a pragmatic clinical trial. A pragmatic clinical trial is a research approach that evaluates interventions used in everyday clinical practice within a study setting, aiming to answer important questions that are applicable to routine care.[2] Integrative Korean medicine treatment (IKMT), which includes acupuncture, Chuna manual therapy, and herbal medicine, is already widely used in clinical practice in Korea, and MSAT is also a treatment for which our Korean medicine hospital has accumulated extensive clinical experience over many years. For these reasons, we chose a pragmatic design rather than an explanatory one.

Importantly, in our study, both groups received the same IKMT, and the experimental group received MSAT in addition to IKMT. As described in the manuscript, IKMT was provided according to the clinical practice guideline for traffic injury syndrome,[3] and acupuncture was performed at major acupoints in the lumbar, gluteal, and lower limb regions, including Ashi points and points along the bladder meridian (eg, BL23, BL24, and BL25). The MSAT group also received the same IKMT, with MSAT additionally administered afterward.

However, because our study was a pragmatic trial and acupoint selection was left to the physician's clinical judgment, the IKMT received by each patient was not strictly identical. Some patients may have received acupuncture mainly at the lumbar region, others at the gluteal region, and others at multiple regions. Nevertheless, since participants were randomly allocated to the two groups, such variability is expected to have been balanced between the groups and therefore unlikely to have introduced a systematic bias favoring either group.

That said, we have come to recognize an important limitation of our study, namely that we did not describe these treatment details in sufficient depth. We should have collected, analyzed, and presented more detailed information, such as the actual distribution of acupoints used in the control group and the specific needling sites applied during MSAT, but we did not do so. This is a limitation of our study, and we are grateful for the reviewers for bringing it to our attention. In future studies, we will systematically record and report detailed treatment information in accordance with reporting guidelines such as STRICTA.

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On Practitioner Standardization and Acupoint Selection

The hip joint MSAT performed in our study is not an intervention that targets specific acupoints, but rather one that targets muscles. As described in the manuscript, the target muscles of MSAT (the piriformis, gluteus medius, and quadratus lumborum) were determined through a predefined clinical assessment algorithm, including palpation, manual muscle strength testing, and tenderness evaluation, and needling was performed at indurated points within these muscles. Therefore, we believe that the concern regarding "lack of standardization in acupoint selection" does not directly apply to MSAT, given the nature of the procedure. In addition, needling at standard acupoints (such as BL23–BL25) was already sufficiently performed during the IKMT phase.

Regarding the qualifications of the practitioners, all clinicians who participated in this study were Korean medicine doctors with at least 3 years of clinical experience. In addition, our hospital operates an internal training system that provides regular education on MSAT, and only practitioners who pass a practical examination for each MSAT technique are permitted to perform the procedure. This system ensures a consistent level of quality in the delivery of the intervention.

On the Timing of Outcome Assessment

Regarding the timing of outcome assessment, all outcomes were measured on the day after each treatment, prior to the next treatment session. That is, the baseline outcome was assessed on hospitalization Day 2 before the first treatment, and the second assessment was performed on Day 3 before that day's treatment. Because patients may experience soreness or discomfort immediately after MSAT, we considered it more reasonable to evaluate outcomes after an interval of about one day, rather than immediately after the treatment, in order to capture a more stable treatment effect.

In another pragmatic clinical trial that evaluated the effects of cervical MSAT,[3] most participants had restricted range of motion (ROM) due to whiplash syndrome, and because cervical MSAT was considered to have an immediate effect on improving ROM, outcomes were additionally measured immediately after treatment, in addition to the routine assessments. Outside of such specific situations, however, we believe that assessing outcomes with a one-day interval is more stable and appropriate.

On Safety Monitoring

Lastly, regarding adverse events, as described in the manuscript, we monitored adverse events through patient self-reports, investigator observation, and review of electronic medical records. In addition, causality was assessed according to the WHO-UMC causality categories, and severity was evaluated using the Spilker classification.

MSAT inherently involves some level of risk, as it requires movement of the body region while the needles remain in place.[4] However, the hip joint MSAT performed in our study targets relatively bulky muscles covered by thicker overlying tissue layers, and therefore carries a relatively lower risk of hematoma or bleeding compared with MSAT applied to other regions. For instance, in a cervical MSAT study,[3] four skin-related adverse events were reported, which is likely related to the anatomical characteristics of the cervical region, where muscle layers are thin and superficial blood vessels are abundant. Likewise, the shoulder MSAT also involves a relatively superficial treatment site.[5] In contrast, the hip joint area is protected by thicker muscles and soft tissues, and we therefore consider it to be a relatively safer site for this type of intervention.

Nevertheless, in future studies, we will consider implementing more systematic and proactive procedures for adverse event collection.

Conclusion

In summary, considering the characteristics of MSAT as an intervention and the pragmatic nature of our clinical trial, we believe that most of the potential biases raised by Shen et al are unlikely to have had a substantial impact on the interpretation of our findings. Nevertheless, we acknowledge as limitations of our study that we did not provide a sufficiently detailed description of MSAT, or the specific treatment details in both groups. We will incorporate these points into the planning of future studies to conduct more rigorous research.

Once again, we sincerely thank Shen et al for their interest in our study and for taking the time to provide such meaningful and valuable comments.

Disclosure

The authors report no conflicts of interest in this communication.

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