

Regarding “Musculoskeletal Ultrasound Assessment of the Clinical Efficacy of the Combination of Acupressure and ‘Three Methods of Neck Movement (TCM)’ Therapy in the Treatment of Cervical Spondylosis” [Response to Letter]

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Dear editor

I am writing on behalf of my co-authors to address the insightful comments and suggestions provided by Cheng Y, Xie W, and Xu L regarding our publication in the Journal of Pain Research.

I. Age Range Consideration We acknowledge the concern about the age range restriction (40–60 years) and its potential impact on the generalizability of our study results. While we noted the trend of younger onset of cervical spondylosis in our abstract, the decision to focus on the 40–60 age group was based on several considerations. First, there is a recognized difference in the classification of cervical spondylosis between domestic and international standards. Second, the typical age of onset for cervical spondylosis in China is between 30–60 years, whereas in international contexts, only spinal cord and nerve root cervical spondylosis have a clear proposal that the age of onset is over 40 years. Lastly, subjects over 60 years often have more underlying diseases, complicating the enrollment process. In alignment with the journal editors' recommendations, we chose to focus on the 40–60 age group.

II. Follow-Up Period We appreciate the observation regarding the 6-month follow-up period and agree that long-term efficacy assessment is crucial for chronic conditions like cervical spondylosis. Our study includes a 6-month follow-up to provide preliminary insights into treatment durability. We concur that extended observation periods are necessary for a comprehensive evaluation and plan to conduct further longitudinal studies. We also ensured that each participant was placed in a stable temperature chamber at 23–25°C during treatment to minimize the impact of temperature changes on the results.

III. Single-Center Design and Ultrasound Operator Expertise We recognize the limitations of a single-center study design and the variability in treatment protocols and expertise levels across different medical institutions. We are committed to pursuing multicenter collaborations in future research to enhance the generalizability of our findings. Regarding the use of musculoskeletal ultrasound, we ensured that all operators underwent professional skills training and passed assessments to use the equipment accurately. Each participant was examined by two trained and certified operators, and a third operator was involved in case of inconsistent results to ensure reliability.

IV. Evaluation of Psychosocial Dimensions We agree that a more extensive evaluation of psychosocial dimensions is necessary. While the McGill Pain Questionnaire and the Neck Disability Index (NDI) are primary outcome measures, they do not fully capture the broader psychosocial context. We plan to incorporate validated psychological assessment tools, such as the Hospital Anxiety and Depression Scale (HADS), the Pain Catastrophizing Scale (PCS), and the

Pittsburgh Sleep Quality Index (PSQI), in future studies to better understand the influence of psychological factors on pain perception and treatment outcomes.

In conclusion, we are grateful for the opportunity to respond to the letter and are committed to refining our research approach to better serve the clinical community. We look forward to contributing to the ongoing discourse on the treatment of cervical spondylosis and to advancing the field of complementary and alternative medicine.

Disclosure

The authors report no conflicts of interest in this communication.

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