

The Role of Manual Body Acupressure in Symptom Management in Adults

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Dear Editor,

Pain, sleep disruption, and fatigue are common symptoms that compromise daily functioning and quality of life. Non-pharmacological complementary approaches represent valuable alternatives to pharmacotherapy. Acupressure—applying manual pressure to specific body points—may serve as a generally feasible and low-risk complementary option. Recent randomized controlled trials demonstrate promising outcomes. Arab et al. (2016) reported improved sleep quality in hemodialysis patients receiving acupressure versus sham controls. Self-administered acupressure showed benefits for pain and sleep quality in coronary artery disease patients (Başak et al., 2025) and symptom improvements in older adults with knee osteoarthritis (Li et al., 2018). Systematic reviews extend these findings: Waits et al. (2018) identified sleep-quality improvements despite acknowledging heterogeneity and blinding limitations, while Hsieh et al. (2021) reported multi-domain fatigue reductions in cancer populations.

However, important clinical distinctions warrant attention. Manual body acupressure (provider-administered) may differ importantly from self-administered acupressure in terms of implementation, fidelity, and adherence variability. Song et al. (2015) noted symptom benefits across diverse conditions while emphasizing methodological limitations in self-administered research.

Sham-controlled evidence requires careful interpretation. Tan et al. (2015) documented substantial variation in sham methods across trials, raising concerns that some sham procedures may not be physiologically inert. Notably, Hmwe et al. (2016) found that acupressure superiority was not consistently demonstrated when compared directly with sham acupressure rather than usual care. This suggests benefits may reflect both acupoint-specific effects and non-specific mechanisms including therapeutic

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attention, touch, patient expectations, and behavioral engagement. Rather than diminishing clinical utility, this observation underscores the necessity for rigorous sham procedures and transparent intervention reporting.

Considerable heterogeneity persists across studies in selected acupoints, pressure intensity, session duration, treatment frequency, practitioner training, and outcome measures. This variability limits direct comparison and complicates protocol standardization.

For nursing and clinical practice, manual or self-administered acupressure may serve as a complementary option within appropriate clinical contexts, aligned with patient preferences and institutional scope. Current evidence does not support acupressure as a replacement for established therapies or as a universal standard intervention. When self-administered practice is introduced, structured patient education, direct technique demonstration, performance verification, and adherence monitoring merit consideration.

In conclusion, growing literature on manual body acupressure indicates potential benefits for pain, sleep disruption, and fatigue while revealing important methodological and clinical uncertainties. The distinction between practitioner-delivered and self-administered approaches, sham-control complexity, and treatment protocol heterogeneity are central to evidence interpretation. Acupressure is most appropriately positioned as an adjunctive complement rather than a primary intervention. Future multicenter randomized controlled trials with standardized protocols, clearly described sham procedures, and consistent outcome measures are essential to clarify acupressure's clinical role and establish evidence-based nursing practice recommendations.

Sincerely,

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