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Effectiveness of Five-Element (Ohaeng) Acupuncture for Low Back Pain: A Systematic Review and Meta-Analysis

by

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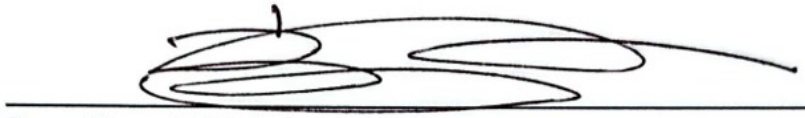

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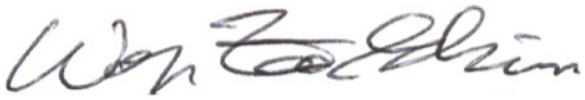

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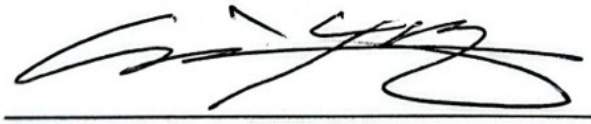

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Effectiveness of Five-Element (Ohaeng) Acupuncture for Low Back Pain: A Systematic Review and Meta-Analysis

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ABSTRACT

Background: Ohaeng (Five-Element) acupuncture is a traditional East Asian medicine-based system aimed at systemic regulation rather than symptom-focused treatment. Despite its clinical use for pain disorders, its effectiveness for low back pain (LBP) has not been systematically evaluated.

Objective: This study evaluated the effectiveness of Ohaeng (Five-Element) acupuncture for LBP using a systematic review and meta-analysis of randomized controlled trials (RCTs).

Methods: International and Korean databases were searched from inception to December 2025. Eligible RCTs were included in a meta-analysis, and observational studies were narratively synthesized. Mean differences (MDs) in Visual Analogue Scale (VAS) scores were pooled using a random-effects model. Heterogeneity was assessed using Higgins' I^2 statistic, and potential publication bias was explored by funnel plot inspection.

Results: Three RCTs (n = 70) were included in the meta-analysis, and five observational

studies were narratively reviewed. The pooled analysis using a random-effects model demonstrated a statistically significant reduction in pain intensity in the experimental groups compared with the control groups (mean difference [MD] = 1.42, 95% CI [0.61, 2.23], $p < 0.01$). Statistical heterogeneity was very low ($I^2 = 5.2\%$, $p = 0.35$), indicating a high level of consistency across studies. Furthermore, the narrative synthesis suggested that specific approaches, particularly Ohaeng-Hwa acupuncture, were associated with improvements in pain severity, functional outcomes, and neurological symptoms. Visual inspection of the funnel plot suggested a relatively symmetrical distribution; however, interpretation was limited by the small number of included studies (n = 3).

Conclusion: Ohaeng (Five-Element) acupuncture may reduce pain in patients with low back pain. Specifically, approaches like Ohaeng-Hwa acupuncture show potential for broader functional recovery. However, the evidence is limited by small sample sizes and a low number of RCTs. Larger, well-designed RCTs are needed to confirm these findings.

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ACKNOWLEGEMENT

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Finally, I am deeply grateful to my family and friends for their unwavering encouragement and support throughout this journey.

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I. INTRODUCTION

Low back pain (LBP) is one of the most prevalent musculoskeletal disorders worldwide and a leading cause of disability and reduced quality of life. Chronic LBP imposes a substantial socioeconomic burden through increased healthcare costs and reduced work productivity. Therefore, identifying effective and safe treatment strategies remains an important clinical priority.

Given the limitations and potential adverse effects of conventional pharmacological therapies, acupuncture has been widely utilized as a non-pharmacological treatment option for LBP. However, most clinical research has evaluated acupuncture as a uniform intervention, often overlooking the distinctive therapeutic characteristics of specific acupuncture systems such as Ohaeng (Five-Element) acupuncture. Ohaeng acupuncture is a therapeutic system grounded in Five-Element theory, emphasizing the regulation of zang-fu (internal organ) functional relationships rather than local symptom targeting. Its therapeutic strategy follows structured inter-element relationships that guide point selection and treatment direction. Because its clinical reasoning and treatment framework differ fundamentally from conventional point-based protocols, evaluating Ohaeng acupuncture within aggregated acupuncture data may obscure its specific therapeutic effects. For this reason, Ohaeng acupuncture should be examined as an independent therapeutic intervention.

Despite its theoretical and clinical relevance, evidence regarding the effectiveness of Ohaeng acupuncture for LBP remains limited and fragmented. Existing studies have primarily consisted of small-scale randomized controlled trials, case reports, and case

series, and to date, no systematic synthesis has specifically evaluated this treatment system. Consequently, the clinical effectiveness of Ohaeng acupuncture remains unclear, highlighting the need for a comprehensive evaluation of its therapeutic utility.

Therefore, this study aimed to systematically evaluate the effectiveness of Ohaeng (Five-Element) acupuncture for LBP. Specifically, a meta-analysis of randomized controlled trials was performed to assess quantitative outcomes related to pain and functional improvement, while a narrative synthesis of observational studies was conducted to incorporate broader clinical evidence.

OBJECTIVES

To evaluate the clinical effectiveness of Ohaeng (Five-Element) acupuncture for low back pain (LBP) by synthesizing quantitative evidence from randomized controlled trials and integrating clinical findings from observational studies.

1. To estimate the pooled effect size of Ohaeng acupuncture on pain intensity, as measured by the Visual Analogue Scale (VAS).

2. To assess the consistency and heterogeneity of treatment effects across the included studies.

3. To explore broader clinical outcomes, including functional and neurological improvements associated with Ohaeng-Hwa acupuncture (五行和鍼法), through a narrative synthesis of case reports and observational studies.

4. To assess the methodological quality of the included studies and evaluate potential publication bias within the current body of literature.

LITERATURE REVIEW

1. Clinical Perspectives on Low Back Pain in Western Medicine

LBP is widely recognized as a multifactorial condition influenced by mechanical, degenerative, and psychosocial factors. Although specific etiologies—such as disc herniation, spinal stenosis, fractures, infections, and inflammatory disorders—can be identified in a subset of patients (Deyo & Weinstein, 2001; Chou et al., 2007), approximately 85–90% of cases are classified as non-specific low back pain without clearly identifiable structural abnormalities (Campbell & Muncer, 2005; Balagué et al., 2012). This observation highlights the complex and multidimensional nature of chronic LBP, in which structural findings alone often fail to fully explain symptom severity or the persistence of pain.

Current management strategies primarily focus on symptom reduction and functional restoration through pharmacological treatments, exercise-based rehabilitation, interventional pain management procedures, and, in selected cases, surgical intervention (Chou et al., 2017; Manchikanti et al., 2018). While these approaches may provide short-term symptom relief for certain patient populations, long-term outcomes remain variable, and recurrence rates are high (Deyo et al., 2015; Buchbinder et al., 2018). As a result, a substantial proportion of patients continue to experience persistent pain and functional limitations despite appropriate biomedical care (Balagué et al., 2012).

In addition to biomechanical contributors, psychosocial and behavioral factors—including psychological stress, depression, sedentary lifestyle, and maladaptive pain beliefs—have been consistently associated with the development of chronic pain and

disability (Linton, 2000; Campbell & Muncer, 2005; Shiri et al., 2010). These findings are consistent with the biopsychosocial model of chronic pain, which conceptualizes LBP as the result of dynamic interactions among biological, psychological, and social determinants.

Given these limitations, increasing attention has been directed toward complementary and integrative treatment approaches that emphasize individualized care and functional recovery. Among these approaches, acupuncture has demonstrated modest but clinically meaningful benefits for chronic LBP in large-scale meta-analyses (Chou et al., 2017; Vickers et al., 2018). However, most clinical research has evaluated acupuncture as a relatively uniform intervention, often overlooking the distinct therapeutic principles of specific acupuncture systems. Within this context, theory-driven systems such as Ohaeng (Five-Element) acupuncture and its clinical application, Ohaeng-Hwa acupuncture (五行和鍼法), warrant independent evaluation to determine whether system-specific therapeutic effects can be distinguished from aggregated acupuncture interventions.

2. Clinical Perspectives on Low Back Pain in Traditional East Asian Medicine

In traditional Chinese medicine (TCM), low back pain (LBP) is conceptualized as arising from systemic imbalances involving the zang-fu organs (internal organs), meridian networks, and the circulation of qi and blood. Classical East Asian medical theory attributes pain to two primary mechanisms: *"bu tong ze tong"* (不通則痛), meaning pain due to obstruction, and *"bu ying ze tong"* (不榮則痛), meaning pain due to insufficient nourishment. These principles reflect the dual pathological processes of

excess conditions—such as qi stagnation, blood stasis, and cold-damp accumulation—and deficiency conditions, including deficiencies of Kidney qi, yin, or yang (Maciocia, 2015; Deadman et al., 2007).

Common etiological patterns associated with LBP include Kidney deficiency (腎虛), cold-damp or damp-heat accumulation (寒濕 / 濕熱), qi and blood stagnation (氣滯血瘀), and Liver qi stagnation (肝氣鬱結). Each pattern presents characteristic symptom profiles and guides individualized treatment strategies through pattern differentiation (辨證論治). Although this diagnostic framework represents a defining feature of TCM practice, it also introduces variability in clinical intervention protocols, presenting challenges for standardization in controlled clinical research.

Diagnosis in TCM is traditionally guided by the four examinations (四診): inspection (observation), auscultation and olfaction, inquiry, and palpation. Particular emphasis is placed on tongue and pulse assessment to determine underlying functional patterns. In research contexts, differences in diagnostic interpretation may influence both intervention design and outcome assessment. Consequently, heterogeneity in diagnostic classification and treatment protocols represents an important methodological consideration in systematic reviews and meta-analyses of acupuncture for LBP.

Treatment strategies aim to regulate both deficiency and excess patterns while addressing localized lumbar symptoms and broader systemic imbalances. Acupuncture protocols commonly combine local lumbar points with distal points selected according to meridian theory and pattern differentiation principles (Deadman et al., 2007). However, inconsistency in pattern classification and point selection remains a major contributor to

between-study heterogeneity. Such variability highlights the importance of clearly defined and reproducible theoretical frameworks when evaluating system-specific acupuncture interventions, including Five-Element–based therapeutic approaches such as Ohaeng-Hwa acupuncture (五行和鍼法).

3. Theoretical Foundations and Clinical Application of Ohaeng-Hwa Acupuncture

3.1 Definition and Theoretical Framework

Ohaeng-Hwa acupuncture (五行和鍼, "Five-Element Harmonizing Acupuncture") is a structured acupuncture system developed within modern Korean clinical scholarship and grounded in classical East Asian medical theory. Although rooted in the universal Five-Phase (五行) framework, Ohaeng-Hwa acupuncture represents a distinctly Korean development that operationalizes inter-element regulation into a reproducible clinical framework. This modality emphasizes the harmonization (*hwa*, 和) of the zang-fu organ systems and meridian networks through the strategic regulation of inter-element dynamics.

Unlike fire needle therapy (火鍼, *huo zhen*), which uses heated needles to produce intense local stimulation, Ohaeng-Hwa acupuncture (五行和鍼) functions primarily as a regulatory and harmonizing treatment modality. It seeks to restore systemic balance through carefully selected point combinations guided by the generating (相生) and controlling (相克) cycles of the Five Elements (Baekdan, 2001). Rather than targeting isolated symptoms, this system conceptualizes treatment as the correction of functional imbalance within an interconnected organ–meridian network. Clinical intervention is

therefore directed toward re-establishing dynamic equilibrium at the systemic level rather than solely addressing localized pathology.

3.2 Core Therapeutic Concept: Hwa (和)

The term *Hwa* (和, harmony) originates from classical East Asian philosophy and denotes a state of balanced regulation rather than the suppression of internal dynamics. In the *Doctrine of the Mean (Zhongyong,* 中庸), harmony is expressed in the phrase "發而皆中節謂之和," which describes a state in which emotions or functional expressions occur in proper proportion and balance (Zhu, 1983). This notion emphasizes regulation and proportionality rather than suppression, providing a conceptual foundation for understanding Hwa (和) in Ohaeng-Hwa acupuncture as a principle of functional balance.

Song Jae-Hoon (pen name: Baekdan, 白丹), the founder of Ohaeng-Hwa acupuncture, formally articulated this concept in his foundational text *Chimbeop Jeongdo* (Baekdan, 2001). In this work, he describes Hwa (和) as a guiding therapeutic principle aimed at restoring functional balance within the *zang-fu* system. Building on this conceptual foundation, the concept of Hwa (和) guides therapeutic strategies toward the harmonization of functional relationships among organ systems rather than merely correcting isolated symptoms.

In this context, *Hwa* (和) acupuncture represents a regulatory framework in which clinical decision-making is guided by the practitioner's awareness of systemic balance and imbalance. It emphasizes treatment that is responsive, adaptive, and proportional to the patient's condition, integrating diagnostic findings with individualized intervention strategies. Thus, Hwa (和) acupuncture is not simply a technical variation of needling but

a clinically oriented method that operationalizes the principle of harmony as functional regulation within the human body.

3.3 Operational Principles of Ohaeng-Hwa Acupuncture (五行和鍼法)

3.3.1 Five Shu Point (五兪穴) Selection within the Ohaeng-Hwa Framework

The Five Shu points (五兪穴)—Jing-Well (井), Ying-Spring (滎), Shu-Stream (兪), Jing-River (經), and He-Sea (合)—are located distal to the elbows and knees along each meridian. Each point corresponds systematically to one of the Five Elements (Wood, Fire, Earth, Metal, and Water), reflecting the progressive flow of qi along the channel system. Notably, the elemental order differs between Yin and Yang meridians, a structural distinction that determines the direction of tonification and sedation in Five-Element-based treatment strategies.

In Ohaeng-Hwa acupuncture, the Five Shu points function as the primary therapeutic units. Accurate understanding of their elemental configuration is therefore fundamental to appropriate point selection and clinical efficacy. Song Jae-Hoon (pen name: Baekdan, 白丹), the founder of Ohaeng-Hwa acupuncture, emphasized in *Chimbeop Jeongdo* (Baekdan, 2001) that “appropriate point selection begins with a precise understanding of the Five Shu point system,” underscoring that this method relies on the structured application of Five-Element principles rather than intuitive or arbitrary needling.

Furthermore, the Five Shu points may also be interpreted through combinatory principles such as the Heavenly Stem correspondences (天干相合), which provide an

additional structural framework for understanding inter-element regulation. Within this configuration, point combinations are not simple aggregations of individual loci but systematically constructed arrangements designed to harmonize elemental imbalance through regulated interaction. In this sense, the Five Shu points constitute the primary operational interface through which the theoretical principles of Ohaeng-Hwa acupuncture are translated into structured clinical decision-making.

3.3.2 Heavenly Stem Combinations Based on Five-Element Theory

The Heavenly Stems (天干, *Tiangan*) represent cyclical phases of qi transformation in classical East Asian cosmology. The system consist of ten designations: Jia (甲), Yi (乙), Bing (丙), Ding (丁), Wu (戊), Ji (己), Geng (庚), Xin (辛), Ren (壬), and Gui (癸). When interpreted within the Five-Element framework, Jia and Yi correspond to Wood; Bing and Ding to Fire; Wu and Ji to Earth; Geng and Xin to Metal; and Ren and Gui to Water (Kwon, 2003, p. 16).

Within classical medical theory, each of the Five Elements is associated with a paired Yin (*zang*) and Yang (*fu*) organ system: Liver–Gallbladder (Wood), Heart–Small Intestine (Fire), Spleen–Stomach (Earth), Lung–Large Intestine (Metal), and Kidney–Bladder (Water). Accordingly, the elemental classifications of the Heavenly Stems can be systematically mapped onto these *zang–fu* systems. The resulting *zang–fu* assignments of the Heavenly Stems are summarized in Table 1.

Table 1. Zang-Fu and Elemental Assignments of the Ten Heavenly Stems.

天干	甲 Jia	乙 Yi	丙 Bing	丁 Ding	戊 Wu	己 Ji	庚 Geng	辛 Xin	壬 Ren	癸 Gui
陰陽	陽 Yang	陰 Yin	陽 Yang	陰 Yin	陽 Yang	陰 Yin	陽 Yang	陰 Yin	陽 Yang	陰 Yin
五行	木 (Wood)		火 (Fire)		土 (Earth)		金 (Metal)		水 (Water)	
臟腑	膽 GV	肝 LV	小腸 SI	心 HT	胃 ST	脾 SP	大腸 LI	肺 LU	膀胱 UB	腎 KD

In the *Huangdi Neijing Suwen*, Chapter 67 (“Wuyun Xingda Lun,” 五運行大論), the relationships between the Five Movements (五運) and the Heavenly Stems are described as follows: 土主甲己, 金主乙庚, 水主丙辛, 木主丁壬, 火主戊癸 (Bae, 1999). This passage describes the following correspondences: Earth governs Jia (甲) and Ji (己); Metal governs Yi (乙) and Geng (庚); Water governs Bing (丙) and Xin (辛); Wood governs Ding (丁) and Ren (壬); and Fire governs Wu (戊) and Gui (癸). Rather than representing fixed elemental identities, this formulation reflects a dynamic model in which elemental relationships emerge through paired correspondences within cyclical movement.

Within Ohaeng-Hwa acupuncture, this principle provides an additional theoretical basis for constructing point combinations. The Heavenly Stem pairing system suggests that elemental balance may be regulated through structured correspondences that emphasize transformation and harmonization between paired elements, rather than through isolated tonification or sedation of a single element. In this way, *Tiangan* combinations support a relational framework of treatment in which therapeutic effects arise from the patterned interaction of points grounded in Five-Element dynamics.

Table 2. Zang–Fu Correspondences and Elemental Transformations of Heavenly Stem Pairings.

Heavenly Stems Combination	Organ Pair	Elemental Nature	Transformation
甲 + 己	GB + Spleen	Wood (Yang) + Earth (Yin)	Earth
乙 + 庚	Liver + Large Intestine	Wood (Yin) + Metal (Yang)	Metal
丙 + 辛	Small Intestine + Lung	Fire (Yang) + Metal (Yin)	Water
丁 + 壬	Heart + Bladder	Fire (Yin) + Water (Yang)	Wood
戊 + 癸	Stomach + Kidney	Earth (Yang) + Water (Yin)	Fire

This table translates the classical formulation into a systematic framework that makes explicit the relational logic underlying Heavenly Stem pairings. By mapping organ correspondences and elemental transformations, it demonstrates how combinatory relationships are conceptualized as dynamic regulatory processes within the theoretical structure of Ohaeng-Hwa acupuncture.

3.3.3 Five-Element Matching Framework (五行相合論) in Ohaeng-Hwa Acupuncture

Ohaeng-Hwa acupuncture is fundamentally grounded in the principles of Heavenly Stem correspondences (天干相合) and the Five-Element Matching Theory (五行相合論). According to this framework, specific Yin and Yang meridians form paired relationships in which their states of deficiency and excess (虛實) are functionally synchronized. Baekdan (2001) defined *xianghe* (相合, “matching” or “harmonizing”) as a relationship in which two meridians share the same tendency toward deficiency or excess, thereby forming a unified regulatory unit for clinical decision-making.

Table 3. Five-Element Correspondences of the Five Shu Points for Yin and Yang Meridians.

Five Shu Points 五俞穴	Jing-Well 井	Ying-Spring 滎	Shu-Stream 俞	Jing-River 經	He-Sea 合
Yin Meridians 陰經	Wood [木]	Fire [火]	Earth [土]	Metal [金]	Water [水]
	Liver [肝]	Heart [心]	Spleen [脾]	Lung [肺]	Kidney [腎]
Yang Meridians 陽經	Metal [金]	Water [水]	Wood [木]	Fire [火]	Earth [土]
	Large Intestine [大腸]	Urinary Bladder [膀胱]	Gallbladder [膽]	Small Intestine [小腸]	Stomach [胃]

Within this system, Yin and Yang meridians are paired according to the xianghe (相合) principles summarized in Table 3 as follows: Liver (陰木) with Large Intestine (陽金), Heart (陰火) with Urinary Bladder (陽水), Spleen (陰土) with Gallbladder (陽木), Lung (陰金) with Small Intestine (陽火), and Kidney (陰水) with Stomach (陽土).

These pairings indicate that imbalance in one meridian is reflected in its corresponding partner, and therapeutic intervention may therefore be directed to either channel to achieve regulatory effects. For example, when the Lung exhibits excess (實), the Large Intestine—its Yin–Yang paired channel—tends toward deficiency (虛). Because Metal controls Wood (金克木), this imbalance may also influence the Liver, resulting in a functional convergence of deficiency between the Liver and the Large Intestine. In this context, tonifying the Liver is considered functionally equivalent to tonifying the Large Intestine, as both channels participate in the same regulatory imbalance (Baekdan, 2001).

Clinically, this means that point selection in Ohaeng-Hwa acupuncture is not based on isolated organ pathology but on paired meridian configurations. For instance, if tonifying a point on the Liver channel, such as LR1, is indicated, tonifying the corresponding point on the Large Intestine channel, such as LI1, may produce equivalent regulatory effects. Thus, Ohaeng-Hwa acupuncture applies the principle of xianghe (相合) as a foundational rule for selecting point combinations.

Table 4. Comprehensive Xianghe (相合) Relationships and Synchronized Deficiency-Excess Dynamics.

Five Shu Points 五兪穴	Jing-Well 井	Ying-Spring 滎	Shu-Stream 兪	Jing-River 經	He-Sea 合
Yin Meridians	Liver [Wood]	Heart [Fire]	Spleen [Earth]	Lung [Metal]	Kidney [Water]
Yang Meridians	Large Intestine [Metal]	Urinary Bladder [Water]	Gallbladder [Wood]	Small Intestine [Fire]	Stomach [Earth]
Clinical State	Synchronized [虛實 同]	Synchronized [虛實 同]	Synchronized [虛實 同]	Synchronized [虛實 同]	Synchronized [虛實 同]

Note. "Synchronized" indicates that deficiency (虛) or excess (實) in one meridian implies a parallel state in its paired xianghe (相合) partner.

The complete set of these xianghe (相合) relationships and their corresponding deficiency-excess (虛實) dynamics is summarized in Table 4. This relational structure demonstrates that Ohaeng-Hwa acupuncture operates according to a configurational logic in which diagnosis and treatment are formulated through paired meridian dynamics rather than isolated organ-based interventions. By transforming traditional correspondence

theory into an operational algorithm, this Five-Element matching system provides a structured framework for clinical regulation.

3.3.4 Application of Xianghe (相合) Principle to the Five Shu Points

The principle of xianghe (相合) is also applied to the Five Shu point system in Ohaeng-Hwa acupuncture, extending beyond organ and meridian pairings to the elemental classification of individual acupuncture points. Because each of the Five Shu points is assigned a specific Five-Element attribute, the *xianghe* relationships therefore operate at the level of point selection as well as meridian dynamics.

For example, on the Lung meridian, the Jing-Well point LU11 is classified as a Wood point, whereas on its paired Yang channel, the Large Intestine meridian, the Jing-Well point LI1 is classified as a Metal point. According to the xianghe principle, Wood (Yin) and Metal (Yang) form a harmonizing pair corresponding to the Heavenly Stem pairing Yi–Geng (乙庚合金). Therefore, if tonification of LU11 is clinically indicated, tonification of LI1 is expected to yield a comparable regulatory effect.

Thus, the Five Shu points function not as isolated elemental units but as paired regulatory components within a structured system. Their Five-Element correspondences are organized according to the same *xianghe* relationships that govern meridian and organ pairings (Wood (Liver) – Metal (Large Intestine), Fire (Heart) – Water (Urinary Bladder), Earth (Spleen) – Wood (Gallbladder), Metal (Lung) – Fire (Small Intestine), and Water (Kidney) – Earth (Stomach)). As

illustrated in Table 5, this configurational arrangement indicates that point selection in Ohaeng-Hwa acupuncture is governed by a unified Five-Element matching framework, in which therapeutic intervention is structured through harmonized pair dynamics rather than isolated point or single-meridian targeting.

Table 5. Xianghe-Based Five-Element Pairing of the Five Shu Points in the Lung–LI Meridians.

Lung Meridian	木 LU 11	火 LU 10	土 LU 9	金 LU 8	水 LU 5
LI Meridian	金 LI 1	水 LI 2	木 LI 3	火 LI 5	土 LI 11

3.3.5 Regulatory Architecture of Five Shu Point Pairing in Ohaeng-Hwa Acupuncture

In summary, functional imbalance at the level of the Five Shu points is understood to occur in parallel between Yin–Yang paired meridians. Because the Five Shu points of interior–exterior paired channels are allocated according to the principle of Heavenly Stem combinations (*tiangan xianghe*), elemental imbalances are shared across these paired channels. Consequently, therapeutic effects achieved by manipulating a point on a Yin meridian are expected to produce a comparable regulatory effect when applied to the corresponding point on its paired Yang meridian. For example, the deficiency–excess dynamics between the Liver and Large Intestine meridians are considered functionally equivalent; thus, tonification of the Liver meridian Jing-Well point (LR1) may produce a clinical response comparable to tonifying the Large Intestine meridian Jing-Well point (LI1).

These relationships demonstrate that in Ohaeng-Hwa acupuncture, point selection is governed by a paired regulatory logic in which the Five Shu points are not treated as isolated entities but as functionally interconnected components within a harmonizing system. Baekdan (2001) emphasized that an accurate understanding of their elemental allocation and Heavenly Stem combinatory structure is a prerequisite for appropriate point selection. Accordingly, prescriptions involving the Five Shu points must be formulated in accordance with the principle of *xianghe* (相合), reflecting that Ohaeng-Hwa acupuncture is grounded in a structured theoretical system rather than arbitrary point selection.

3.4 Operationalization of Nan Jing Difficulty 75 in Ohaeng-Hwa Acupuncture: : A Zang-Based Therapeutic Framework

Ohaeng-Hwa acupuncture (五行和鍼法), formulated by Song Jae-Hoon, is grounded in a synthesis of classical principles derived from the *Huangdi Neijing* and the *Nan Jing*. In particular, this system operationalizes the theoretical frameworks presented in Nan Jing Difficulty 75 and Difficulty 69. Difficulty 75 describes pathological changes of the zang organs following the controlling cycle (相克), whereas Difficulty 69 explains disorders of the fu organs according to the generating cycle (相生) (Gam & Park, 2005).

According to Baekdan (2001), diseases of the five zang organs tend to progress along the controlling cycle of the Five Phases and should therefore be treated based on the therapeutic principles described in *Nan Jing* Difficulty 75. In contrast, disorders of the six fu organs follow the generating cycle and are treated in accordance with the principles

outlined in Difficulty 69. This distinction forms the core operational framework of Ohaeng-Hwa acupuncture (五行和鍼).

Nan Jing Difficulty 75 opens with the statement: “When the East is excess and the West is deficient, drain the South and tonify the North.” Clinically, this passage is interpreted as representing a pattern of Liver excess and Lung deficiency (木實金虛, 肝實肺虛). In this situation, the recommended treatment is to drain Fire (Heart) and tonify Water (Kidney), expressed as 瀉火補水.

This therapeutic strategy is derived from the controlling relationships of the Five Phases. When Fire becomes excessive, it overcontrols Metal, resulting in Metal deficiency. Deficient Metal subsequently fails to restrain Wood, allowing Wood to become excessive. However, the root of this pathological cascade is attributed to Water deficiency, which weakens the Water–Fire controlling relationship and permits Fire to become excessive.

Accordingly, treatment must address the root imbalance by tonifying Water to restore its controlling function over Fire while simultaneously draining Fire to reduce its pathological excess. Once Fire is regulated, Metal can recover its capacity to restrain Wood, thereby restoring systemic balance within the Five-Phase network. This mechanism reflects the classical principle expressed in Difficulty 75: “If the deficiency is not treated, how can the remaining disorders be addressed?”

As illustrated in Figure 1, although clinical manifestations are typically observed at the levels of Wood and Metal, the underlying pathology originates from Water

deficiency accompanied by secondary Fire excess. These two elements therefore constitute the primary therapeutic targets in Ohaeng-Hwa acupuncture.

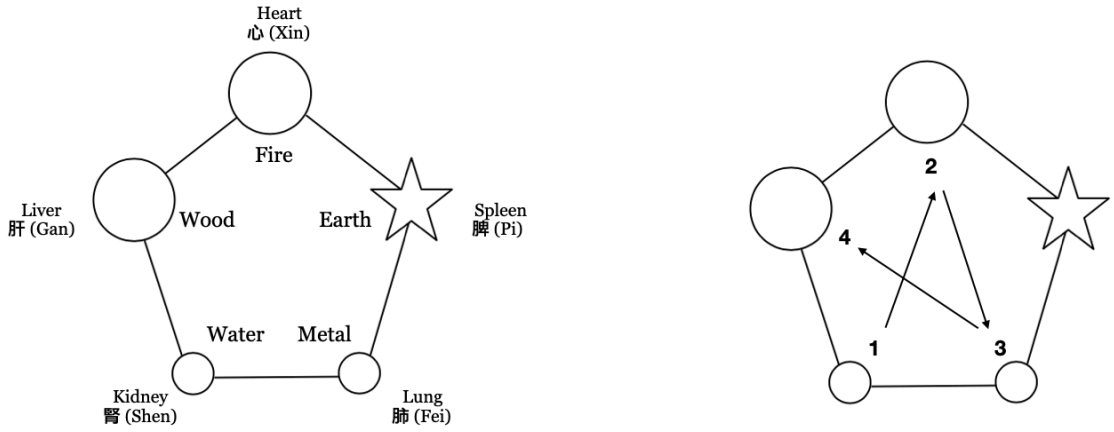

Figure 1. Pathological progression of Wood Excess and Metal Deficiency (木實金虛) based on the controlling cycle in Nan Jing, Difficulty 75.

The diagram illustrates the underlying pathology of Water deficiency and the secondary manifestation of Fire excess. From the perspective of Ohaeng-Hwa acupuncture (五行和鍼), Nan Jing Difficulty 75 provides a regulatory framework in which diagnosis and treatment are formulated not merely on the basis of superficial organ imbalance but through identification of the underlying pathological layer within the Five-Phase network.

3.5 Hetu (河圖) and Luoshu (洛書) as Cosmological Regulatory Models: The Theoretical Basis for Zang and Fu Treatment (腑方)

3.5.1 Hetu (河圖) and Luoshu (洛書) as Foundational Models of Generation and Control

In classical East Asian medical cosmology, Hetu (河圖) and Luoshu (洛書) represent two complementary regulatory models that describe the dynamic relationships among the Five Phases and the internal organ systems. Hetu corresponds to the pre-heaven (先天) order and is associated with Yang and the principle of generation (相生). In contrast, Luoshu represents the post-heaven (後天) order and is associated with Yin and the principle of control (相剋).

From the perspective of Ohaeng-Hwa acupuncture, these two cosmological models provide the operational logic for differentiating treatment strategies for the zang and fu organ systems. Luoshu forms the theoretical basis for zang-oriented treatment (臟方), which follows the controlling cycle to regulate deep-seated pathological imbalances. In contrast, Hetu serves as the conceptual foundation for fu-oriented treatment (腑方), which follows the generating cycle to facilitate the circulation and transformation of qi.

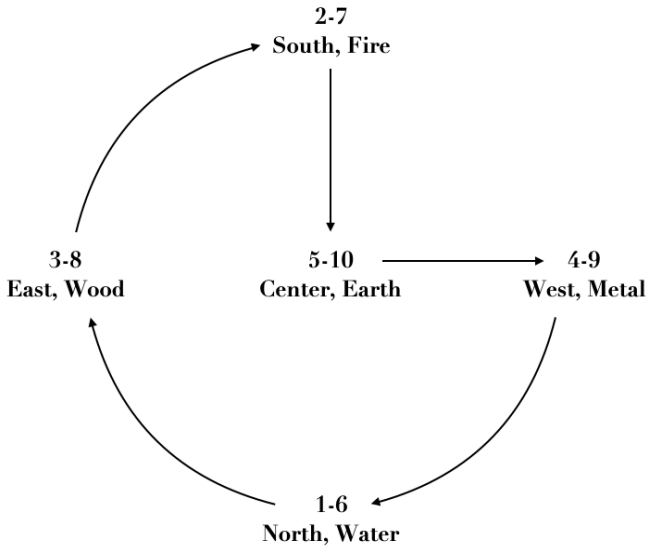

Figure 2. Hetu (河圖) as the Pre-heaven (先天) Regulatory Model.

As illustrated in Figure 2, *Hetu* (河圖) represents the pre-heaven (先天) order and embodies Yang, Qi, and the principle of generation (相生). The circulation follows the sequence Water → Wood → Fire → Earth → Metal → Water, reflecting a self-supporting and nourishing regulatory system. Within the framework of Ohaeng-Hwa acupuncture, Hetu is associated with the fu organs and forms the theoretical foundation of fu-oriented treatment (腑方).

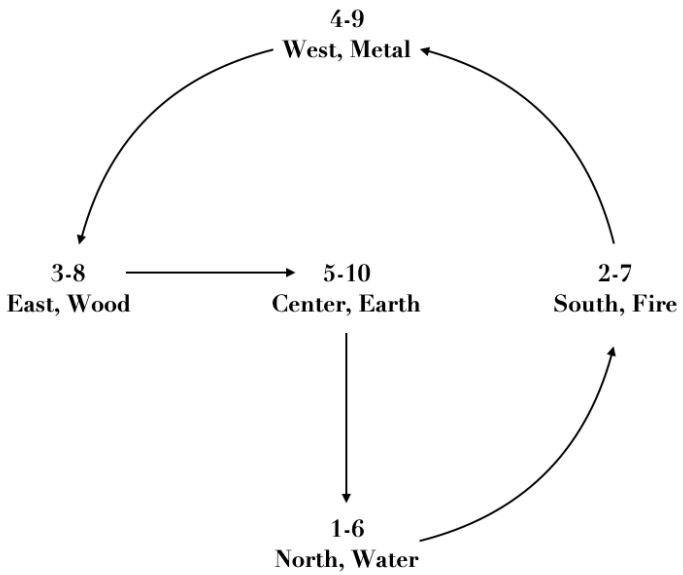

Figure 3. Luoshu (洛書) as the Post-heaven (後天) Regulatory Model.

In contrast, *Luoshu* (洛書) represents the post-heaven (後天) order and embodies Yin, Blood, and the principle of control (相剋). The circulation follows the sequence Water → Fire → Metal → Wood → Earth → Water, reflecting a regulatory system based on restraint and balance. Accordingly, Luoshu is associated with the zang organs and provides the theoretical foundation for zang-oriented treatment (臟方) in Ohaeng-Hwa acupuncture.

Table 6. Comparative Characteristics of Hetu (河圖) and Luoshu (洛書).

Model	Cosmological Phase	Yin-Yang	Regulatory Principle	Functional Aspect	Symbolic Domain	Direction of Rotation	Total Number	Systemic Characteristic
河圖	Pre-Heaven 先天	Yang 陽	Generation 相生	Qi 氣	Heaven 象天	Left Rotation 左旋	55 五十五	Yang Excess 陽有餘
洛書	Post-Heaven 後天	Yin 陰	Control 相剋	Blood 血	Earth 象地	Right Rotation 右旋	45 四十五	Yin Deficiency 陰不足

In this framework, Hetu and Luoshu are not merely symbolic cosmological diagrams but function as operational models that distinguish between fu- and zang-oriented therapeutic strategies. As summarized in Table 7, Hetu governs the principle of generation (相生) and provides the theoretical basis for fu treatment, whereas Luoshu governs the principle of control (相剋) and informs zang treatment strategies. This structural distinction enables Ohaeng-Hwa acupuncture to translate classical cosmological theory into a coherent clinical algorithm rather than a purely philosophical framework.

3.5.2 *Nan Jing* Difficulty 54: Zang vs Fu Pathology

Nan Jing, Difficulty 54 describes that zang disorders are transmitted along the controlling cycle, whereas fu disorders are transmitted along the generating cycle. This passage establishes a fundamental distinction: zang pathology follows the logic of control (相剋), while fu pathology follows the logic of generation (相生). Conceptually, this framework aligns with the theoretical distinction between Luoshu and Hetu, providing a

pathological basis for the divergent treatment strategies employed in Ohaeng-Hwa acupuncture.

3.5.3 *Nan Jing* Difficulty 69: Generating-Cycle Treatment Principle

According to *Nan Jing* Difficulty 69, “deficiency should be treated by tonifying the mother, and excess should be treated by draining the child” (虛者補其母, 實者瀉其子). This rule operationalizes the generating cycle (相生) as a structured therapeutic principle. In Ohaeng-Hwa acupuncture, Difficulty 69 provides the classical foundation for fu-oriented treatment (腑方), in which diagnosis and point selection are structured through the reinforcing and reducing dynamics of the generating cycle.

3.5.4 Fu Formula (腑方) in Ohaeng-Hwa Acupuncture

Collectively, Hetu, Nan Jing Difficulty 54, and Nan Jing Difficulty 69 establish the theoretical foundation for fu treatment strategies (腑方) in Ohaeng-Hwa acupuncture. Whereas zang formulas (臟方) are structured according to the controlling cycle—grounded in Luoshu and Nan Jing Difficulty 75—fu formulas are structured according to the generating cycle, grounded in Hetu and Nan Jing Difficulty 69.

This structured distinction between the controlling and generating systems systematizes classical cosmological theory into a coherent clinical regulatory framework. Through this differentiation, Ohaeng-Hwa acupuncture integrates cosmological order, pathological transmission patterns, and therapeutic formulation into a unified regulatory architecture.

3.6 Diagnostic Reasoning and Pulse Interpretation in Ohaeng-Hwa Acupuncture

In Ohaeng-Hwa acupuncture, diagnostic reasoning is primarily based on the Cunkou (寸口) pulse method described in the *Nan Jing* and is integrated with the Comparative Pulse Diagnosis Based on the Controlling Cycle (相剋比較脈診法) proposed by Lee Jae-Won. This diagnostic approach evaluates deficiency and excess by directly comparing the pulse strengths of meridians linked through the controlling (相剋) relationships within the Five-Element network.

The diagnostic topography follows the classical arrangement: the left wrist corresponds to the Heart, Liver, and Kidney, while the right wrist corresponds to the Lung, Spleen, and Mingmen. Importantly, pulse diagnosis is conducted through pairwise comparison rather than isolated assessment. This comparative approach enables the practitioner to identify relative imbalances within the Five-Phase regulatory network.

The standard diagnostic procedure consists of three sequential steps:

1. Cun Position Comparison:

   A direct comparison of the Heart (Left) and Lung (Right) pulses.
2. Guan Position Comparison:

   A direct comparison of the Liver (Left) and Spleen (Right) pulses.
3. Decisive Synthesis:

   A final comparative evaluation between two adjacent pulses within the Five-Phase diagram, integrating the results of the previous steps.

Omitting the third stage may result in misclassification of the underlying pattern, as the final determination depends on identifying the deeper regulatory imbalance. As

illustrated in the following figures, these comparative findings are translated into specific pathological configurations within the Five-Element regulatory network.

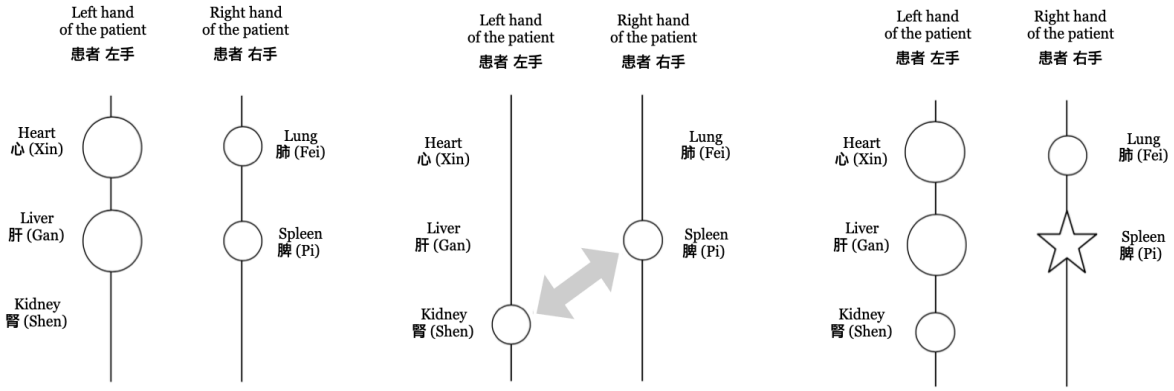

Figure 4. Pulse Pattern Diagram: Wood Excess–Metal Deficiency (木實金虛).

This pulse pattern is characterized by relatively stronger and fuller pulses at the Wood positions and comparatively weaker pulses at the Metal positions, indicating a pattern of Wood excess and Metal deficiency.

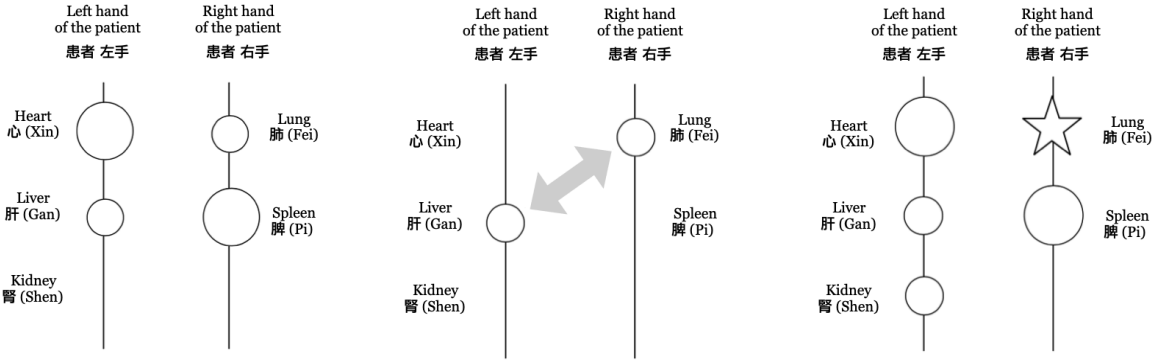

Figure 5. Pulse Pattern Diagram: Fire Excess–Water Deficiency (火實水虛).

This pulse pattern is characterized by relatively stronger and fuller pulses at the Fire positions and comparatively weaker pulses at the Water positions, indicating a pattern of Fire excess and Water deficiency

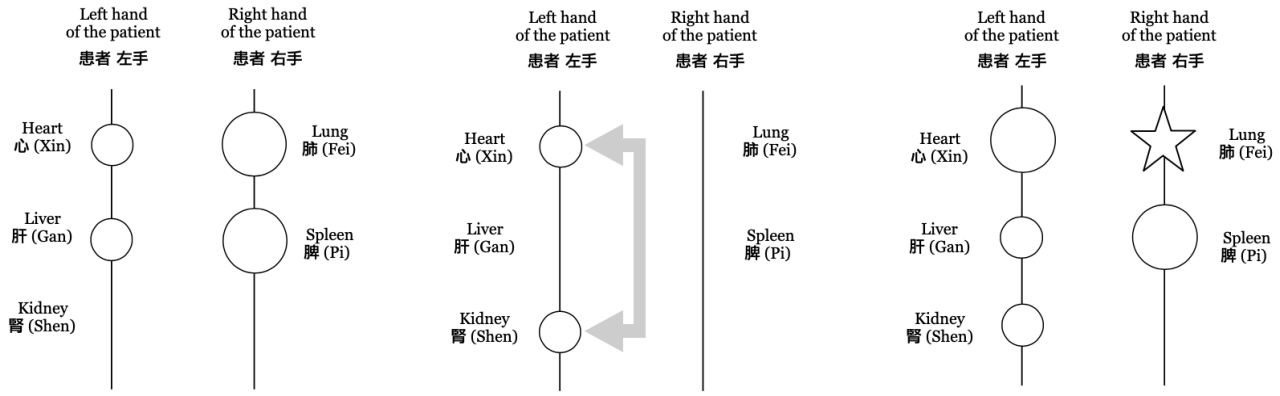

Figure 6. *Pulse Pattern Diagram: Earth Excess–Wood Deficiency (*土實木虛*)*

This pulse pattern is characterized by relatively stronger and fuller pulses at the Earth positions and comparatively weaker pulses at the Wood positions, indicating a pattern of Earth excess and Wood deficiency.

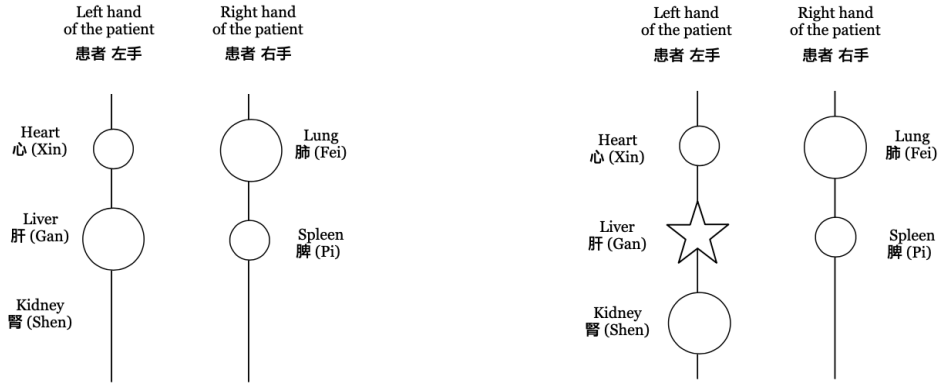

Figure 7. Pulse Pattern Diagram: Metal Excess–Fire Deficiency (金實火虛).

This pulse pattern is characterized by relatively stronger and fuller pulses at the Metal positions and comparatively weaker pulses at the Fire positions, indicating a pattern of Metal excess and Fire deficienc

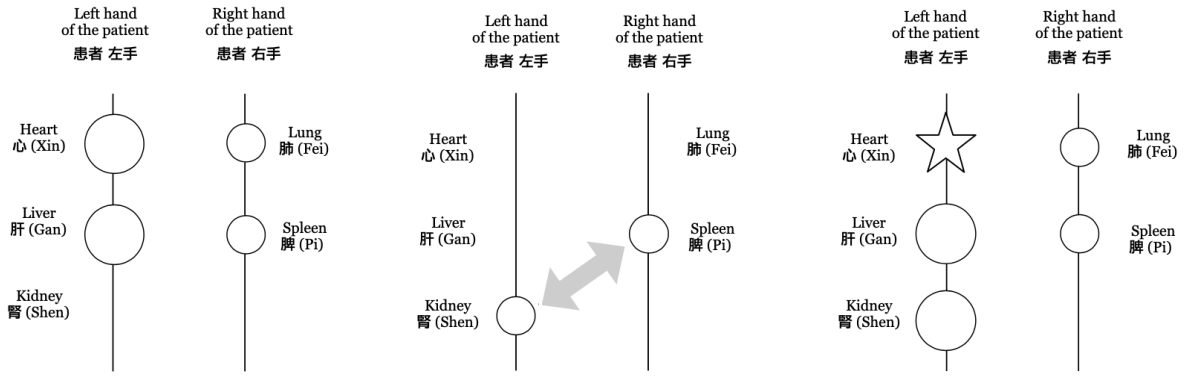

Figure 8. Pulse Pattern Diagram: Water Excess–Earth Deficiency (水實土虛).

This pulse pattern is characterized by relatively stronger and fuller pulses at the Metal positions and comparatively weaker pulses at the Fire positions, indicating a pattern of Metal excess and Fire deficiency.

Based on the results of comparative pulse diagnosis, patients are classified into five diagnostic patterns: Wood Excess–Metal Deficiency, Fire Excess–Water Deficiency, Earth Excess–Wood Deficiency, Metal Excess–Fire Deficiency, and Water Excess–Earth Deficiency. These five pulse configurations constitute the diagnostic basis for individualized treatment strategies in Ohaeng-Hwa acupuncture.

3.7 Treatment Strategies and Acupuncture Point Selection

3.7.1 Wood Excess–Metal Deficiency Pattern (木實金虛)

In the Wood Excess–Metal Deficiency pattern, the pulse configuration is represented as a pentagonal structure derived from comparative pulse diagnosis.

Diagnostic analysis identifies Kidney deficiency as the primary etiological root (Level 1), followed by Heart excess (Level 2), Lung deficiency (Level 3), and Liver excess (Level 4), with the Spleen functioning as a neutral stabilizing organ (中立臟腑). This pentagonal configuration reflects a temporal progression of pathological transmission rather than a simple hierarchy of pulse strength.

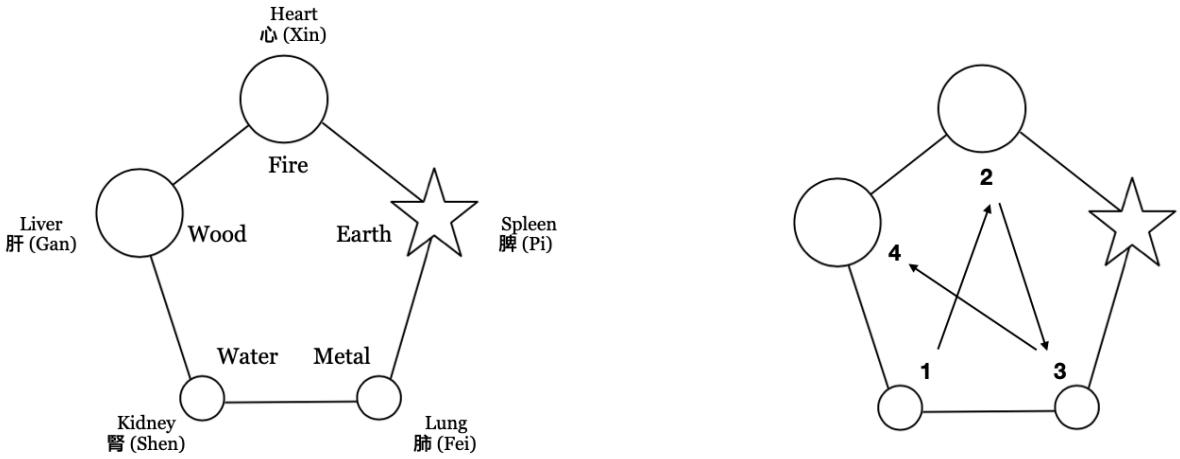

Figure 9. Pathological Transmission Sequence for the Wood Excess–Metal Deficiency Pattern (木實金虛).

According to *Nan Jing* Difficulty 75, treatment follows the principle of "tonifying the North (Water) and draining the South (Fire)" (補北方水, 瀉南方火). Therefore, treatment is directed first toward the deepest deficient layer (Kidney) and subsequently toward the regulation of excessive Fire activity to restore systemic balance. The fundamental therapeutic prescription consists of:

- **Tonification (+):** KI10 (Yin-gu, 陰谷)
- **Sedation (-):** HT8 (Shao-fu, 少府)

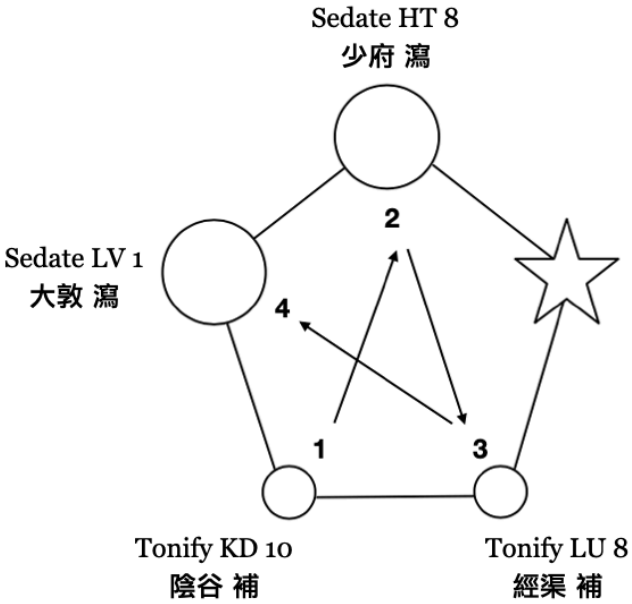

Figure 10. Therapeutic Application of Nan Jing Difficulty 75 for the Wood Excess–Metal Deficiency Pattern (木實金虛).

Additional prescriptions may be systematically derived by applying the same Five-Element logic within each meridian, allowing multiple clinically effective point combinations while preserving the core therapeutic structure. Although various point combinations are possible, all prescriptions share the same therapeutic principle: tonifying the primary deficiency and draining the secondary excess in accordance with the controlling-cycle pathology described in *Nan Jing*, Difficulty 75.

This pattern reflects a temporal sequence in which Kidney deficiency precedes Heart excess, followed by Lung deficiency and Liver excess, thereby establishing the Kidney as the primary etiological root.

Table 7. Representative Acupuncture Prescriptions for the Wood Excess–Metal Deficiency Pattern (木實金虛).

Formula	Tonification (+)	Sedation (−)
1.	KI10 (陰谷)	HT 8 (少府)
2.	LU 8 (**經渠**)	LV 1 (大敦)
3.	KI 7 (復溜)	HT 9 (少衝)
4.	HT 3 (少海)	LU10 (魚際)
5.	LU 5 (尺澤)	LV 2 (行間)

3.7.2 Fire Excess–Water Deficiency Pattern (火實水虛)

In the Fire Excess–Water Deficiency pattern (火實水虛), the pulse configuration is represented as a pentagonal structure derived from comparative pulse diagnosis. Diagnostic analysis identifies Liver deficiency as the primary etiological root (Level 1), followed by Spleen excess (Level 2), Kidney deficiency (Level 3), and Heart excess (Level 4), with the Lung functioning as a neutral stabilizing organ (中立臟腑). This configuration reflects a temporal progression of pathological transmission rather than a simple hierarchy of pulse strength.

This pattern indicates that the apparent Fire excess is a secondary manifestation arising from an underlying failure of Water to restrain Fire, rooted in earlier imbalances within the generating and controlling cycles.

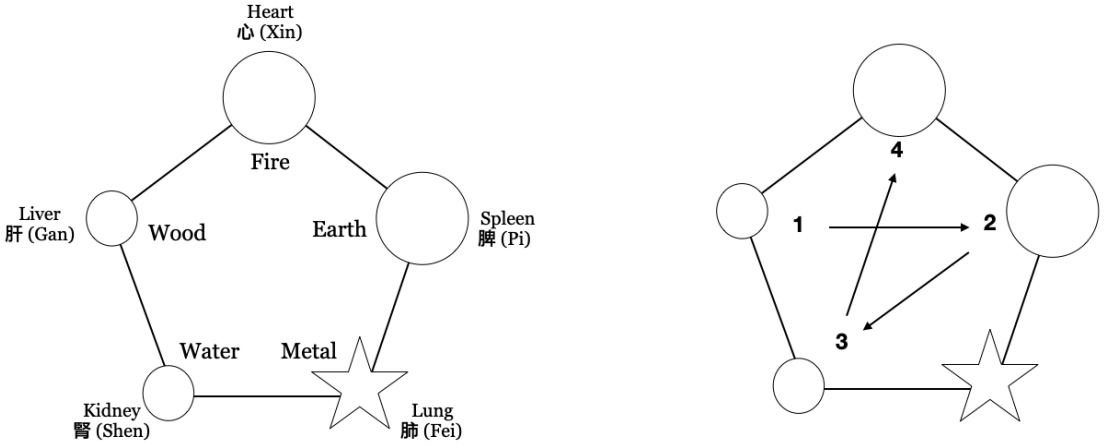

Figure 11. Pathological Transmission Sequence for the Fire Excess–Water Deficiency Pattern (火實水虛).

According to the principle articulated in *Nan Jing*, Difficulty 75, “failure to treat the root deficiency renders all subsequent treatments ineffective” (不能治其虛, 何問其餘). Therefore, therapeutic priority must be given to tonifying the primary deficient layer (Level 1) before draining the secondary excessive layer (Level 2).

From the perspective of Five-Element theory, Fire excess arises from the failure of Water to restrain Fire (水不克火), reflecting disruption within the generating sequence. Accordingly, treatment must restore systemic balance by strengthening the root deficiency while reducing the secondary excess.

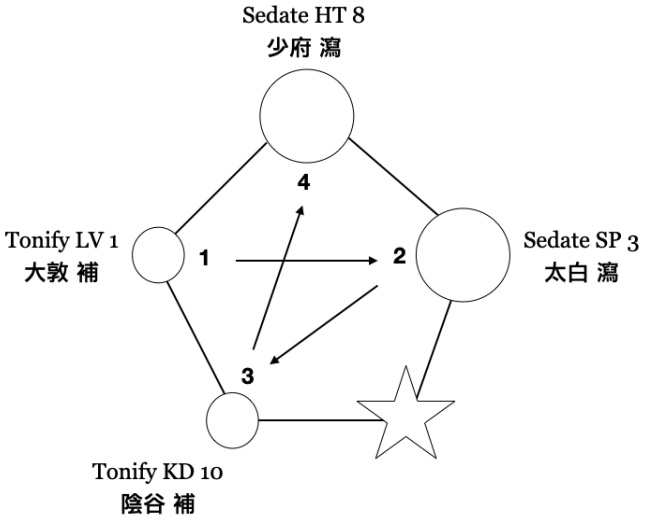

Figure 12. Therapeutic Application of Nan Jing Difficulty 75 for the Fire Excess–Water Deficiency Pattern (火實水虛).

Following the teaching of *Nan Jing*, Difficulty 75, the therapeutic strategy is: "Tonify the first deficient layer and drain the second excessive layer."

- **Formula 1** addresses the primary pathological axis by tonifying the Liver (Level 1) and draining the Spleen (Level 2).
- **Formula 2** regulates the secondary axis by tonifying the Kidney (Water) and sedating the Heart (Fire), reinforcing the same Five-Element logic at a deeper systemic level.

Additional prescriptions (Formulas 3–5) may be derived by applying the same Five-Element algorithm within each meridian, thereby preserving the structural logic of tonifying the root deficiency and draining the secondary excess.

Table 8. Representative Acupuncture Prescriptions for the Fire Excess–Water Deficiency Pattern (火實水虛).

Formula	Tonification (+)	Sedation (−)
1.	LV 1 (大敦)	SP 3 (太白)
2.	KD10 (陰谷)	HT 8 (少府)
3.	LV 8 (曲泉)	SP 2 (大都)
4.	SP 1 (隱白)	KI 3 (太谿)
5.	KD 1 (湧泉)	HT 7 (神門)

This pulse pattern represents a temporal sequence of pathological transmission rather than a simple hierarchy of magnitude. Correct interpretation of this temporal structure is essential, as treatment directed solely at symptomatic Fire excess without correcting the underlying deficiency contradicts the classical warning described in *Nan Jing* Difficulty 75.

3.7.3 Earth Excess–Wood Deficiency Pattern (土實木虛)

In the Earth Excess–Wood Deficiency pattern, the pulse configuration is represented as a pentagonal structure derived from comparative pulse diagnosis. Diagnostic analysis identifies Heart deficiency as the primary etiological root (Level 1), followed by Lung excess (Level 2), Liver deficiency (Level 3), and Spleen excess (Level 4), with the Kidney functioning as a neutral stabilizing organ (中立臟腑).

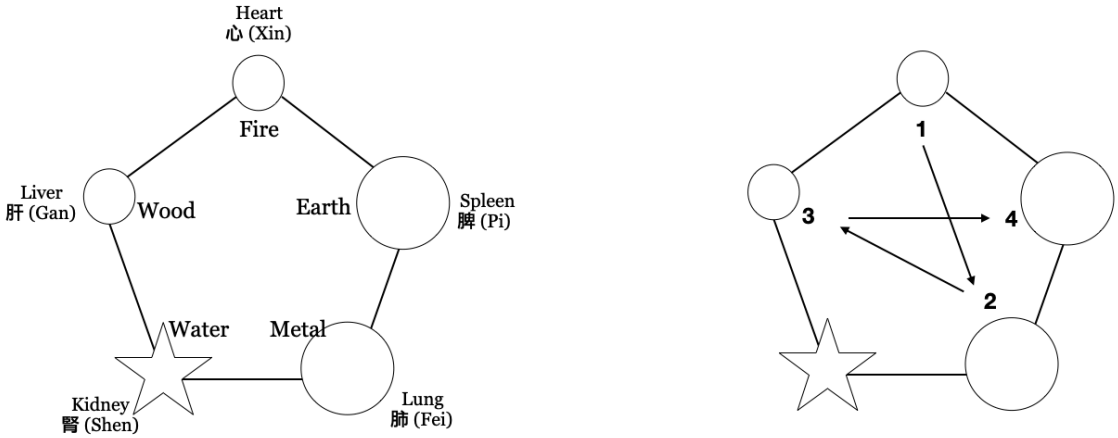

Figure 13. Pathological Transmission Sequence for the Earth Excess–Wood Deficiency Pattern (土實木虛).

This pentagonal configuration reflects a temporal progression of pathological transmission rather than a simple hierarchy of pulse strength. Clinically, although Spleen (Earth) excess often appears as the dominant manifestation, it is not the primary cause. According to the principle "the child makes the mother excessive" (子能令母實), Earth excess arises from earlier imbalance within its generating and controlling relationships. The true pathological origin lies in Heart deficiency, initiating the following sequence: Heart deficiency (Level 1) → Lung excess (Level 2) → Liver deficiency (Level 3) → Spleen excess (Level 4).

Thus, the apparent Earth excess represents a downstream manifestation of a deeper deficiency pattern. Following *Nan Jing* Difficulty 75, the therapeutic strategy is to "tonify the first deficient layer and drain the second excessive layer." When Levels 1 and 2 are properly regulated, the imbalances at Levels 3 and 4 resolve naturally, as they represent secondary and tertiary manifestations.

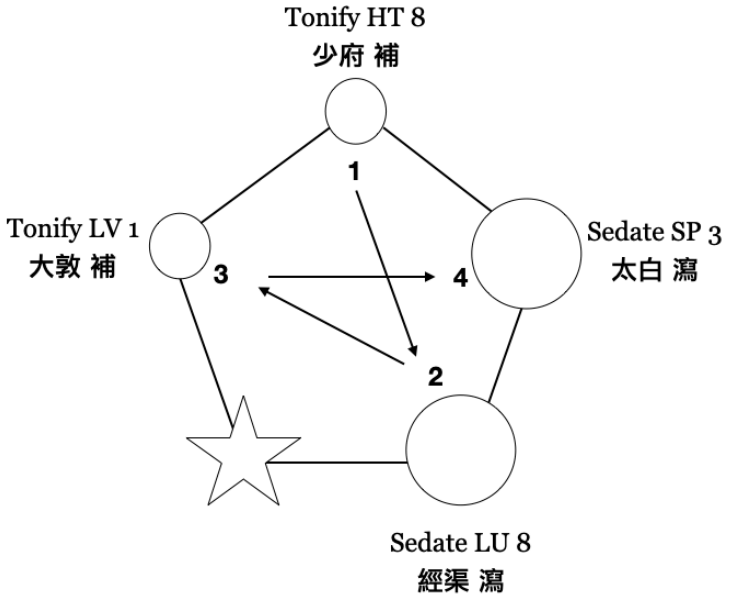

Figure 14. Therapeutic Application of Nan Jing Difficulty 75 for the Earth Excess–Wood Deficiency Pattern (土實木虛).

Formula 1 addresses the core pathology by tonifying the Heart (Level 1) and draining the Lung (Level 2). Formula 2 supports the resolution of secondary imbalance by tonifying the Liver (Level 3) and draining the Spleen (Level 4).

Additional prescriptions (Formulas 3, 4, and 5) are generated using the same Five-Element logic within each meridian. All prescriptions follow the same structural rule: tonification of the primary deficiency and sedation of the secondary excess, guided by the controlling-cycle pathology described in *Nan Jing*, Difficulty 75.

Table 9. Representative Acupuncture Prescriptions for the Earth Excess–Wood Deficiency Pattern (土實木虛).

Formula	Tonification (+)	Sedation (−)
1.	HT 8 (少府)	LU 8 (經渠)
2.	LV 1 (大敦)	SP 3 (太白)
3.	HT 9 (少衝)	LU 9 (太淵)
4.	LU10 (魚際)	LV 4 (中封)
5.	LV 2 (行間)	SP 5 (商丘)

This formulation demonstrates that the Earth Excess–Wood Deficiency pattern is not merely a local imbalance of the Spleen and Liver but a systemic disorder rooted in the Heart–Lung axis. Correcting this root deficiency is therefore essential, consistent with the principle emphasized in *Nan Jing* Difficulty 75: failure to treat the primary deficiency renders treatment of secondary manifestations ineffective.

3.7.4 Metal Excess–Fire Deficiency Pattern (金實火虛)

In the Metal Excess–Fire Deficiency pattern, the pulse configuration is represented as a pentagonal structure derived from comparative pulse diagnosis. Diagnostic analysis identifies Spleen deficiency as the primary etiological root (Level 1), followed by Kidney excess (Level 2), Heart deficiency (Level 3), and Lung excess (Level 4), with the Liver functioning as the neutral stabilizing organ (中立臟腑).

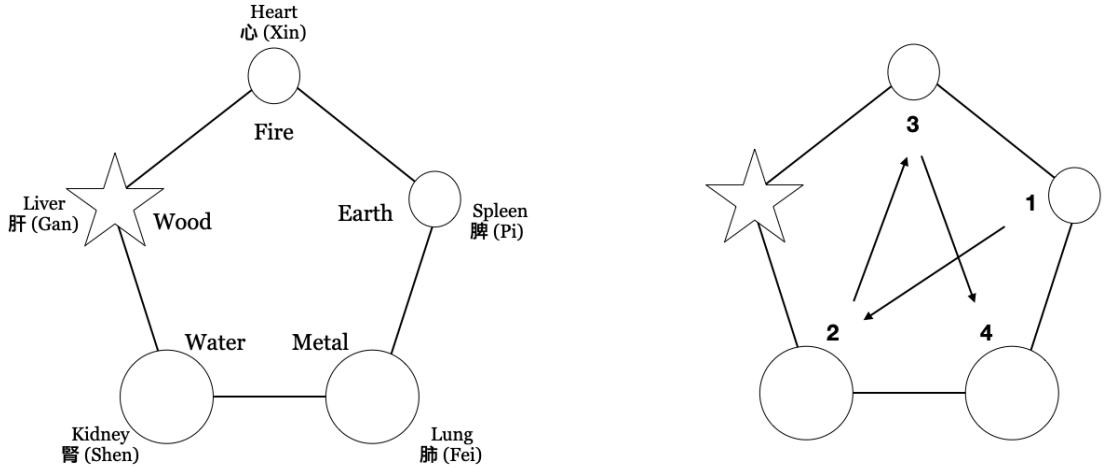

Figure 15. Pathological Transmission Sequence for the Metal Excess–Fire Deficiency Pattern (金實火虛).

This pattern reflects a structural imbalance in which Metal (Lung) becomes excessive because Fire (Heart) is deficient, while Water (Kidney) becomes excessive because Earth (Spleen) is deficient. Accordingly, the excess observed in Metal and Water does not arise autonomously but represents a secondary manifestation of prior deficiencies within their respective controlling elements. From a temporal perspective, the pathological sequence unfolds as follows: Spleen deficiency (Level 1) → Kidney excess (Level 2) → Heart deficiency (Level 3) → Lung excess (Level 4).

Although clinical symptoms often present as abnormalities of the Lung and Heart, the true pathological origin lies in the initial deficiency of the Spleen. The Liver remains functionally neutral (中立臟腑), maintaining relative stability within the Five-Phase network.

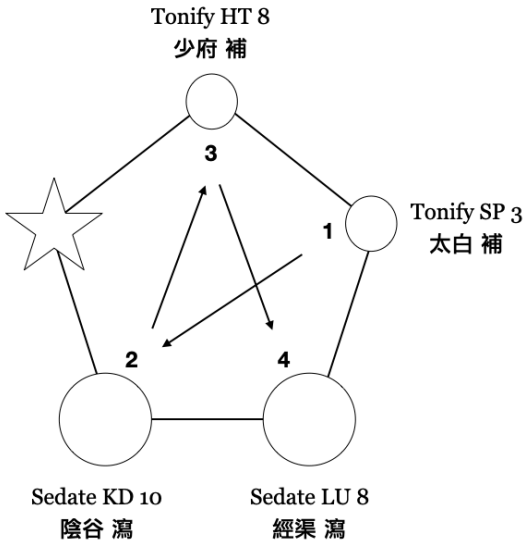

Figure 16. Therapeutic Application of Nan Jing Difficulty 75 for the Metal Excess–Fire Deficiency Pattern (金實火虛).

Following *Nan Jing* Difficulty 75, the fundamental therapeutic strategy is to "tonify the first deficient layer and drain the second excessive layer." When Levels 1 and 2 are appropriately regulated, the imbalances at Levels 3 and 4 resolve naturally as secondary consequences.

- Formula 1 addresses the root pathology by tonifying the Spleen (Level 1) and draining the Kidney (Level 2).
- Formula 2 regulates the secondary axis by tonifying the Heart (Level 3) and draining the Lung (Level 4).

Additional prescriptions may be formulated by applying the same Five-Element logic within each meridian. All prescriptions follow the same operational principle: tonifying the primary deficiency and draining the secondary excess, guided by the controlling-cycle pathology described in *Nan Jing* Difficulty 75.

Table 10. Representative Acupuncture Prescriptions for the Metal Excess–Fire Deficiency Pattern (金實火虛).

Formula	Tonification (+)	Sedation (−)
1.	SP 3 (太白)	KD10 (陰谷)
2.	HT 8 (少府)	LU 8 (經渠)
3.	SP 2 (大都)	KI 7 (復溜)
4.	KI 3 (太谿)	HT 3 (少海)
5.	HT 7 (神門)	LU 5 (尺澤)

This formulation demonstrates that the Metal Excess–Fire Deficiency pattern is not merely a localized imbalance of the Lung and Heart but a systemic disorder rooted in Earth deficiency. Recognition of the full pentagonal structure through comparative pulse diagnosis is therefore essential for identifying the true pathological origin and establishing a logically coherent treatment strategy.

As emphasized in *Nan Jing* Difficulty 75, failure to treat the primary deficiency renders subsequent therapeutic interventions ineffective. Accordingly, clinical focus must first be directed toward correcting the Level 1 pathology before addressing secondary and tertiary manifestations

3.7.5 Water Excess–Earth Deficiency Pattern (水實土虛)

In the Water Excess–Earth Deficiency pattern, the pulse configuration is represented as a pentagonal structure derived from comparative pulse diagnosis. Diagnostic analysis identifies Lung deficiency (Metal deficiency) as the primary etiological root (Level 1), followed by Liver excess (Wood excess, Level 2), Spleen deficiency (Earth deficiency, Level 3), and Kidney excess (Water excess, Level 4), with the Heart functioning as the neutral stabilizing organ (中立臟腑).

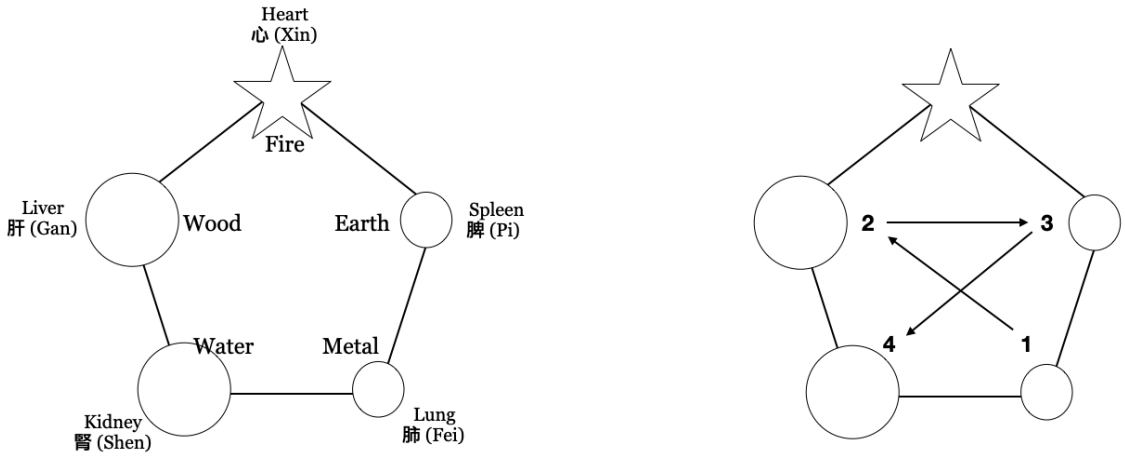

Figure 17. Pathological Transmission Sequence for the Water Excess–Earth Deficiency Pattern (水實土虛).

This configuration indicates that although Water excess and Earth deficiency are the most prominent clinical manifestations, they are not the primary cause. Rather, the imbalance originates from Metal deficiency, which disrupts the controlling and generating relationships within the Five-Phase network. The pathological dynamics are

interpreted through the principles of “the child makes the mother excessive” (子能令母實) and “the mother makes the child deficient” (母能令子虛).

From a temporal perspective, the sequence of pathological transmission unfolds as follows: Lung deficiency (Level 1) → Liver excess (Level 2) → Spleen deficiency (Level 3) → Kidney excess (Level 4). In this sequence, deficiency of the Lung weakens its regulatory control over Wood, allowing the Liver to become excessive. Excessive Wood subsequently impairs Earth, resulting in Spleen deficiency. Failure of Earth to regulate Water then permits the Kidney to become excessive. Thus, Water excess represents a downstream manifestation of an earlier imbalance rooted in Metal deficiency.

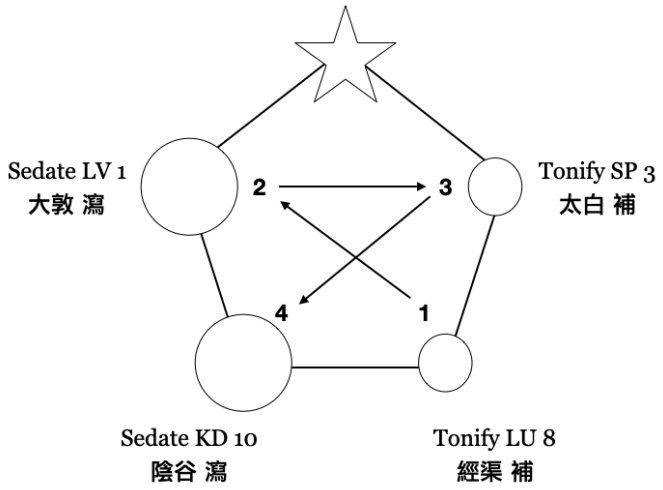

Figure 18. Therapeutic Application of Nan Jing Difficulty 75 for the Water Excess–Earth Deficiency Pattern (水實土虛).

Following *Nan Jing* Difficulty 75, the therapeutic strategy is to “tonify the first deficient layer and drain the second excessive layer.” Once Levels 1 and 2 are corrected,

the pathological disturbances of Levels 3 and 4 resolve naturally as secondary consequences.

- Formula 1 addresses the root pathology by tonifying the Lung (Level 1) and draining the Liver (Level 2).
- Formula 2 supports deeper regulation by tonifying the Spleen (Level 3) and draining the Kidney (Level 4).

Additional prescriptions may be generated using the same Five-Element operational logic within each meridian. All prescriptions follow the same governing principle: tonifying the primary deficiency and draining the secondary excess in accordance with the controlling-cycle pathology described in *Nan Jing* Difficulty 75.

This formulation demonstrates that the Water Excess–Earth Deficiency pattern is not merely a local disorder of the Kidney and Spleen but a systemic imbalance rooted in Metal deficiency. Accordingly, accurate identification of the primary pathological layer through comparative pulse diagnosis is essential for restoring regulatory harmony within the Five-Phase network.

Table 11. Representative Acupuncture Prescriptions for the Water Excess–Earth Deficiency Pattern (水實土虛).

Formula	Tonification (+)	Sedation (−)
1.	LU 8 (**經渠**)	LV 1 (大敦)
2.	SP 3 (太白)	KD10 (**陰谷**)
3.	LU 9 (太淵)	LV 8 (曲泉)
4.	LV 4 (中封)	SP 1 (隱白)
5.	SP 5 (商丘)	KD 1 (湧泉)

This pattern reflects a temporal structure of disease transmission rather than a simple hierarchy of pulse strength. The earliest pathological event is deficiency of the Lung, which weakens its regulatory control over Wood. As a result, the Liver becomes excessive, subsequently impairing Earth and producing Spleen deficiency. Failure of Earth to regulate Water then allows the Kidney to become excessive.

Therefore, although Water excess is prominent clinically, it is secondary in nature. According to *Nan Jing* Difficulty 75, effective treatment must begin with correction of the primary deficiency; otherwise, regulation of downstream excesses remains incomplete and unstable.

3.8 Summary of Zang and Fu Regulatory Framework

Although the present study primarily focuses on the zang-based treatment system (臟方) derived from *Nan Jing* Difficulty 75, the Ohaeng-Hwa acupuncture system also incorporates a complementary fu-based treatment framework (腑方) grounded in the principles of *Nan Jing* Difficulties 54 and 69 and the generating cycle (相生).

The fu-based patterns are structured according to the Hetu (河圖) model and emphasize the dynamics of generation rather than control. While a detailed exposition of the five fu-based constitutional patterns lies beyond the scope of the present study, their theoretical foundation parallels that of the zang-based system, together forming the dual regulatory architecture of Ohaeng-Hwa acupuncture.

3.9 Clinical Evidence of Ohaeng-Hwa Acupuncture

Although Ohaeng-Hwa acupuncture is theoretically well structured and widely applied in clinical practice, the current body of empirical research remains relatively limited. Existing studies primarily consist of small-scale randomized controlled trials (RCTs) and descriptive case reports.

These studies have reported favorable outcomes in pain reduction, functional recovery, and relief of neurological symptoms. However, their clinical significance is often constrained by methodological heterogeneity and small sample sizes, which limit the generalizability of the findings.

3.10 Research Gap and Objectives of the Present Study

Despite the theoretical sophistication and clinical promise of Ohaeng-Hwa acupuncture, its effectiveness has not yet been rigorously established through high-level quantitative synthesis. To date, no study has integrated both quantitative and qualitative evidence to evaluate its therapeutic value for low back pain (LBP).

This lack of consolidated evidence creates a significant gap between the well-developed theoretical framework of Ohaeng-Hwa acupuncture and its empirical

clinical validation. Therefore, a systematic review and meta-analysis are required to synthesize existing evidence, assess methodological quality, and provide a clearer clinical evaluation of the effectiveness of Ohaeng-Hwa acupuncture for LBP.

II. MATERIALS AND METHODS

2.1 Study Design and Reporting Guideline

This study was conducted as a systematic review and meta-analysis of randomized controlled trials (RCTs) to evaluate the clinical efficacy of Ohaeng-Hwa acupuncture (五行和鍼) for the treatment of low back pain (LBP). The study protocol and reporting were conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

2.2 Data Sources and Search Strategy

Relevant studies were identified through a comprehensive search of international and Korean academic databases from database inception to December 2025. The databases searched included PubMed, Scopus, RISS (Research Information Sharing Service), and KMbase (Korean Medical Database).

Although the search of international databases (PubMed and Scopus) did not yield eligible studies that met the inclusion criteria for Ohaeng-Hwa acupuncture, these databases were included to ensure the comprehensiveness and transparency of the systematic search process. The final eligible studies were primarily identified through Korean databases and institutional repositories.

Two doctoral dissertations (Yang, 2019; Lee, 2015) were retrieved from the South Baylo University Doctoral Research Archive, and one peer-reviewed article (Kim et al., 2002) was obtained from *The Journal of Korean Acupuncture & Moxibustion Society*.

Additional qualitative studies, including case reports and case series, were identified from major Korean journals such as the *Korean Journal of Acupuncture*, *Journal of the Korean Medical Institute of Daejeon University*, *Journal of Oriental Neuropsychiatry*, and *Journal of Oriental Obstetrics & Gynecology*. These studies were included for qualitative narrative synthesis only.

The search strategy was developed based on the PICO framework (Table 12). Search terms included combinations of keywords related to Ohaeng acupuncture (e.g., "Ohaeng acupuncture," "Five-Element acupuncture," "Ohaeng-Hwa acupuncture"), low back pain (e.g., "low back pain," "lumbar pain," "musculoskeletal pain"), and study design (e.g., "randomized controlled trial," "clinical study"). Both English and Korean search terms were applied, and keywords were combined using Boolean operators (AND, OR).

Table 12. *PICO Framework for the Literature Search Strategy.*

Problem (P)	Low back pain
Intervention (I)	Ohaeng (Five-Element) acupuncture
Comparison (C)	Control or conventional treatment
Outcome (O)	Pain intensity, primarily assessed by the visual analog scale (VAS).

2.3 Eligibility Criteria

To ensure methodological objectivity and transparency, the following inclusion and exclusion criteria were established.

2.3.1 Inclusion Criteria for Meta-analysis

Studies were included in the quantitative meta-analysis if they met the following criteria:

- Study Design: Randomized controlled trials (RCTs).
- Population: Participants diagnosed with low back pain (LBP), regardless of chronicity.
- Intervention: Investigated Ohaeng (Five-Element) acupuncture as the primary intervention.
- Comparison: Included a control group receiving conventional acupuncture or other standard treatments not involve Ohaeng (Five-Element) acupuncture.
- Outcomes: Reported quantitative pain outcomes using validated scales, such as the Visual Analogue Scale (VAS).
- Data Completeness: Provided sufficient statistical data to calculate effect sizes, including means, standard deviations, and sample sizes (*M, SD, N*).

2.3.2 Exclusion Criteria

Studies were excluded from the meta-analysis if they met any of the following criteria:

- Review articles, theoretical papers, or narrative discussions without original clinical outcome data.
- Case reports or case series without a control group (these were reserved for narrative synthesis only).
- Studies that did not provide extractable quantitative data required for statistical pooling.

- Studies focusing on pain conditions unrelated to the lumbar region.

2.4 Study Selection

A total of three randomized controlled trials (Yang, 2019; Lee, 2015; Kim et al., 2002), with a total sample size of 70 participants, met the eligibility criteria and were included in the quantitative meta-analysis.

In addition, five case reports and case series (Kuk, 2020; Lee et al., 2010; Yoo, 2008; Na et al., 2005; Kong et al., 2006) were included in the qualitative narrative synthesis. These studies were excluded from the meta-analysis because they lacked control groups.

2.5 Data Extraction

Data were extracted from each eligible RCT using a predefined standardized data extraction form. The extracted information included the first author, publication year, study design, sample sizes of the experimental and control groups, intervention type, outcome measures, and reported outcome data.

For the meta-analysis, the following quantitative data were collected from each study: mean Visual Analogue Scale (VAS) scores, standard deviations, and the number of participants in both the experimental and control groups.

The following parameters were defined for the quantitative synthesis:

- Me, Mc: Mean change in VAS score for the experimental and control groups, respectively.

- Se, Sc: Standard deviation of the change for the experimental and control groups.
- Ne, Nc: Number of participants in the experimental and control groups.

2.6 Outcome Measures

The primary outcome measure was pain intensity assessed using the Visual Analogue Scale (VAS). All included randomized controlled trials (RCTs) utilized the VAS as the primary outcome measure. The specific data extracted for the meta-analysis are presented in Table 14.

Secondary outcomes derived from qualitative studies—including pain severity, musculoskeletal function, and neurological symptoms—were synthesized narratively. Detailed information regarding these findings is provided in Appendix A.

2.7 Risk of Bias Assessment

Potential publication bias was evaluated using a funnel plot (Figure 21). Visual inspection of the funnel plot did not demonstrate clear asymmetry. However, because of the small number of included studies, the reliability of this assessment remains limited.

2.8 Statistical Analysis

For studies that only reported baseline and endpoint values without the mean change and its standard deviation (SD), the SD of change was estimated using a variance imputation method with a correlation coefficient (r) assumed to be 0.4 in accordance with Follmann et al (1992).

$$SD_{change} = \sqrt{SD_{base}^2 + SD_{post}^2 - (2 \times r \times SD_{base} \times SD_{post})}$$

Meta-analysis was performed using a random-effects model to account for potential inter-study heterogeneity. Effect sizes were expressed as weighted mean differences (WMDs) with 95% confidence intervals (CIs). Statistical heterogeneity was quantified using Cochran's Q test and the I^2 statistic. Publication bias was evaluated using a funnel plot.

2.9 Ethical Review

This study was reviewed by the Institutional Review Board (IRB) of South Baylo University and was classified as exempt because it involved only the secondary analysis of previously published data.

III. RESULTS

3.1 Study Selection

A total of three RCTs (Yang, 2019; Lee, 2015; Kim, 2002), with a total sample size of 70 participants, met the eligibility criteria and were included in the quantitative meta-analysis. In addition, five additional studies, including case reports and case series (Kuk, 2020; Lee et al., 2010; Yoo, 2008; Na et al., 2005; Kong et al., 2006), were included for narrative synthesis. These studies were excluded from the meta-analysis because they lacked control groups. The study selection process is illustrated in the PRISMA flow diagram (Figure 19).

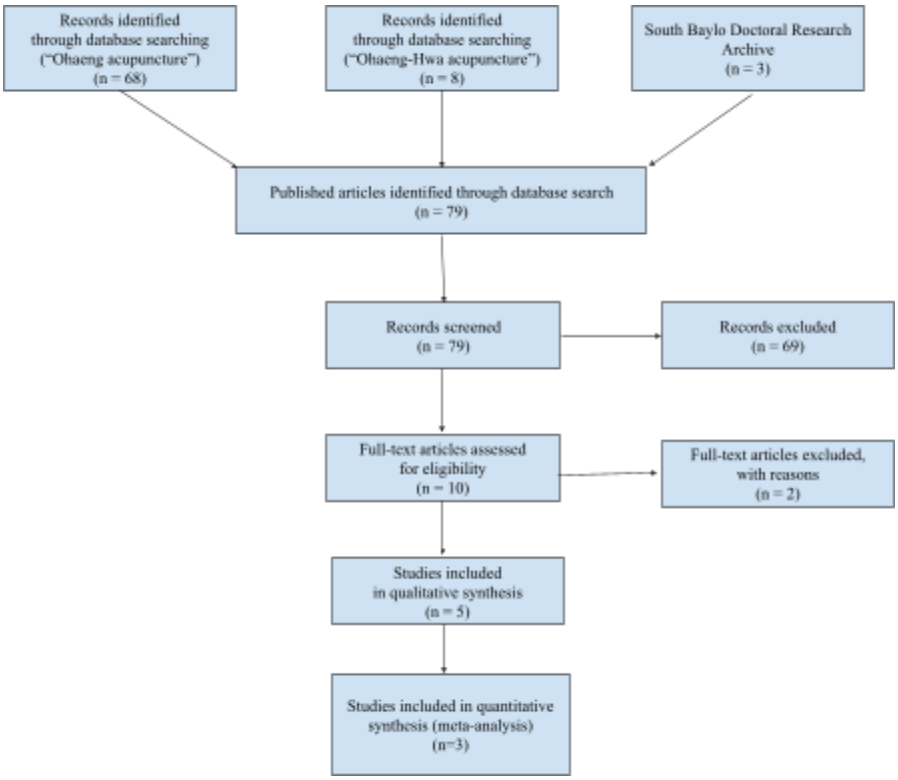

Figure 19. *PRISMA Flow Diagram of the Study Selection Process.*

3.2 Characteristics of Included Studies

The characteristics of the three included RCTs are summarized in Table 13 (Characteristics) and Table 14 (Outcome Measures). All studies utilized a randomized design comparing Ohaeng (Five-Element) acupuncture with conventional or traditional acupuncture treatments. Sample sizes across the trials ranged from 12 to 40 participants. In all included studies, pain intensity assessed using the Visual Analogue Scale (VAS) served as the primary outcome measure.

Table 13. Characteristics of Included Randomized Controlled Trials.

No	Author (Year)	Condition	Design	Group	n
1	Yang D (2019)	KD Deficiency LBP	RCT	Exp (Ohaeng-Hwa)	6
				Ctrl (Traditional)	6
2.	Lee H (2015)	KD Deficiency LBP	RCT	Exp (SaAm)	9
				Ctrl (Traditional)	9
3.	Kim J (2002)	LBP	RCT	Exp (Ohaeng)	20
				Ctrl (Traditional)	20

Table 14. Summary of VAS Scores and Clinical Efficacy Outcomes.

No	Group	Mean VAS (Before)	SD (Before)	Mean VAS (After)	SD (After)	Mean difference (ΔVAS ± SD)	p-value
1	Exp	7.0	2.00	0.8	1.33	6.2 ± 1.9	$p < 0.001$
	Ctrl	5.2	2.04	1.2	0.75	4.0 ± 1.3	$p = 0.022$
2.	Exp	8.0	0.8	3.1	2	4.9	$p < 0.001$
	Ctrl	7.7	0.6	4.9	1.7	2.8	$p < 0.001$
3.	Exp	10	0	3	1.7472	7	$p < 0.001$
	Ctrl	10	0	3.95	1.3945	6.05	$p < 0.001$

Table 15. Extracted Parameters for Quantitative Synthesis (Meta-analysis).

Author	Year	Me	Se	Ne	Mc	Sc	Nc
Yang D	2019	6.2	1.91	6	4	1.87	6
Lee H	2015	4.9	1.83	9	2.8	1.56	9
Kim J	2002	7	1.75	20	6.05	1.3945	20

3.3 Quantitative Synthesis (Meta-analysis)

A meta-analysis using a random-effects model was conducted to evaluate the pooled effect of Ohaeng acupuncture on pain reduction in patients with low back pain. The results for individual studies and the overall synthesis are presented in the forest plot (Figure 20).

Among the included trials, Yang D (2019) and Lee H (2015) demonstrated statistically significant reductions in pain in the experimental groups, with mean differences (MD) of 2.20 (95% CI [0.06, 4.34]) and 2.10 (95% CI [0.53, 3.67]), respectively. In contrast, Kim J (2002) reported a positive but not statistically significant

effect (MD = 0.95, 95% CI [-0.03, 1.93]), although it contributed the largest weight to the analysis (60.6%) due to its larger sample size.

The pooled analysis showed a statistically significant reduction in pain intensity in the experimental groups compared with the control groups (MD = 1.42, 95% CI [0.61, 2.23], $p < 0.01$). The forest plot indicated that the overall effect size favored the intervention. Statistical heterogeneity was low ($I^2 = 5.2\%$, $p = 0.35$), suggesting a high level of consistency across studies and supporting the reliability of the pooled estimate.

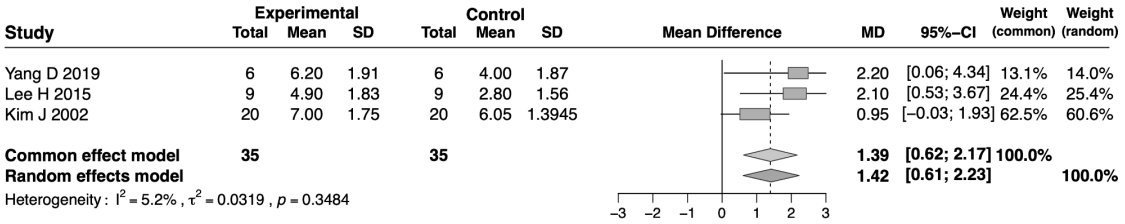

Figure 20. Forest Plot of the Meta-analysis for VAS Outcomes.

3.4 Publication Bias

Potential publication bias was assessed using a funnel plot (Figure 21). Visual inspection did not indicate substantial asymmetry. However, given that only three studies were included in the meta-analysis, the assessment of publication bias is inherently limited and should be interpreted with caution.

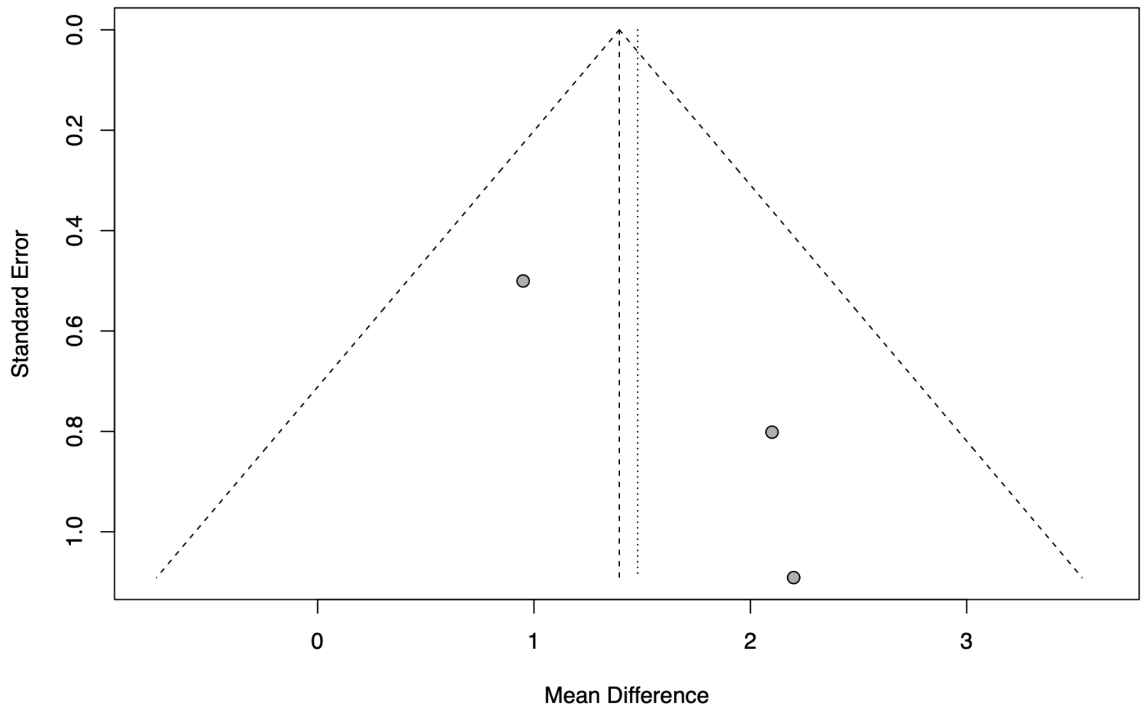

Figure 21. Funnel Plot Assessing Publication Bias in the Meta-analysis of VAS Outcomes.

3.5 Qualitative (Narrative) Synthesis

Five qualitative studies, comprising three case series and two single-case reports, were included in the narrative synthesis. These studies investigated the clinical application of Ohaeng-Hwa acupuncture (五行和鍼) across a range of musculoskeletal and neurological conditions, including chronic low back pain, polymyositis, central nervous system (CNS) gait disturbance associated with cerebral infarctions (lacunar, cortical, pontine, thalamic, and multifocal infarctions), gluteal muscle weakness during pregnancy, and pre-stroke syndrome accompanied by somatization disorder.

Pain reduction was the most consistently reported outcome. In a case series of patients with chronic low back pain characterized by a Fire Excess pattern, the mean VAS

score decreased significantly from 6.36 ± 0.66 to 1.3 ± 1.55 ($p < 0.001$), representing a 79.6% reduction in pain intensity over four weeks of treatment. Additionally, a case report of a 35-year-old pregnant patient suffering from gluteal muscle weakness and pelvic asymmetry demonstrated complete resolution of pain at the *Hwando* (GB30) acupoint, along with the normalization of pelvic alignment during sitting, standing, and rotational movements, following 13 treatment sessions over 17 days.

Substantial functional recovery was also reported in patients with CNS-related gait disturbances caused by cerebral infarctions, including lacunar, cortical, pontine, thalamic, and multifocal lesions. Patients with severe gait impairment regained independent ambulation or demonstrated marked improvement in mobility within approximately 9–20 days following Ohaeng-Hwa acupuncture treatment.

A single-case report of polymyositis demonstrated significant recovery over a 13-week treatment period. Muscle strength in the proximal limbs improved from grade 3-/5 to 4+/5 or higher, and the creatine kinase (CK) level—a key biochemical marker of muscle inflammation—decreased substantially from 2,236 U/L to near-normal levels.

Psychosomatic and sensory regulation was also observed in cases diagnosed with undifferentiated somatoform disorder or psychosomatic disease. Two patients presenting with Mamok (numbness or abnormal sensation) in the tongue or limbs reported rapid resolution of symptoms. In one case, a patient with tongue numbness and dysarthria experienced a decrease in symptom severity from VAS 10 to VAS 2 within approximately 35 days of treatment.

Overall, the qualitative evidence suggests that Ohaeng-Hwa acupuncture may provide therapeutic benefits beyond pain reduction, contributing to rapid functional recovery, biochemical improvement, and systemic regulation across diverse and complex clinical presentations. Detailed qualitative findings are summarized in Appendix A.

IV. DISCUSSION

This systematic review and meta-analysis evaluated the clinical effectiveness of Ohaeng (Five-Element) acupuncture for LBP by integrating quantitative evidence from RCTs with qualitative findings from case reports and case series. The pooled analysis demonstrated that Ohaeng acupuncture was associated with greater reductions in pain intensity compared with conventional or traditional acupuncture treatments. The pooled effect size, expressed as the mean difference in VAS scores, indicated a clinically meaningful reduction in pain with very low heterogeneity ($I^2 = 5.2\%$, $p = 0.35$). This high level of consistency suggests that the direction of treatment effects was remarkably uniform across studies despite variations in treatment protocols and sample sizes.

Across the RCTs included in the meta-analysis, patients receiving Ohaeng-based interventions consistently showed greater decreases in pain intensity than those receiving control treatments. Although the magnitude of improvement varied among studies, all trials demonstrated a direction of effect favoring Ohaeng acupuncture. This consistency supports the hypothesis that Ohaeng acupuncture may provide additional therapeutic benefits beyond those achieved with conventional acupuncture approaches. One possible explanation is that Ohaeng acupuncture incorporates diagnostic and treatment strategies based on systemic functional relationships among the Five Elements, which may facilitate broader regulatory effects on physiological systems involved in pain perception.

The qualitative synthesis provided additional context for interpreting the quantitative findings. Case reports and case series described improvements not only in pain severity but also in musculoskeletal function, neurological symptoms, and gait disturbances. In several cases, patients regained functional mobility or experienced

improvements in neurological symptoms following treatment. Notably, rapid recovery of independent ambulation was reported within approximately 9–20 days in patients with CNS-related gait disturbances following cerebral infarction. In addition, a case involving polymyositis demonstrated biochemical improvement, including a marked reduction in creatine kinase (CK) levels, indicating potential modulation of systemic inflammatory processes.

Furthermore, Ohaeng-Hwa acupuncture demonstrated therapeutic effects in other complex clinical presentations, including gluteal muscle weakness during pregnancy. In this case, treatment resulted in substantial improvement in pelvic alignment and functional mobility, suggesting potential benefits in musculoskeletal stabilization and neuromuscular coordination. Collectively, these findings suggest that Ohaeng-Hwa acupuncture may influence mechanisms beyond analgesic effects alone, potentially involving neuromuscular coordination, autonomic regulation, and systemic homeostasis. The convergence of quantitative pain reduction with qualitative functional improvements strengthens the overall plausibility of the therapeutic effects observed in the meta-analysis.

From a theoretical perspective, Ohaeng-Hwa acupuncture is grounded in the concept of restoring balance among the Five Elements and regulating systemic disharmony. Rather than focusing solely on local symptom relief, this approach aims to harmonize functional relationships among organ systems and physiological networks. Such a framework may correspond to multidimensional physiological processes, including modulation of autonomic nervous system activity, regulation of inflammatory pathways, and improvement of neuromuscular integration. The observed improvements

in both subjective pain measures and functional outcomes are consistent with this theoretical model and suggest that Ohaeng-Hwa acupuncture may exert broader regulatory effects compared with symptom-focused needling strategies.

Clinically, these findings indicate that Ohaeng-Hwa acupuncture may serve as a useful complementary treatment for patients with low back pain, particularly for individuals who experience insufficient improvement with conventional acupuncture or standard therapies. The magnitude of VAS reduction observed in the pooled analysis (MD = 1.42) may be considered clinically meaningful, as it approaches or exceeds commonly reported thresholds for the minimal clinically important difference (MCID) in chronic pain studies. This suggests that the treatment effect is not only statistically significant but also clinically relevant. Incorporating Ohaeng-Hwa diagnostic principles into acupuncture practice may therefore support greater treatment individualization and potentially improve therapeutic outcomes.

Despite these promising findings, several limitations should be acknowledged. First, the number of included RCTs was small (n = 3), and the total sample size across studies was limited. This restricts the generalizability of the results and reduces the statistical power of the meta-analysis. Second, variations in diagnostic criteria, treatment protocols, and comparator interventions may have contributed to residual heterogeneity among the studies. Third, although publication bias was explored through visual inspection of a funnel plot, which indicated a generally symmetrical distribution of studies, the small number of included studies limits the reliability of this assessment, and the results should therefore be interpreted cautiously. In addition, most of the included

studies were conducted within a limited geographic context, primarily in South Korea, which may further restrict the generalizability of the findings.

Another limitation concerns the methodological reporting within the included studies. In several trials, details regarding randomization procedures, allocation concealment, and blinding were insufficiently described. These factors introduce potential risks of bias and may influence the reliability of the reported treatment effects. In addition, the qualitative studies included in the narrative synthesis lacked control groups and standardized outcome measures. Although these reports provide valuable clinical observations, they do not allow for strong causal inference regarding treatment efficacy.

The design of the present review also warrants consideration. By combining quantitative and qualitative evidence, the study aimed to provide a more comprehensive understanding of the potential therapeutic role of Ohaeng-Hwa acupuncture. However, the integration of heterogeneous evidence types may also introduce interpretive challenges. While the qualitative findings help contextualize the clinical relevance of the quantitative results, they should be interpreted as supportive evidence rather than definitive proof of efficacy.

Future research should focus on larger, well-designed RCTs with standardized Ohaeng-Hwa acupuncture protocols and clearly defined diagnostic criteria for LBP. Consistent outcome measures, including both pain intensity and functional assessments, would improve comparability across studies. Long-term follow-up studies are also needed to evaluate the durability of therapeutic effects. Furthermore, mechanistic studies

exploring the physiological pathways underlying Ohaeng-Hwa acupuncture may help clarify how this modality influences pain modulation and functional recovery.

In conclusion, this systematic review and meta-analysis provides preliminary evidence that Ohaeng-Hwa acupuncture may offer additional clinical benefits for the management of low back pain compared with conventional acupuncture approaches. The integration of quantitative pain outcomes and qualitative functional observations suggests that Ohaeng-Hwa acupuncture may contribute to both pain reduction and broader functional recovery. Although the current evidence base remains limited, the findings highlight the potential therapeutic value of Ohaeng-Hwa acupuncture and underscore the need for further rigorous clinical research.

V. CONCLUSIONS

This study aimed to evaluate the clinical effectiveness of Ohaeng (Five-Element) acupuncture for the treatment of low back pain through a systematic review and meta-analysis. Quantitative evidence from randomized controlled trials was combined with qualitative evidence from case reports and case series in order to examine both pain outcomes and broader clinical effects.

The quantitative analysis demonstrated that Ohaeng-based acupuncture interventions were associated with greater reductions in pain intensity compared with conventional acupuncture treatments. The pooled analysis showed a statistically significant reduction in VAS pain scores (MD = 1.42, 95% CI [0.61, 2.23], $p < 0.01$), with very low heterogeneity ($I^2 = 5.2\%$), indicating a high level of consistency across the included studies.

Furthermore, the magnitude of the pooled effect may be considered clinically meaningful, as it approaches or exceeds commonly reported thresholds for the minimally clinically important difference (MCID) in chronic pain research. These findings suggest that Ohaeng acupuncture may provide additional analgesic benefits beyond those observed with conventional acupuncture approaches.

The qualitative synthesis further supported these results by documenting improvements not only in pain severity but also in musculoskeletal function, neurological symptoms, and overall functional recovery. Taken together, the integration of quantitative and qualitative evidence suggests that Ohaeng acupuncture, particularly the Ohaeng-Hwa

approach (五行和鍼, “Five-Element Harmonizing Acupuncture”), may contribute to both pain reduction and functional improvement in patients with low back pain.

However, the conclusions of this study should be interpreted within the context of several limitations. The number of available randomized controlled trials was small, and the overall sample sizes were limited. In addition, variations in diagnostic criteria and treatment protocols across studies may influence the generalizability of the findings.

Future research should focus on conducting larger, well-designed randomized controlled trials using standardized diagnostic frameworks and treatment protocols for Ohaeng acupuncture. The use of consistent outcome measures and long-term follow-up assessments will be essential to clarify the durability and clinical significance of treatment effects.

In conclusion, this systematic review and meta-analysis provides preliminary evidence that Ohaeng acupuncture may offer additional clinical benefits for the management of low back pain compared with conventional approaches. The integration of qualitative observations further suggests that Ohaeng-Hwa acupuncture may contribute not only to pain reduction but also to broader functional recovery. Although the current evidence base remains limited, these findings highlight the potential therapeutic value of Five-Element–based acupuncture systems and underscore the need for further rigorous, large-scale clinical research.

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APPENDICES

Appendix A. Summary of Qualitative Studies Included in Narrative Synthesis

Study No.	Author (Year)	Condition	Design	Group	n	Mean VAS (Before)	SD (Before)	Mean VAS (After)	SD (After)	(ΔVAS ± SD)	p-value	Outcome	Notes
1	Kuk S (2020)	Chronic LBP (Fire Excess)	Case Series	All Patients	7	6.36	0.66	1.3	1.55	5.06 ± 1.23	0.000 ***	ODI 43.5 → 14.4	VAS ↓ 79.6 % 4 weeks, paired t-test
2	Lee B (2010)	Polymyositis	Case Report	Single Case	1	10	n=1 → 계산 불가	10	n=1 → 계산 불가	9	N/A	CK 2236 → 61	Shoulder 3-/5 → 4+/5 Muscle strength ↑ - Functional improvement
3	Yoo H (2008)	CNS Gait Disturbance	Case Series	4	4	5.25		1.5		3.75	N/A	Gait Score 6 → 1	All regained independent gait within 9-20 days
		Lacunar infarction (Rt. genu corpus callosum)		Ohaeng-Hwa	1	6		1		5	N/A		Indepdendent gait after 20 days
		Cortical & Pons infarction		Ohaeng-Hwa	1	1		0		1	N/A		Recovered after 20 days
		Thalamus infarction		Ohaeng-Hwa	1	6		5		1	N/A		Improved gait within 11 days
		Multifocal infoarctions (Frontal, Cingulate, T-O-P lobes)			1	8		0		8	N/A		Indepdendent gait after 9 days
4	Na H (2005)	Gluteal muscle Weakness during p	Case Report	Single Case	1	VAS - Sitting 10		VAS - Sitting 0		10	N/A	↓10	Improved by 9/21
						VAS – Standing 10		VAS – Standing 0		10	N/A	↓10	Improved by 9/21
						VAS – Turning 10		VAS – Turning 0		10	N/A	↓10	Improved by 9/13
						Lt. PSIS elevation (cm) 3.0		0		3	N/A	↓3.0	Normalized by 9/14
						Lateral bending (°) - 25/10		25/25		15	N/A	↑15° (Lt side)	Symmetry restored
5	Kong H (2006)	Pre-stroke syndrome +	Case Series	Ohaeng-Hwa Acu	1	VAS Speech10		0		10	N/A	↓10	Speech & Numbness fully resolved
		Somatization disorder				VAS neck stiffness 5		0		5	N/A	↓5	Neck Stiffness resolved
		Dysarthria & Left facial numbness				VAS insomnia 8		0		8	N/A	↓8	Sleep normalized (no residual insomnia)
						VAS anger 8		3		5	N/A	↓5	Symptoms fully remitted except mild stress triggers
		Emotional Instability,		Ohaeng-Hwa Acu+	1	VAS Rt arm/leg 10		0		10	N/A	↓10	Pain resolved by March 25, 2006
		Throat foreign body sensation		Herbal Medicine		VAS 매핵기 10		0		10	N/A	↓10	Persisted until March 16 (VAS 3), disappeared by March 30
		Right-sided weakness				GGT (U/L) 1877		263		1614		↓1614	Normalized over treatment course