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Research Article

Acupuncture Care for Patients with Post-Stroke Left-Hand Weakness at 3naz Therapy House Karimun

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Abstract:

Background: Stroke may result in persistent motor impairment of the upper extremity, affecting hand use and daily activities. Acupuncture has been investigated as a complementary intervention in post-stroke rehabilitation; however, evidence concerning spasticity should not be equated with evidence for recovery from general motor weakness.

Objective: This case study describes acupuncture care provided to a patient with left-hand weakness following a reported stroke at 3Naz Therapy House, Karimun. Methods: A descriptive case-study approach was used involving one 49-year-old woman. Clinical information was collected using a Client Data Sheet and the traditional four examinations: inspection (Wang), listening and smelling (Wen), inquiry (Wen), and palpation (Qie). The participant received six acupuncture sessions. The first session was conducted on 9 February 2026. The documented acupuncture points were HT5, LI15, LI11, LI4, LI18, ST36, ST38, and ST41.

Results: At the initial assessment, the participant reported inability to move the left fingers and hand, left-arm pain, and finger swelling. At the sixth assessment, she was able to move the fingers, grip weakly, and raise the arm, although she could not maintain the elevated position for long. Arm pain and finger swelling were described as reduced. These findings were based on descriptive clinical observations; standardized motor, pain, and edema measurements were not recorded.

Conclusion: Improvement in several reported and observed features was documented between the first and sixth assessments. Because this was a single case without a comparator, standardized outcome measures, or complete information on stroke characteristics and concomitant rehabilitation, the observed changes cannot be attributed to acupuncture alone.

Keywords: acupuncture; stroke; upper-limb weakness; case study; complementary therapy

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1. INTRODUCTION

Stroke is a cerebrovascular event that can cause neurological impairment when blood flow to part of the brain is interrupted or when a cerebral blood vessel ruptures. Depending on the affected brain region and the extent of injury, survivors may experience weakness, impaired coordination, sensory changes, communication difficulties, and limitations in activities of daily living. Upper-limb impairment is particularly consequential because hand function is required for grasping, carrying, dressing, eating, and other routine activities. Studies of people living with

stroke-related hand impairment describe persistent limitations in hand use, especially among individuals with severe chronic impairment (Barry et al., 2022).

Stroke-related motor impairment may also be accompanied by secondary changes in skeletal muscle. A systematic review described structural and pathophysiological muscle changes occurring during the first year after post-stroke hemiplegia, emphasizing that the consequences of stroke extend beyond the initial cerebral injury (Aze et al., 2023). The clinical presentation and recovery trajectory vary according to stroke type, lesion characteristics, time since onset, baseline impairment, comorbidities, and access to rehabilitation.

Medical management and rehabilitation after stroke depend on the stroke subtype, timing, and clinical condition. Antiplatelet medicines are used in appropriate patients with ischemic stroke, while thrombolytic treatment is considered only for eligible patients within defined clinical time windows. These treatments have distinct indications and potential adverse effects; they should not be presented as interchangeable or as a single treatment pathway. Research has examined antiplatelet utilization and adverse drug reactions in stroke populations (Ariani et al., 2023; Samirah et al., 2025), while work on thrombolytic development describes the role and challenges of thrombolytic treatment in acute stroke (Nikitin et al., 2021). The present case report does not provide sufficient information to determine the participant's stroke subtype, acute treatment, or medication history.

Acupuncture has been studied as an adjunctive intervention in post-stroke rehabilitation. Cai et al. (2021) conducted a pilot pragmatic randomized controlled trial of electroacupuncture for post-stroke spasticity. A systematic review and meta-analysis by Xue et al. (2022) also evaluated acupuncture for post-stroke spasticity and reported potentially favorable findings, while noting limitations related to risk of bias and heterogeneity. Importantly, spasticity refers to a velocity-dependent increase in muscle tone, whereas weakness refers to reduced ability to generate voluntary force. The two may coexist after stroke but are not equivalent clinical outcomes. Evidence about spasticity therefore cannot, by itself, establish an effect on isolated hand weakness.

In traditional Chinese medicine practice, acupuncture treatment may be planned according to the pattern identified through inspection, listening and smelling, inquiry, and palpation. In the case described here, the practitioner documented a pattern interpreted as Qi and blood stagnation in the meridians and selected points intended to promote the flow of Qi and blood and activate the collateral meridians. This traditional diagnostic framework is reported as part of the care process and should be distinguished from biomedical diagnosis of stroke.

The purpose of this case study was to describe the acupuncture care provided to a patient with reported post-stroke left-hand weakness at 3Naz Therapy House, Karimun, and to document the clinical features recorded at the first and sixth assessments. The report does not aim to establish treatment efficacy or causal effects.

2. METHODS

2.1. Study design and setting

This study used a descriptive case-study approach to document acupuncture care for one participant. The care was provided at 3Naz Therapy House, located at Jl. Gang H.M. Nawawie No. 200, Tanjung Batu Kota, Kundur District, Karimun Regency, Riau Islands, Indonesia. The first acupuncture session was conducted on 9 February 2026. The source record states that six treatment sessions were provided.

2.2. Participant

The participant was a 49-year-old woman who worked as a housekeeper. She presented with a main complaint of inability to move the fingers and hand on the left side, accompanied by left-arm pain and swelling of the fingers. The history recorded that the symptoms began after

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a sudden stroke attack when she woke up. The stroke subtype, exact date of stroke onset, interval between stroke onset and the first acupuncture session, neuroimaging findings, previous medical treatment, medication use, and participation in conventional rehabilitation were not documented in the available case record.

2.3. Data collection and assessment

Information was obtained from a Client Data Sheet (CDS) and documented through the traditional four examinations: Wang (inspection), Wen (listening and smelling), Wen (inquiry), and Qie (palpation). The assessment included the participant's reported complaints, general appearance, speech and voice, movement, tongue appearance, bowel habits, palpation of symptomatic areas and selected acupuncture-related points, and pulse examination.

The available documentation contains detailed findings for the first and sixth assessments. Separate clinical records for sessions two through five were not available in the source manuscript. Therefore, the report compares only the documented initial and final assessments and does not infer the course of change at intermediate sessions.

Motor function was described qualitatively. At the first assessment, the participant was unable to move the left fingers and hand. At the sixth assessment, she could move the fingers, grip weakly, and raise the arm but could not maintain the elevated position for long. No standardized motor assessment, such as the Medical Research Council (MRC) scale or Fugl-Meyer Assessment of the Upper Extremity, was reported. Grip strength was not measured using a dynamometer. Pain intensity was not recorded using a numerical rating scale or visual analogue scale, and finger swelling was not measured using a standardized edema method. Accordingly, the findings are presented as descriptive observations rather than quantified treatment outcomes.

2.4. Acupuncture intervention

The participant received six acupuncture sessions. The first session took place on 9 February 2026. The exact dates and intervals of the subsequent sessions were not reported. The treatment principle was described as promoting the flow of Qi and blood in the meridians and activating the collateral meridians. The traditional acupuncture diagnosis was recorded as left-hand weakness after stroke with a pattern of Qi and blood stagnation in the meridians.

Table 1. Selected points and documented needling procedures

Acupuncture point	Documented needling direction and depth	Stimulation method
Tongli (HT5)	Perpendicular; 0.3–0.5 cun	Neutral stimulation (平补平泻 / balanced method)
Jianyu (LI15)	Perpendicular; 0.5–1 cun	Xie (reducing method)
Quchi (LI11)	Perpendicular; 0.5–1 cun	Xie (reducing method)
Hegu (LI4)	Perpendicular toward Houxi (SI3); 0.5–0.8 cun	Xie (reducing method)
Futu (LI18)	Perpendicular; 0.5–1.2 cun	Xie (reducing method)
Zusanli (ST36)	Perpendicular; 0.5–1.2 cun	Xie (reducing method)
Tiaokou (ST38)	Perpendicular; 0.5–1.2 cun	Xie (reducing method)
Jiexi (ST41)	Perpendicular; 0.5–0.8 cun	Xie (reducing method)

2.5. Data analysis

The documented clinical information was organized descriptively. Findings from the first and sixth assessments were compared to identify differences in reported symptoms and observed clinical features. No inferential statistical analysis was performed.

2.6. Ethical considerations and safety reporting

The study was conducted in accordance with the principles of the Declaration of Helsinki and applicable research ethics guidelines. Ethical approval was obtained from the relevant institutional ethics committee prior to data collection. Informed consent was obtained from the patient, and participation was entirely voluntary. Patient confidentiality and anonymity were strictly maintained by removing all personal identifying information. The patient was also informed of the right to withdraw from participation at any time without affecting access to clinical care.

3. RESULTS AND DISCUSSION

3.1. Case presentation and initial assessment

The participant was a 49-year-old woman who presented with an inability to move the fingers and hand on the left side. She also reported pain in the left arm and swelling of the fingers. According to the recorded history, the symptoms followed a sudden stroke attack on waking. The participant's occupation was recorded as housekeeper.

At the first assessment, inspection documented a tired facial expression, reduced eye brightness, pale-yellow facial complexion, a thin body build, asymmetry of shoulder posture, and limited movement on the left side. Speech was described as weak, slow, and unclear. The tongue was described as short, thin, pale, with a thin, smooth, white coating. Listening and smelling documented a weak voice and no strong mouth odor. Inquiry recorded weakness in the fingers and toes, left-arm pain, and fragmented, infrequent bowel movements. Palpation identified tenderness at Yangchi (TE4), Hegu (LI4), and Wangu (SI4), with a generally weak pulse.

3.2. Findings at the sixth assessment

At the sixth assessment, the participant was reported to be able to move the fingers and to grip, although grip strength remained weak. She could raise the left arm but could not maintain the raised position for a prolonged period. The participant reported reduced pain in the left arm and reduced swelling in the fingers. Inspection described slightly brighter eyes, a more expressive facial appearance, a pinker complexion, clearer and stronger speech that remained hesitant, and a tongue that was easier to protrude and was no longer described as short and thin. The tongue was pink with a thin, smooth, white coating. Palpation continued to identify tenderness at TE4, LI4, and SI4, although pain in the symptomatic arm and finger swelling were described as less marked. The pulse remained weak.

The participant's ability to move the fingers, grip weakly, and raise the arm at the sixth assessment represents a descriptive change from the initial report of inability to move the left hand. Such observations are relevant to daily hand function, but they do not establish the magnitude of motor recovery. The absence of MRC grading, Fugl-Meyer scores, dynamometer measurements, or standardized functional assessments limits comparison with other clinical studies.

Cai et al. (2021) evaluated electroacupuncture for post-stroke spasticity in a pilot pragmatic randomized controlled trial. Xue et al. (2022) synthesized evidence on acupuncture for post-stroke spasticity and reported potentially favorable effects, while emphasizing the limitations of the included evidence, including risk of bias and heterogeneity. These studies provide context for research on acupuncture as an adjunctive intervention after stroke. Nevertheless, their focus on spasticity is not identical to the primary complaint in this case,

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which was weakness and inability to move the hand. Spasticity concerns increased muscle tone and resistance to passive movement; weakness concerns impaired voluntary force production. The current case did not document a formal assessment of spasticity, such as the Modified Ashworth Scale, and therefore should not claim that spasticity improved.

The case was managed using a traditional pattern diagnosis of Qi and blood stagnation in the meridians. The treatment principle and point selection were consistent with the practitioner's documented traditional framework. This description explains the rationale recorded by the practitioner; it does not establish a biomedical mechanism or demonstrate that the selected points caused the observed changes. The source manuscript cites Sim (2021) for the traditional interpretation of post-stroke sequelae and meridian-based treatment. The bibliographic details of this book should be checked against the physical or publisher record before final submission.

Recovery after stroke may occur over time and is influenced by the timing and severity of the stroke, spontaneous neurological recovery, medical treatment, rehabilitation intensity, and other patient-specific factors. The present report does not document the interval from stroke onset to acupuncture, neuroimaging results, stroke subtype, medication use, or whether the participant received physiotherapy, occupational therapy, or other rehabilitation during the observation period. These omissions prevent the authors from separating the possible contribution of acupuncture from natural recovery or concomitant care.

3.6. Limitations

This report has several limitations. First, it describes only one participant and has no control or comparison group. Second, the stroke subtype, onset date, diagnostic investigations, previous treatment, medication history, and concomitant rehabilitation were not documented. Third, motor function, grip strength, pain, and edema were not assessed using standardized or quantitative instruments.

3.7. Implications and recommendations

Future case documentation should record the stroke subtype, date of onset, diagnostic findings, baseline neurological deficits, medication use, and all concurrent rehabilitation. Motor outcomes should be assessed using validated instruments appropriate to the clinical question, such as the MRC scale for muscle strength and the Fugl-Meyer Assessment for upper-extremity motor function. Grip strength may be measured with a calibrated dynamometer; pain may be rated using a numerical rating scale; and edema should be assessed using a reproducible measurement method. Each treatment session should be documented, including date, interval, points, needle details, retention time, stimulation technique, and any adverse events. These improvements would strengthen future case reports and allow more meaningful comparison with published studies.

4. CONCLUSION

This case report describes six acupuncture sessions provided to a 49-year-old woman with reported post-stroke left-hand weakness at 3Naz Therapy House, Karimun. Between the first and sixth assessments, the clinical notes described a change from inability to move the left fingers and hand to the ability to move the fingers, grip weakly, and raise the arm, although sustained elevation remained limited. Left-arm pain and finger swelling were also described as reduced.

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AUTHOR CONTRIBUTIONS

All authors contributed to the conception and design of the case report, data collection, data analysis and interpretation, and manuscript preparation. All authors critically reviewed the manuscript, approved the final version, and agreed to be accountable for the integrity and accuracy of the work.

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