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Acupuncture Management of Bronchial Asthma with Lung Qi Deficiency and Spleen Qi Deficiency Syndrome: A Case Study at Griya Sehat Al Hafidz Purwakarta

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Acupuncture; Bronchial Asthma; Traditional Chinese Medicine; Lung Qi Deficiency; Spleen Qi Deficiency; Case Study

Abstract
Bronchial asthma is a chronic inflammatory airway disease characterized by bronchial hyperresponsiveness. In Traditional Chinese Medicine (TCM), it corresponds to Xiao Chuan and is primarily associated with dysregulation of Lung Qi; chronic progression frequently involves Spleen Qi deficiency, which promotes phlegm formation and aggravates respiratory symptoms. The objective of this study was to describe acupuncture management in a patient with bronchial asthma presenting with Lung Qi Deficiency and Spleen Qi Deficiency syndrome and to evaluate the clinical outcomes following eight treatment sessions. This descriptive case study involved one 58-year-old female participant treated at Griya Sehat Al Hafidz Purwakarta from August to September 2025. Eight weekly acupuncture sessions were performed using BL13, LU9, LU1, BL20, SP3, SP6, CV4, CV17, CV22, EX-B1, and ST40, with Bu Fa as the primary needling technique. The TCM four diagnostic methods, known as Si Zhen, were used for data collection. After eight sessions, dyspnea decreased by approximately 85–90%, wheezing resolved, sputum production decreased markedly, exercise tolerance and sleep quality improved, and appetite increased. The tongue findings progressively normalized, while the pulse strengthened from deep, slow, and weak to stronger and more regular. Acupuncture based on the Bian Zheng Lun Zhi principle was associated with improvements in clinical symptoms, tongue characteristics, and pulse quality, suggesting that it may serve as a promising complementary approach to bronchial asthma management when combined with appropriate medical follow-up and patient education.

INTRODUCTION

Bronchial asthma is a chronic, heterogeneous inflammatory disease of the airways characterized by bronchial hyperresponsiveness, variable airflow limitation, and progressive structural changes collectively referred to as airway remodeling. Its cardinal symptoms—dyspnea, wheezing, recurrent cough, and chest tightness—vary in intensity over time and may disrupt daily activities and substantially diminish quality of life. The Global Initiative for Asthma (GINA, 2015) recognizes asthma as a major global health burden, with an estimated prevalence ranging from 1% to 18% across different populations and geographic regions (see Figure 1). The World Health Organization (WHO, 2015) reported that approximately 235 million individuals worldwide are affected, with annual mortality approaching 250,000 deaths, the majority of which occur in low- and middle-income countries where diagnostic and therapeutic resources remain limited. Beyond its mortality burden, asthma imposes substantial economic costs, including direct expenditures associated with emergency department visits, hospitalizations, and medications, as well as indirect costs resulting from reduced workplace productivity, school absenteeism, and premature disability. The disease disproportionately affects vulnerable populations, including children, women of reproductive age, and workers

exposed to occupational respiratory hazards, making it a priority concern in global public health policy (Usman et al., 2015; Ikawati, 2016).

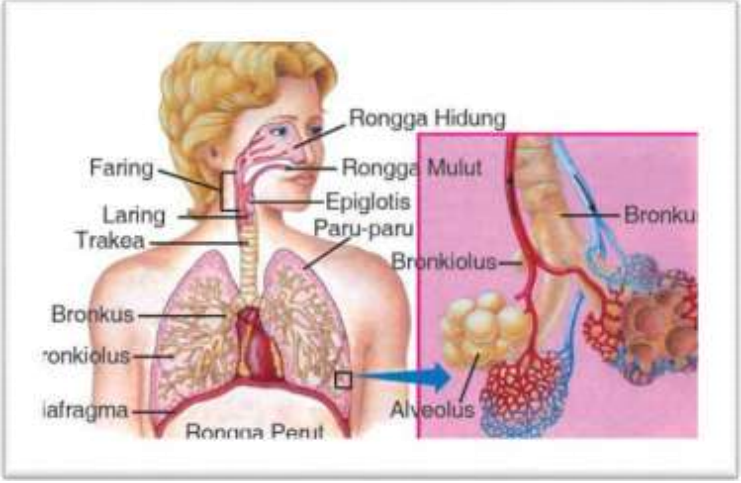

Figure 1. Anatomy of the Human Respiratory System
Source: Campbell et al., 1999

In Indonesia, asthma represents a significant and growing public health challenge. National health surveys estimate its prevalence at approximately 5% of the total population, equivalent to roughly 12.5 million patients distributed across the archipelago (Ikawati, 2016). Regional data further illustrate the magnitude of the problem: outpatient records from the pulmonology clinic at RSUD dr. Zainoel Abidin in Banda Aceh documented 1,441 patients with bronchial asthma in a single year, with a higher proportion of women (58.8%) than men (41.2%) (Husna, 2014). In urban centers such as those in West Java, where this study was conducted, rapid urbanization, industrial air pollution, vehicular emissions, and seasonal climatic variations create environmental conditions that may contribute to asthma exacerbations. Despite national efforts to implement guideline-based care aligned with the Global Initiative for Asthma (GINA) at the primary healthcare level, a substantial proportion of Indonesian patients continue to experience poorly controlled symptoms, frequent exacerbations, and impaired functional capacity, underscoring the need for complementary approaches that may augment the benefits of conventional pharmacological management.

The etiology of bronchial asthma is multifactorial and involves complex interactions among genetic predisposition, immune dysregulation, and environmental triggers. Predisposing and precipitating factors include atopic constitution, respiratory tract infections caused by viruses and Mycoplasma species, psychological stress, and physical exertion, whereas external triggers include allergens such as house dust mites, pollen, animal dander, mold, and certain foods; air pollutants such as particulate matter, ozone, and sulfur dioxide; occupational sensitizers; and cigarette smoke (Danusantoso, 2011; Muttaqin, 2014). At the pathophysiological level, asthma is commonly associated with type 2 (T2) immune responses involving T-helper 2 (Th2) cells, which promote immunoglobulin E (IgE) production, mast cell activation and degranulation, and eosinophilic airway inflammation. The resulting release of inflammatory mediators, including histamine, leukotrienes, prostaglandins, and pro-inflammatory cytokines such as interleukin (IL)-4, IL-5, and IL-13, contributes to bronchoconstriction, mucosal edema, increased vascular permeability, and hypersecretion of viscous mucus (Djojodibroto, 2014; Suryana, 2016). With chronic disease, structural changes

collectively referred to as airway remodeling may develop, including airway smooth muscle hypertrophy, subepithelial fibrosis, goblet cell hyperplasia, and basement membrane thickening. These changes contribute to persistent bronchial hyperresponsiveness and may lead to progressive airflow limitation and declining lung function, as illustrated in Figure 2.

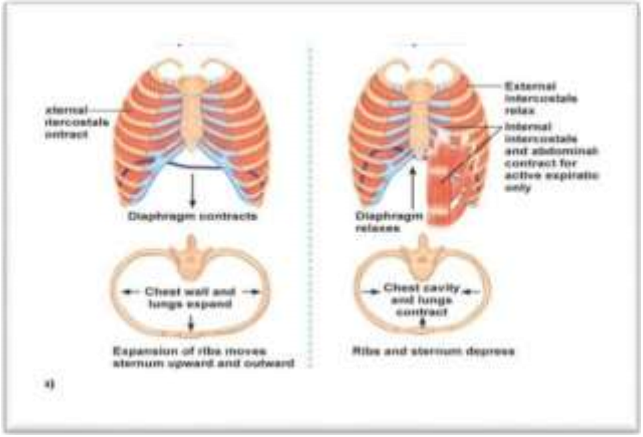

Figure 2. Comparison of Normal Bronchiole and Bronchiole in Bronchial Asthma
Source: Muttaqin, A. (2014)

Contemporary asthma management follows the stepwise pharmacological framework recommended by GINA, incorporating controller medications such as inhaled corticosteroids (ICS), long-acting β_2-agonists (LABAs), and leukotriene receptor antagonists, alongside reliever medications, including short-acting β_2-agonists (SABAs), for acute symptom relief. Nonpharmacological strategies—including trigger identification and avoidance, structured patient education, breathing exercises, and regular clinical monitoring—are also important components of comprehensive asthma care. Although this evidence-based approach effectively controls symptoms in many patients, important clinical limitations remain. Prolonged or high-dose corticosteroid exposure may be associated with adverse effects such as adrenal suppression, reduced bone mineral density, oropharyngeal candidiasis, growth suppression in pediatric populations, and metabolic disturbances (Rengganis, 2008; Mansjoer, 2008). A clinically significant subset of patients continues to experience symptoms despite optimized pharmacological therapy, while barriers such as medication affordability, incorrect inhaler technique, poor adherence, and inadequate follow-up may further reduce real-world treatment effectiveness. The pathophysiological cascade from initial trigger exposure to chronic airway dysfunction is depicted in Figure 3. These limitations have generated sustained clinical and research interest in complementary and integrative approaches, including acupuncture, as adjunctive therapies to conventional asthma management (Nurwati, 2015).

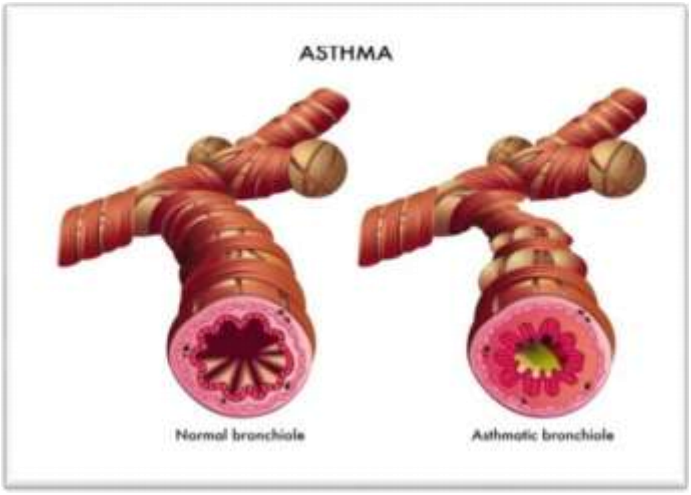

Figure 3. Pathophysiology of Bronchial Asthma and Status Asthmaticus
Source: Djojodibroto, D. (2014)

Traditional Chinese Medicine (TCM) offers a comprehensive, time-tested theoretical framework for understanding and treating bronchial asthma through the concept of Xiao Chuan (哮喘). Xiao refers to the characteristic whistling or wheezing sound associated with airway obstruction, whereas Chuan denotes labored breathing and dyspnea; together, these terms encompass the cardinal respiratory manifestations of asthma within TCM nosology (Yin & Liu, 2000; Jie, 2002). According to TCM physiology, the Lung governs Qi and controls respiration through two essential functions: Xuan Fa, the diffusion of Qi and defensive Wei Qi outward toward the body surface and skin, and Su Jiang, the descending and purifying movement of Qi toward the Kidney. Disruption of these functions—whether caused by external pathogenic factors such as Wind-Cold (Feng Han) or Wind-Heat (Feng Re) invading the Lung or by dysfunction of internally related organs—can obstruct the normal flow of Qi and clinically manifest as dyspnea, wheezing, and cough. In chronic presentations, the Spleen (Pi) plays an important secondary role. Through its function of transformation and transportation (Yun Hua), the Spleen converts ingested food and fluids into postnatal Qi and Blood. When Spleen function is deficient, fluid metabolism becomes impaired, promoting the accumulation of phlegm (Tan), which may ascend and obstruct the Lung. This relationship is expressed in the classical maxim Pi Wei Sheng Tan, Fei Wei Chu Tan ("The Spleen is the source of phlegm; the Lung is its place of storage") (Maciocia, 2015). In advanced or long-standing cases, Kidney Yang deficiency may further impair the Kidney's function of receiving and anchoring the Qi descending from the Lung (Na Qi), resulting in shallow breathing and exertional dyspnea. This pathological progression—from Lung Qi deficiency and phlegm accumulation to potential Kidney involvement—provides the theoretical basis for TCM pattern differentiation and individualized treatment planning (Yin & Zenghua, 2000).

Acupuncture, as a major therapeutic modality within TCM, has attracted growing scientific interest as a complementary intervention for bronchial asthma. Biomedical research has proposed several neurophysiological and immunological mechanisms through which acupuncture may exert therapeutic effects. Needle stimulation activates Aδ and C sensory nerve fibers, transmitting afferent signals to the spinal cord, brainstem, hypothalamus, and limbic system, where the subsequent release of β-endorphins, enkephalins, serotonin, and

norepinephrine may modulate nociception, autonomic nervous system activity, and inflammatory signaling pathways (Saputra, 2000; Lundeberg, 1993). In asthma, stimulation of thoracic acupoints such as Feishu (BL13) has been proposed to influence neuropeptides, including calcitonin gene-related peptide (CGRP), and neuroendocrine pathways involving adrenocorticotropic hormone (ACTH), thereby contributing to the modulation of airway resistance and inflammation through the hypothalamic-pituitary-adrenal axis (Lundeberg, 1993). Clinical studies have also reported that acupuncture may reduce pro-inflammatory cytokines, including IL-4, IL-5, IL-13, and TNF-α, as well as serum IgE levels, while enhancing regulatory T-cell (Treg) activity and the anti-inflammatory cytokine IL-10, thereby potentially attenuating the type 2/Th2-skewed immune response associated with allergic asthma (Li et al., 2022; Zhang et al., 2023). Furthermore, Masao et al. (2009) reported improvements in pulmonary function parameters and reductions in eosinophil counts following acupuncture treatment, whereas Nurwati (2015) observed reductions in bronchial inflammation and airway remodeling in animal models treated at BL13 and ST36. Muthmainah (2011) also reported a significant decrease in CD4+ lymphocyte levels in acupuncture-treated groups, suggesting modulation of inflammatory responses at the bronchiolar level.

Despite the growing body of evidence supporting the potential benefits of acupuncture in asthma management, detailed case reports systematically documenting the application of Bian Zheng Lun Zhi—the TCM principle of treatment based on pattern differentiation—in patients presenting with concurrent Lung Qi Deficiency and Spleen Qi Deficiency remain limited, particularly within the Indonesian clinical context. A thorough understanding of the rationale underlying acupoint selection, needle manipulation techniques, and session-by-session clinical progression is important for both clinical practice and academic development. Moreover, case-based evidence derived from actual clinical settings can provide valuable insights into the real-world implementation and outcomes of TCM-based interventions that may not be fully captured by randomized controlled trials. Therefore, this study aims to describe the complete acupuncture management protocol applied to a patient with bronchial asthma presenting with concurrent Lung Qi Deficiency and Spleen Qi Deficiency syndrome and to evaluate the clinical outcomes following eight structured weekly treatment sessions using the four TCM diagnostic methods (Si Zhen). This study provides a practical acupuncture protocol for managing asthma associated with Lung and Spleen Qi deficiency and may serve as a clinical reference for practitioners. Academically, it contributes to the limited body of Indonesian TCM case literature through the systematic documentation of pattern differentiation based on Bian Zheng Lun Zhi. For patients, the findings may support the use of acupuncture as an adjunctive therapeutic option when integrated with appropriate conventional medical care. Furthermore, this case study contributes to the evidence base concerning the integration of traditional medicine into Indonesia's healthcare system, in alignment with the WHO Traditional Medicine Strategy 2025–2034.

METHOD

This research employed a descriptive qualitative case study design to document the acupuncture management of a single patient with bronchial asthma at Griya Sehat Al Hafidz Purwakarta. One 58-year-old female participant was enrolled based on a previous diagnosis of bronchial asthma, classification as intermittent asthma according to GINA criteria, and a

Traditional Chinese Medicine (TCM) diagnosis of Lung Qi Deficiency (Fei Qi Xu) with concurrent Spleen Qi Deficiency (Pi Qi Xu). Written informed consent was obtained before the study began, and participant confidentiality was maintained throughout the research process in accordance with applicable ethical standards.

The study was conducted at Griya Sehat Al Hafidz Purwakarta, Purwakarta, West Java, from August to September 2025. During this period, the participant received eight weekly acupuncture sessions between August 8 and September 26, 2025. The treatments were performed using sterile, single-use acupuncture needles and standard infection prevention and control procedures appropriate for acupuncture practice.

Data were collected using the four TCM diagnostic methods (Si Zhen), consisting of inspection (Wang Zhen), auscultation and olfaction (Wen Zhen), inquiry, and palpation (Qie Zhen). Clinical assessment included observation of the participant's general condition, facial complexion, tongue characteristics, respiratory symptoms, cough, sleep quality, appetite, bowel habits, and other relevant complaints. Palpation included assessment of tenderness at selected acupuncture points and pulse examination based on depth, rate, strength, and rhythm. Clinical assessments were conducted systematically at the first, fourth, and eighth sessions to evaluate changes in symptoms and TCM diagnostic findings throughout the treatment period.

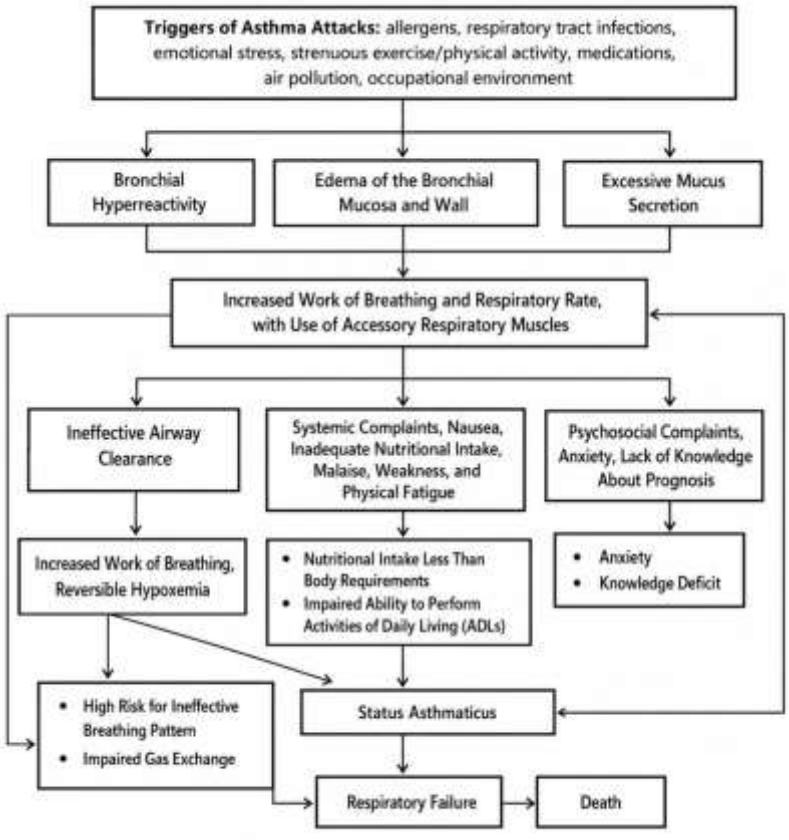

Figure 4. Research Framework: Acupuncture Care Process for Bronchial Asthma with Lung Qi Deficiency and Spleen Qi Deficiency at Griya Sehat Al Hafidz Purwakarta
Source: Primary data (2025)

Acupuncture diagnosis was established using the Bian Zheng Lun Zhi principle based on the Eight Principles (Ba Gang). The findings from Si Zhen, including a pale and slightly swollen tongue with a white, moist coating; a deep, slow, and weak pulse (Chen–Chi–Ruo); chronic dyspnea; spontaneous sweating; a weak voice; recurrent upper respiratory infections; decreased appetite; abdominal bloating; and a tendency toward loose stools, indicated Lung Qi Deficiency (Fei Qi Xu) with concurrent Spleen Qi Deficiency (Pi Qi Xu). Based on this diagnosis, the treatment focused on strengthening Lung Qi, supporting Spleen function, resolving phlegm, relieving cough and dyspnea, and improving overall resistance to recurrence. The acupuncture prescription included BL13 (Feishu), LU9 (Taiyuan), LU1 (Zhongfu), BL20 (Pishu), SP3 (Taibai), SP6 (Sanyinjiao), CV4 (Guanyuan), CV17 (Shanzhong), CV22 (Tiantu), EX-B1 (Dingchuan), and ST40 (Fenglong). The Bu Fa tonification technique was applied to most points, while ST40 (Fenglong) received Ping Bu Ping Xie stimulation. Sterile, single-use acupuncture needles were used and retained for approximately 20–30 minutes after elicitation of the Deqi sensation. Standard safety and infection-control procedures were followed throughout all treatment sessions. The participant also received guidance regarding dietary habits, breathing exercises, and avoidance of known asthma triggers. Data credibility was supported through methodological and temporal triangulation across the eight-week treatment period.

RESULTS AND DISCUSSIONS

Table 1. Participant Characteristics

Variable	Description
Participant Code	P-01
Name (Initial)	Ny. D.R.
Gender	Female
Age	58 Years (DOB: 12 December 1966)
Occupation	Housewife
Domicile	Purwakarta Regency
First Visit	8 August 2025
Medical Diagnosis	Bronchial Asthma (Intermittent)
TCM Syndrome Diagnosis	Lung Qi Deficiency (Fei Qi Xu) with Spleen Qi Deficiency (Pi Qi Xu)
Number of Sessions	8 sessions
Treatment Period	8 August – 26 September 2025

Source: Primary clinical data. (2025)

The participant (Ny. D.R.) presented with a four-year history of recurrent dyspnea, frequently triggered by cold weather, excessive fatigue, and prolonged travel. Associated complaints included productive morning cough with white sputum, easy fatigue, spontaneous diaphoresis without exertion, recurrent upper respiratory infections, decreased appetite, postprandial abdominal bloating, and tendency toward loose stools. On initial Wang Zhen examination, she displayed dull affect, pale yellowish complexion, dim and lusterless eyes, pale-pink slightly swollen tongue with white moist coating, and deep (Chen), slow (Chi), weak (Ruo) pulse on palpation. These findings are collectively consistent with TCM Lung Qi Deficiency compounded by Spleen Qi Deficiency, as described by Maciocia (2015) and Cheng (2010).

Table 2. Acupuncture Points Used and Their Functions

Point	Meridian	Key TCM Function	Clinical Role
BL13 (Feishu)	Bladder	Back-Shu of Lung; Bu Fei Qi	Strengthens Lung Qi; reduces bronchospasm
LU9 (Taiyuan)	Lung	Yuan-Source; tonifies Lung Qi	Improves respiratory capacity; strengthens voice
LU1 (Zhongfu)	Lung	Front-Mu of Lung; opens chest	Relieves chest fullness; reduces dyspnea
CV17 (Shanzhong)	Ren Mai	Hui Point of Qi; strengthens Zong Qi	Enhances respiratory muscle strength; opens chest
CV22 (Tiantu)	Ren Mai	Descends rebellious Lung Qi	Reduces wheezing; calms cough and dyspnea
EX-B1 (Dingchuan)	Extra	Specific point for asthma and dyspnea	Attenuates bronchospasm; stops wheezing
BL20 (Pishu)	Bladder	Back-Shu of Spleen; Jian Pi	Strengthens Spleen; reduces phlegm formation
SP3 (Taibai)	Spleen	Yuan-Source of Spleen; Yun Hua	Optimizes fluid metabolism; prevents phlegm
SP6 (Sanyinjiao)	Spleen	Intersection of 3 Yin meridians (Foot)	Strengthens Spleen & Kidney; improves stamina
CV4 (Guanyuan)	Ren Mai	Strengthens Yuan Qi & Zheng Qi	Builds root resistance; prevents recurrence
ST40 (Fenglong)	Stomach	Luo-Connecting; Hua Tan (resolve phlegm)	Resolves phlegm accumulation; clears airways

Source: Deadman, Al-Khafaji, & Baker (2007); Maciocia (2015)

Table 3. Summary of Acupuncture Treatment Sessions (Sessions 1, 4, and 8)

No	Stage	Session 1 (8 Aug 2025)	Session 4 (29 Aug 2025)	Session 8 (26 Sep 2025)
1	**Exam-ination**	**Wang Zhen:** Pale yellowish complexion, dull eyes, lesu. **Wen Zhen:** Mild wheezing on breathing. **Wen:** Dyspnea ±4 years, fatigue, weak voice, spontaneous sweating, recurrent colds, excessive morning sputum, abdominal bloating, loose stool. **Qie Zhen:** LU1, BL13, CV17 cold on palpation; Chen–Chi–Ruo pulse; tongue pale-pink, swollen, moist, white coating.	Improved complexion; brighter eyes. Wheezing only on deep inspiration. Dyspnea ↓60%; sputum decreased; fatigue improving; household activities manageable; sleep better. LU1, BL13, CV17 warmer; reduced tenderness. Pulse stronger though still deep. Tongue less swollen; thinner coating.	Shen good; fresh complexion; bright eyes. No audible wheezing. Dyspnea near-resolved; no night cough; minimal sputum; full household activity resumed; no recurrent colds. LU1, BL13, CV17 normally warm. Pulse stronger, regular rhythm. Tongue near-normal; thin white coating.
2	**Diagnosis**	Bronchial Asthma; TCM: Lung Qi Deficiency (Fei Qi	Diagnosis unchanged — improvement phase. Lung &	Diagnosis unchanged — recovery phase. Lung Qi restored;

		Xu) with Spleen Qi Deficiency (Pi Qi Xu).	Spleen Qi strengthening; phlegm reducing; Wei Qi beginning to improve.	Spleen function improved; minimal phlegm; Wei Qi strong.
3	**Treatment**	Bu Qi, Jian Pi, Yi Fei, Hua Tan, Zhi Ke Ping Chuan. Points: BL13, LU9, BL20, SP3, CV4, SP6, LU1, CV22, CV17, EX-B1, ST40. Bu Fa dominant; ST40 Ping Bu Ping Xie; retention 30 min. Education: warm diet, breathing exercises.	Same principles and points. Tonification continued for Zheng Qi strengthening. ST40 shifting to even technique as sputum reduced. Education on breathing and trigger avoidance maintained.	Consolidation: strengthen Lung & Spleen Qi; prevent recurrence. Light tonification. Maintenance 1×/2–4 weeks recommended. Continued education on trigger avoidance and medical compliance.
4	**Evaluation**	Slight reduction in dyspnea; chest feels lighter; body warmer; sleep improved. Prognosis: Bonam (Good). Therapy continued.	Dyspnea ↓60%; sputum ↓70%; spontaneous sweating rare; voice stronger; appetite improved; stool normal; stamina up; sleep quality improved. Prognosis: Bonam. Therapy continued to session 8.	Dyspnea ↓90–95%; no nocturnal attacks; no wheezing; minimal sputum; full ADL restored; QoL improved; tolerance ≥30 min walking without significant dyspnea. Prognosis: Bonam. Maintenance therapy recommended.

Source: Primary clinical documentation, (2025)

Examination findings (Si Zhen) demonstrated consistent and progressive clinical improvements across the three evaluated time points. The pale-yellow complexion, dull eyes, swollen pale tongue with white moist coating, and deep-slow-weak pulse observed at session 1 represent classical TCM manifestations of chronic Lung Qi Deficiency compounded by Spleen Qi Deficiency. According to TCM theory, deficient Lung Qi impairs the diffusion function (Xuan Fa) and descending action (Su Jiang) of the Lung, while Spleen Qi deficiency disrupts fluid transformation, promoting phlegm accumulation within the Lung and airways (Cheng, 2010; Maciocia, 2015). By session 4, a brighter complexion, reduced tongue swelling, thinner coating, and progressively stronger pulse indicated improved Qi production by the Spleen and enhanced distribution by the Lung. Session 8 demonstrated near-complete normalization of all four diagnostic parameters, confirming the therapeutic efficacy of the applied protocol. These objective examination improvements directly reflect the restoration of Xuan Fa and Su Jiang Lung functions and the resolution of phlegm obstruction, providing objective TCM-based evidence of successful pattern resolution.

The TCM diagnosis of Fei Pi Qi Xu demonstrated dynamic evolution across sessions—from the deficiency phase (session 1), through improvement (session 4), to recovery (session 8)—consistent with Yin's (2000) assertion that TCM diagnosis is inherently dynamic and evolves alongside the patient's changing patterns. The point prescription combined Back-Shu

points (BL13, BL20) with Yuan-Source points (LU9, SP3), Front-Mu points (LU1), and meeting points (CV17, SP6, CV4) to simultaneously address both the root (Ben) and manifestation (Biao) of the disease. BL13 (Feishu) and LU9 (Taiyuan) directly strengthened Lung Qi and restored Xuan Fa/Su Jiang functions. BL20 (Pishu) and SP3 (Taibai) fortified Spleen function to curtail phlegm at its source. ST40 (Fenglong) cleared accumulated phlegm from the airways, while EX-B1 (Dingchuan) specifically attenuated bronchospasm. CV4 (Guanyuan) consolidated Yuan Qi and Zheng Qi to prevent recurrence. This comprehensive strategy embodies the principle of Zhi Bing Qiu Ben (treating the root of disease) as described by Deadman et al. (2007).

From a biomedical perspective, the mechanisms underlying these improvements are well-supported by contemporary evidence. Acupuncture stimulates A-delta and C sensory nerve fibers, triggering release of endorphins, serotonin, and norepinephrine that modulate autonomic nervous system balance and promote bronchial smooth muscle relaxation, reducing airway hyperresponsiveness. Evidence further demonstrates that acupuncture decreases pro-inflammatory cytokines (IL-4, IL-5, IL-13, TNF-α) and serum IgE while increasing regulatory T cells (Treg) and anti-inflammatory IL-10 (Li et al., 2022; Zhang et al., 2023). The observed improvements—85–90% reduction in dyspnea, complete resolution of wheezing, decreased sputum, and improved exercise tolerance—are consistent with these mechanisms and corroborate findings from earlier studies (Masao et al., 2009; Nurwati, 2015; Muthmainah, 2011). Specifically, the reduction in sputum production corresponds to the anti-phlegm effect of ST40 stimulation, which biomedically may reduce mucus hypersecretion via autonomic modulation and decreased inflammatory mediator levels.

The clinical trajectory in this case aligns closely with GINA (2025) therapeutic goals: symptom control, prevention of exacerbations, maintenance of lung function, and improvement of quality of life. The participant's ability to perform a 30-minute walk without meaningful dyspnea by session 8—compared to being significantly limited by breathlessness during routine activities at baseline—represents a clinically meaningful improvement in exercise tolerance and functional capacity. Patient education provided alongside each treatment session reinforced trigger avoidance (cold air, dust, cigarette smoke, excessive fatigue), warm dietary practices, diaphragmatic breathing exercises, and compliance with any prescribed conventional medical therapy, collectively contributing to sustaining treatment gains between sessions.

Comparing these results with previous studies, Masao et al. (2009) reported significant improvements in pulmonary function tests and symptomatic relief following acupuncture in asthma patients over a similar treatment duration, while Li et al. (2022) demonstrated immunological rebalancing with reduced serum IgE and IL-4 levels after a structured acupuncture protocol. The present case similarly demonstrated clinical improvements consistent with these immune-modulatory findings, as evidenced by decreased wheezing, reduced sputum production, and improved resistance to respiratory infections—indicators that correlate with suppression of Th2-driven inflammatory activity and enhanced mucosal immune defense. Nurwati (2015) specifically highlighted that combined stimulation at Feishu (BL13) and Zusanli (ST36) effectively reduced airway remodeling markers in experimental models; the present study's use of BL13 as a primary point supports these findings in a clinical context. Furthermore, the progressive pulse improvement from Chen–Chi–Ruo to a stronger, more regular quality provides an objective TCM biomarker reflecting the restoration of Zheng Qi,

consistent with Maciocia's (2015) assertion that pulse normalization is a reliable indicator of successful organ function recovery.

It is important to acknowledge certain limitations of this study. As a single-case descriptive study, findings cannot be generalized to the broader asthma population without further investigation. The absence of objective pulmonary function testing—such as spirometry or peak expiratory flow (PEF) measurement—or validated instruments like the Asthma Control Test (ACT) limits quantitative comparison with standard clinical benchmarks. Additionally, as a naturalistic clinical observation without a control group, it is not possible to attribute all improvements exclusively to acupuncture, as concurrent lifestyle modifications and the natural history of asthma may have contributed. These limitations notwithstanding, the case provides valuable clinical documentation of a complete TCM acupuncture protocol—from initial Si Zhen assessment through eight-session treatment and outcome evaluation—which can serve as a reference for future controlled research. Future studies should involve larger participant samples with diverse severity levels, objective lung function measurements, longer follow-up periods to assess durability of treatment effects, and comparative designs to establish the specific contribution of acupuncture to overall asthma management.

CONCLUSION

This case study demonstrated that acupuncture management based on the Bian Zheng Lun Zhi principle was associated with improvements in clinical outcomes in a 58-year-old female patient with bronchial asthma presenting with concurrent Lung Qi Deficiency and Spleen Qi Deficiency syndrome. Over eight weekly treatment sessions using BL13, LU9, LU1, BL20, SP3, SP6, CV4, CV17, CV22, EX-B1, and ST40, with Bu Fa (tonification) as the primary technique, the patient experienced an approximately 85–90% reduction in the frequency of dyspnea, complete resolution of wheezing, a marked decrease in sputum production, improved exercise tolerance, better sleep quality, and increased appetite. Improvements were also observed in TCM diagnostic findings, including progressive normalization of the tongue from pale and swollen with a white, moist coating to near-normal with a thin white coating, as well as strengthening of the pulse from deep, slow, and weak (Chen–Chi–Ruo) to a stronger and more regular quality.

The therapeutic principles of Bu Fei Jian Pi (strengthening the Lung and Spleen), Hua Tan (resolving phlegm), and Fu Zheng Gu Ben (strengthening constitutional resistance) were applied to address both the patient's symptoms and the underlying TCM pattern. These findings were consistent with previous biomedical evidence suggesting that acupuncture may exert neuroimmunomodulatory effects, including modulation of pro-inflammatory cytokines and autonomic nervous system activity. This case suggested that acupuncture may have potential as a complementary approach to asthma management in patients presenting with Lung and Spleen Qi deficiency patterns when integrated with conventional medical care, patient education, and lifestyle modification. However, because this was a single-case descriptive study without a control group, the findings should be interpreted as preliminary and hypothesis-generating rather than confirmatory. Definitive conclusions regarding efficacy and safety could not be established from this case alone. Future studies should include larger samples, objective pulmonary function assessments such as spirometry and peak expiratory flow (PEF), validated clinical instruments such as the Asthma Control Test (ACT), randomized controlled designs,

and longer follow-up periods to confirm these observations and clarify the specific contribution of acupuncture to asthma management.

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