

practitioners' attention on this article and better reflect the effectiveness of PC6 for PONV in the medical industry.

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Conflict of interest: None to report.

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Reply to Lu et al



Reply from the Editor:

Thank you for your contributions and suggestions for our article.

1. As in the literature used,¹⁻³ pericardium 6 point (Neiguan) was shortened to P6 and is referred to as P6 in our article. Traditional Chinese Medicine theory was used for PC6 (P6) point location, and PC6 regional location was not explained in detail.
2. During the research, 2 patients were given antiemetic drugs for optimal benefit and removed from the research because they expressed that their nausea did not stop. Thus, harm was prevented for these patients. In the evaluation of postoperative nausea and vomiting, a visual analog scale was preferred because the Gagging Severity Index and Gagging Prevalence Index should be used after validity and reliability analysis, which would significantly extend this master's degree thesis process.

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Response to “The Effect of Neiguan Point (P6) Acupressure With Wristband on Postoperative Nausea, Vomiting, and Comfort Level: A Randomized Controlled Study” from Moran et al



To the Editor:

We have read with interest the randomized controlled study from Ünülu and Kaya¹ about the effect of Neiguan point (P6) acupressure with wristband on postoperative nausea, vomiting, and comfort level. Authors conclude that because of its effectiveness and feasibility, wristband P6 acupuncture point acupressure application is a great alternative to pharmacologic methods in the gynecologic surgery population.

We have some concerns about the data analysis in the article regarding the nausea variable. On the basis of the data presented in Table 4 of Ünülu and Kaya,¹ there were no differences in the presence of vomiting along the study between control and experimental groups. However, statistically significant differences were found in the intensity of nausea with use of a visual analog scale between the two studied groups. These differences were present at baseline (0 to 2 hours) ($P < .001$) with higher intensity of nausea in the control group. Authors

indicate that these differences in the intensity of nausea are in favor of the experimental group. However, the data analysis does not allow to confirm such assumption. First, as authors have observed differences between groups from the beginning till the end, how can authors assure that such differences were because of the intervention? By simple comparisons using the Mann-Whitney U test authors cannot interpret that such differences are because of the treatment. An approach that is often more practical is to use analysis of covariance, which has high statistical power and adjusts each subject's follow-up measurement according to their baseline measurement. Second, authors have failed to correctly analyze the within results. There is not only a need of statistically significant difference between the groups, but also within the group from the baseline to some point (often the end) in the follow-up. There is no within group analysis in this study. The need of a within and between group analysis could be avoided by the authors by a crossover design, but it was not the design.

We regrettably disagree with the conclusions of Ünülu and Kaya as the analysis of the data presented does not prove that the wrist P6 acupuncture point acupressure application with wristband is effective neither for prevention of nausea occurring in the postoperative period nor for prevention of vomiting occurring in the postoperative period.

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