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International standard of WFCMS

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针刀医学技术操作规范

Standardized technical manipulations of needle-knife medicine

（发布稿，International Standard）

WFCMS

世界中联国际组织标准

International Standard

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前　言

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针刀医学技术操作规范

1 范围

本文件规定了针刀医学临床的环境要求、施术流程、禁忌证、注意事项等内容。

本文件适用于开展针刀医学临床活动。

2 规范性引用文件

下列文件中的内容通过文中的规范性引用而构成本文件必不可少的条款。其中，注日期的引用文件，仅该日期对应的版本适用于本文件；不注日期的引用文件，其最新版本（包括所有的修改单）适用于本文件。

GB 15982-2012 医院消毒卫生标准

WS/T 313-2009 医务人员手卫生规范

WS/T 368-2012 医院空气净化管理规范

T/CACM 1063-2018 针刀医学临床 基础术语

3 术语和定义

T/CACM 1063-2018界定的术语和定义适用于本文件。

4 环境准备

4.1 治疗室环境

治疗室应具备良好的通风和照明条件。可采用自然通风和（或）机械通风保证空气流通。治疗室地面、墙面、天花板、桌面应光洁，便于清洁消毒。

治疗室应划分无菌准备区、治疗区，区域之间要有实际隔断。温度应控制在（26±1）℃。治疗室空气菌落总数应符合GB 15982-2012中Ⅳ类环境的要求。

4.2 设备配置

4.2.1 无菌准备区

应配备洗手设施、手卫生及干手物品，包括流动水、非手触式水龙头、洗手皂液、免洗手消毒剂等，宜使用一次性包装的洗手液，重复灌装的洗手液容器，应每天清洁与消毒。

应配备洗手流程图及说明图，干手用品宜使用一次性干手纸巾或消毒毛巾。

应配置手卫生设施及用品、更衣柜、移动式无影灯、医用帽子、医用口罩、隔离衣、无菌手套、无菌一次性针刀、外科手消毒剂、一次性洞巾、医疗垃圾桶，以及急救药品和设备。

4.2.2 治疗区

应配置治疗床、治疗车、无菌物品存放柜、医疗垃圾桶。

4.3 清洁消毒

4.3.1 常规清洁

应使用不掉纤维织物材料制作的清洁工具，不应与其他房间混用清洁工具。

每天针刀治疗结束后应进行湿式打扫地面、桌面，每周应擦拭吊灯、墙壁。

4.3.2 环境、物体表面消毒

按照GB 15982-2012中5.5规定对治疗室环境、物体表面消毒。

4.3.3 空气消毒

治疗活动前后或接诊呼吸道传染病患者后，应进行空气消毒。可选用WS/T 368-2012中第5章提供的空气净化方法进行操作。不宜常规采用化学喷雾进行空气消毒。

5 施术流程

5.1 术前准备

5.1.1 体位选择

5.1.1.1 原则

患者体位选择宜遵循以下原则：

a）便于患者放松；

b）充分暴露施治部位；

c）便于施术者操作。

5.1.1.2 体位

患者体位包括但不限于以下方式：

a）坐位：适用于头、颈、肩及上肢部位的治疗。

b）卧位：适用于全身各个部位的治疗，包括但不限于俯卧、仰卧、侧卧、俯卧垫腰位、屈膝位、屈髋位。

5.1.2 体表定位

对治疗点进行体表定位，参见附录B。

5.1.3 皮肤消毒

5.1.3.1 消毒方法

用于皮肤消毒的棉球不可重复使用，皮肤消毒可选用下列方法之一：

a) 使用浸有碘伏消毒液原液的无菌棉球擦拭皮肤表面3遍，作用时间在2～3 min。

b) 使用浸有碘酊原液的无菌棉球擦拭皮肤表面3遍，作用时间在1～3 min，稍干后再用乙醇（70 %～80 %，体积分数）脱碘3遍。

c) 使用浸有效含量≥2g/L氯己定-乙醇（70 %，体积分数）溶液的无菌棉球擦拭皮肤表面3遍，作用时间遵循产品使用说明。

d) 其他合法、有效的皮肤消毒产品，应遵循说明书使用。

5.1.3.2 消毒范围

以治疗点为中心，由内向外缓慢旋转，逐步涂擦，消毒皮肤范围直径应在15～20 cm。

5.1.4 铺巾

施治部位皮肤消毒后，待消毒液自然干燥，应铺大小适宜的无菌洞巾。

5.2 术中操作

5.2.1 定向

a）可垂直于皮肤方向进针刀的治疗点，应垂直皮肤方向进针刀；不可垂直于皮肤方向进针刀的治疗点，如头项部进针刀的治疗点，应紧贴骨面。针刀持握方法参见附录C。

b) 进针刀时应对准病灶所在的方向。

c) 针刀刀口线方向应与脊柱纵轴方向平行。

5.2.2 加压分离

以手指压在定点的皮肤上，使重要的神经血管被挤向一侧。

5.2.3 刺入

针刀快速穿透皮肤到达皮下。

5.3 术后

a) 清理治疗点的血渍，应按压数分钟止血并使用无菌敷料覆盖。

b) 患者应平卧10～20 min，每5 min观察询问1次患者情况，包括施治部位和全身的情况，患者感觉无异常后方可起身。

c) 根据患者病情予以手法治疗，必要时予以相应药物治疗，并在术后6 h内完成手术记录。

5.4 康复指导

叮嘱患者避免沾水等预防感染注意事项，如伤口进水应及时局部消毒处理，有渗血渗液，应及时消毒，更换敷料，并做病历记录。配合不同部位功能锻炼，颈腰部针刀术后24 h，卧床为主，之后以脊柱平衡锻炼为主。四肢部分针刀术后局部加压20 min，24 h后被动锻炼关节肌肉。

6 禁忌证

6.1 忌用

血友病。

6.2 慎用

a) 孕期。

b) 施治部位有红肿、灼热、皮肤破溃、肌肉坏死或深部有脓肿。

c) 施治部位有重要血管或脏器。

d) 内脏功能严重不全。

e) 高血压危象。

f) 肝硬化、活动性结核、糖尿病、溶酶体贮积症、线粒体病，以及代谢小分子类疾病。

g) 颅内疾患，包括但不限于脑出血、蛛网膜下腔出血、硬脑膜外及硬脑膜下出血、脑梗塞、短暂性脑缺血发作，以及各种脑动脉炎、脑动脉缺血性综合征、颅内静脉窦、静脉血栓等。

h) 传染病，包括但不限于丙肝、乙肝等。

i) 由支原体、衣原体引起的发热，或由病毒、细菌引起的发热。

j) 体质极度虚弱或精神极度紧张。

7 注意事项

a) 施治部位存在皮肤感染及出血倾向时，不应进行治疗。

b) 有毛发的施治部位应备皮。

c) 同一施治部位的治疗间隔时间以 3～5 d 为宜，以局部恢复情况为准，不同病种施治部位的治疗间隔可不受时间限制。

d) 应使用一次性无菌针刀，其规格、型号应与施治部位相匹配；针刀包装应完整无破损，并在有效期限内，从打开包装到治疗操作结束的时间应≤1 h。

e) 针刀应一人一针一部位，禁止重复使用，治疗结束后应放入利器盒，并遵照《医疗废物管理条例》规定集中处置。

f) 治疗 4 次为一个疗程，部分疾病视病情而定。

g) 应按照附录 A 的规定对意外进行预防和处理。

h) 应进行手术记录，包括治疗过程中患者出现的异常反应及对意外情况的处理。

i) 应在符合规定的针刀治疗室中进行治疗。

g) 施术者应于术前、术中穿着医用隔离服、佩戴无菌手套，手部卫生应符合 WS/T 313 的规定。

附录 A
（规范性）
意外预防和处理

A.1 晕针刀

A.1.1 晕针刀的预防

A.1.1.1 对初次接受针刀治疗和精神紧张者，应先做好解释工作。
A.1.1.2 患者宜尽量采取舒适且能持久的体位，如卧位。
A.1.1.3 针刀治疗时，要密切注意患者的整体情况，如有晕针刀征兆，应立即停止治疗。

A.1.2 晕针刀的处理

A.1.2.1 立即停止治疗，将针刀迅速取出，用无菌敷料或创可贴覆盖针刀施治部位。
A.1.2.2 让患者平卧，头部放低，松开衣带，注意保暖。
A.1.2.3 让患者立即饮用温开水，静卧休息。
A.1.2.4 状况轻者，对患者水沟、合谷、内关等腧穴进行针刺或指压。
A.1.2.5 状况重者，应吸氧或做人工呼吸，和/或静脉推注50 %葡萄糖注射液10 mL。

A.2 断针刀

A.2.1 断针刀的预防

A.2.1.1 术前要认真检查针刀状况，保证针刀无锈蚀和裂纹、刚性和韧性良好。
A.2.1.2 针刀操作时，患者不可随意改变体位。
A.2.1.3 针刀刺入人体深部或骨关节内，应避免用力过猛；针刀体在体内弯曲时，不可强行取出针刀。

A.2.2 断针刀的处理

A.2.2.1 施术者应冷静，嘱患者不要恐惧，保持原有体位，防止针刀体残端向肌肉深层陷入。
A.2.2.2 若皮肤外尚露有针刀体残端，可用镊子钳出。
A.2.2.3 若针刀体残端与皮肤相平行或稍低，但仍能看到残端，可用拇指、食指按压针刀旁的皮肤，使之下陷，以使残端露出皮肤，再用镊子将针刀钳出。
A.2.2.4 针刀体残端完全没入皮肤下，若残端下面是坚硬的骨面，可用力下压针刀孔两侧的皮肤，借骨面将残端顶出皮肤；若残端下面是软组织，可捏住该部肌肉，将残端向上托出；若断端很短，埋入人体深部，体表无法触及，应采用外科手术方法取出。手术宜就地进行，不宜搬动移位。必要时，可借助X线定位。

A.3 出血

A.3.1 出血的预防

A.3.1.1 施术者应熟练掌握施治部位的精细和立体解剖知识，明确施治部位周围血管位置和体表投影。

A.3.1.2 术前应耐心询问患者病情，详细了解病史，做出血和凝血时间检查

A.3.1.3 针刀治疗过程中密切观察患者反应。若针刀下有弹性阻力感，患者感觉刺痛，应将针刀稍提起并改变进针方向再刺入；若施治部位在骨面，松解时针刀刃不能离开骨面，更不可大幅度提插。

A.3.2 出血的处理

A.3.2.1浅血管出血

用消毒棉球压迫止血。手足、头面、后枕部等小血管丰富处，针刀松解后，无论出血与否，都应常规按压针孔3～5 min。若少量出血导致皮下青紫瘀斑者，可不必特殊处理，一般可自行消退。

A.3.2.2深部血肿

一般较小的血肿，无需特殊处理，经1～2 周多能自行吸收。若局部肿胀疼痛明显，或仍继续加重，可先做局部冷敷止血或肌肉注射止血敏，48 h后，局部热敷，外擦活血化瘀药物，以加速瘀血的消退和吸收。较大的血肿可在B超定位下穿刺抽除，同时局部用弹力绷带加压包扎。穿刺治疗无效，血肿不消或继续增大时，可切开引流并止血。

A.3.2.3有重要脏器的部位出血

椎管内、胸腹腔内出血较多或不易止血者，需立即进行外科手术。

A.4 气胸

A.4.1 气胸的预防

A.4.1.1 施术者应熟悉掌握胸背部解剖知识，明确施术部位肺界的体表投影。
A.4.1.2 施术者在胸背部进行针刀操作前，应清楚患者是否患有肺部疾病。

A.4.2 气胸的处理

当患者出现胸部不适或吸气困难时应立即停止针刀操作，并将患者转入呼吸病房观察治疗。

A.4.3 感染

如术后出现针眼红肿热痛，应立即进行血常规检验，细菌培养检查，待明确诊断后进行相应的抗感染治疗

附录 B
（资料性）
体表定位方法

B.1 识别体表标志

常用的体表标志包括：

——骨性标志：骨性突起，为肌腱、韧带等组织的附着处，是最常用的体表标志。特点是易找、清楚、准确。通常也是病灶所在之处。

——肌性标志：身体的某些部位没有骨性标志时，可利用肌肉的边缘作为体表标志。

——纹理标志：四肢表皮上的纹路清晰可见，而且比较固定，可用于寻找深部病灶的体表定位标志。

——静脉标志：根据浅表静脉的走行线路和位置，来判断深部组织的位置。由于每个人的浅表静脉的显现程度不同，在体表定位时要区别对待。

——发际标志：在头部做针刀治疗时，可以根据发际线进行定点治疗。但发际线的高低相差较大，不易做到准确定位。

B.2 确定体表投影

利用体表标志确定深层组织在体表的投影范围，并判断血管、神经走向，帮助针刀定位。

B.3 体表定点

在有病变组织的体表范围内寻找到阳性点并标记。

附录 C
（资料性）
针刀持握方法

C.1 双手持针刀法

C.1.1双手持针刀扶针法

施术者操作手的拇、食指拿捏针刀柄，中指和无名指扶住针刀体。辅助手的拇、食指拿捏距离刀刃1 cm处的针刀体的位置。

C.1.2双手持针刀不扶针法

施术者操作手拇、食指拿捏针刀柄。辅助手拇、食指拿捏距离刀刃1 cm处的针刀体的位置。

注：辅助手控制首次进针刀的深度，防止产生不必要的损伤。

C.2 单手持针刀法

C.2.1单手持针刀扶针法

施术者操作手拇指、食指拿捏针刀柄，中指和无名指扶住距离刀刃1 cm处的针刀体的位置。

C.2.2单手持针刀不扶针法

施术者用操作手的拇、食指拿捏针刀柄。

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Foreword

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Standardized technical manipulations of needle-knife medicine

1 Scope

This document specifies the environmental requirements, operational procedures, contraindications, precautions and other contents for clinical practice of needle-knife medicine.

This document is applicable to clinical activities of needle-knife medicine.

2 Normative references

The contents of the following documents constitute indispensable provisions of this document through normative reference in the text. For dated reference documents, only the version corresponding to the specified date shall apply to this document; for undated reference documents, the latest version (including all amendment sheets) shall apply to this document.

GB 15982-2012 Hygienic Standard for Disinfection in Hospitals
WS/T 313-2009 Hygienic Standard for Hand Hygiene of Medical Staff
WS/T 368-2012 Administrative Standard for Air Purification in Hospitals
T/CACM 1063-2018 Clinical Basic Terms of Needle-Knife Medicine

3 Terms and definitions

Terms and definitions defined in T/CACM 1063-2018 are applicable to this document.

4 Environmental preparation

4.1 Treatment room environment

The treatment room shall be well-ventilated and well-lit. Natural ventilation and/or mechanical ventilation may be adopted to ensure air circulation.

The floor, walls, ceiling, and work surfaces in the treatment room shall be smooth and easy to clean and disinfect.

The treatment room shall be divided into an aseptic preparation area and a treatment area, with physical barriers between the zones.

The temperature shall be controlled at (26 ± 1) °C.

The total airborne colony count in the treatment room shall comply with the requirements for Class IV environments specified in GB 15982-2012.

4.2 Equipment configuration

4.2.1 Aseptic preparation area

Handwashing facilities, hand hygiene and hand-drying supplies shall be provided, including running water, touch-free faucets, handwashing soap, alcohol-based hand rub, etc.

Single-use packaged hand sanitizer is preferred. Reusable hand sanitizer containers shall be cleaned and disinfected daily.

Handwashing flowcharts and instructional diagrams shall be posted. Disposable paper towels or disinfected towels are recommended for hand drying.

The following shall be equipped: hand hygiene facilities and supplies, lockers, mobile shadowless lamps, medical caps, medical masks, isolation gowns, sterile gloves, sterile disposable needle-knives, surgical hand disinfectant, disposable surgical drapes, medical waste containers, as well as emergency medicines and equipment.

4.2.2 Treatment area

A treatment bed, treatment cart, sterile supply cabinet, and medical waste container shall be provided.

4.3 Cleaning and disinfection

4.3.1 Routine cleaning

Non-lint cleaning tools shall be used and shall not be shared with other rooms.

Wet cleaning of floors and surfaces shall be performed daily after needle-knife treatment. Ceiling lamps and walls shall be wiped weekly.

4.3.2 Environmental and surface disinfection

Disinfection of the treatment room environment and object surfaces shall be performed in accordance with Clause 5.5 of GB 15982-2012.

4.3.3 Air disinfection

Air disinfection shall be performed before and after treatment or after receiving patients with respiratory infectious diseases.

Air purification methods provided in Chapter 5 of WS/T 368-2012 may be selected. Routine chemical spraying for air disinfection is not recommended.

5 Operational procedure

5.1 Preoperative preparation

5.1.1 Patient positioning

5.1.1.1 Principles

Patient positioning shall follow these principles:

a) facilitate patient relaxation;
b) ensure adequate exposure of the treatment site;
c) facilitate operator manipulation.

5.1.1.2 Positions

Patient positions include, but are not limited to:

a) Sitting position: suitable for treatment of the head, neck, shoulder, and upper extremities.
b) Recumbent position: suitable for treatment of all body regions, including but not limited to prone, supine, lateral recumbent, prone with lumbar support, knee-flexed, and hip-flexed positions.

5.1.2 Surface localization

Surface localization of treatment points shall be performed in accordance with Annex E.

5.1.3 Skin disinfection

5.1.3.1 Disinfection methods

Sterile cotton balls used for skin disinfection shall not be reused. One of the following methods may be used:

a) Wipe the skin three times with sterile cotton balls soaked in full-strength iodophor disinfectant, with a contact time of 2 – 3 minutes.
b) Wipe the skin three times with sterile cotton balls soaked in full-strength iodine tincture, with a contact time of 1 – 3 minutes. After drying, deiodinate three times with ethanol (70 % – 80 %, volume fraction).
c) Wipe the skin three times with sterile cotton balls soaked in chlorhexidine-ethanol (70 %, volume fraction) solution with an effective concentration ≥ 2 g/L, with a contact time in accordance with the product instructions.
d) Other legally approved and effective skin disinfection products shall be used according to their instructions.

5.1.3.2 Disinfection range

Wipe gradually and slowly outward in a rotating pattern centered on the treatment point.
The disinfected skin area shall have a diameter of 15– 20 cm.

5.1.4 Draping

After skin disinfection and natural drying of the disinfectant, an appropriately sized sterile surgical drape shall be applied.

5.2 Intraoperative procedure

5.2.1 Orientation

a) For treatment points allowing vertical insertion, the needle-knife shall be inserted perpendicular to the skin. For points not allowing vertical insertion, such as those on the occipital region, the needle-knife shall be inserted closely along the bone surface.

Needle-knife grasping methods shall follow Appendix C.

b) The needle-knife shall be inserted toward the lesion.

c) The cutting edge line of the needle-knife shall be parallel to the longitudinal axis of the spine.

5.2.2 Pressure separation

Press the skin at the marked point with a finger to push aside important nerves and blood vessels.

5.2.3 Puncture

The needle-knife penetrates the skin rapidly to the subcutaneous layer.

5.3 Postoperative management

a) Clean blood at the treatment site, apply pressure for several minutes to achieve hemostasis, and cover with a sterile dressing.

b) The patient shall lie supine for 10 – 20 minutes. The patient's condition shall be checked and inquired every 5 minutes, including local and general status. The patient may get up only when no abnormality is reported.

c) Provide manual therapy according to the patient's condition and appropriate medication if necessary. Complete the operation record within 6 h after treatment.

5.4 Rehabilitation guidance

Instruct the patient to avoid water contact and other infection-prevention measures.

If the wound gets wet, perform local disinfection promptly.

If bleeding or exudation occurs, disinfect and change the dressing in time and record in the medical chart.

Functional exercise shall be prescribed according to different body regions:

For cervical and lumbar regions: maintain bed rest for 24 h after needle-knife treatment, followed mainly by spine-balancing exercises.

For extremities: apply local compression for 20 minutes after needle-knife treatment; passive joint and muscle exercises may begin after 24 h.

6 Contraindications

6.1 Absolute contraindications

Hemophilia

6.2 Relative contraindications

a) Pregnancy

b) Redness, swelling, heat, skin ulceration, muscle necrosis, or deep abscess at the treatment site
c) Presence of important blood vessels or organs at the treatment site
d) Severe visceral insufficiency
e) Hypertensive crisis
f) Liver cirrhosis, active tuberculosis, diabetes mellitus, lysosomal storage diseases, mitochondrial diseases, and other small-molecule metabolic diseases
g) Intracranial disorders, including but not limited to cerebral hemorrhage, subarachnoid hemorrhage, epidural and subdural hemorrhage, cerebral infarction, transient ischemic attack, various cerebral arteritides, cerebral artery ischemic syndromes, intracranial venous sinus and venous thrombosis
h) Infectious diseases, including but not limited to hepatitis B, hepatitis C
i) Fever caused by Mycoplasma, Chlamydia, viruses, or bacteria
j) Extreme physical weakness or severe mental stress

7 Precautions

a) Treatment shall not be performed if there is skin infection or bleeding tendency at the treatment site.
b) Shaving shall be performed at hairy treatment sites.
c) The interval between treatments at the same site is preferably 3 d – 5 d, based on local recovery. The interval may vary for different diseases.
d) Disposable sterile needle-knives shall be used, with specifications matching the treatment site. Packaging shall be intact and within the validity period. The time from opening the package to completion of treatment shall be ≤ 1 h.
e) One needle-knife per patient per site is required; reuse is prohibited. Used needle-knives shall be placed in a sharps container and disposed of centrally in accordance with the Regulations on the Administration of Medical Wastes.
f) Four treatments constitute one course; some diseases may be adjusted according to condition.
g) Prevention and management of accidents shall follow Appendix A.
h) Operation records shall be kept, including abnormal reactions of the patient and management of adverse events.
i) Treatment shall be performed in a qualified needle-knife treatment room.
j) The operator shall wear medical isolation gown and sterile gloves during preoperative and intraoperative procedures. Hand hygiene shall comply with WS/T 313.

Annex A
(Normative)
Accident prevention and management

A.1 Syncope induced by needle-knife therapy

A.1.1 Prevention of syncope

A.1.1.1 Adequate explanation shall be provided in advance for patients receiving needle-knife therapy for the first time or those with mental tension.
A.1.1.2 The patient shall assume a comfortable and sustainable position, preferably a recumbent position.
A.1.1.3 During needle-knife therapy, closely monitor the patient's general condition. If any prodromal signs of syncope occur, discontinue treatment immediately.

A.1.2 Management of syncope

A.1.2.1 Discontinue treatment immediately, withdraw the needle-knife promptly, and cover the treatment site with a sterile dressing or adhesive bandage.
A.1.2.2 Place the patient in a supine position with the head slightly lowered, loosen clothing, and keep the patient warm.
A.1.2.3 Instruct the patient to drink warm boiled water immediately and rest quietly.
A.1.2.4 For mild cases, perform acupuncture or finger pressure on acupoints such as Shuigou (GV26), Hegu (LI4), and Neiguan (PC6).
A.1.2.5 For severe cases, administer oxygen or perform artificial respiration, and/or inject 10 mL of 50% glucose injection intravenously.

A.2 Broken needle-knife

A.2.1 Prevention of needle-knife breakage

A.2.1.1 Inspect the needle-knife carefully before operation to ensure it is free from rust and cracks, with satisfactory rigidity and toughness.
A.2.1.2 The patient shall not change position arbitrarily during needle-knife manipulation.
A.2.1.3 Avoid excessive force when inserting the needle-knife into deep tissues or articular structures. Do not forcefully withdraw the needle-knife if it bends inside the body.

A.2.2 Management of broken needle-knife

A.2.2.1 The operator shall remain calm, reassure the patient, and maintain the original position to prevent the broken fragment from sinking deeper into the muscle.
A.2.2.2 If the fragment is exposed outside the skin, remove it with forceps.
A.2.2.3 If the fragment is level with or slightly below the skin surface but still visible, press the adjacent skin with the thumb and index finger to expose the fragment, then remove it with forceps.

A.2.2.4 If the fragment is completely submerged under the skin:

if a hard bone surface is present below the fragment, press firmly on both sides of the needle portal to push the fragment out using the bone as support.

if soft tissue lies below the fragment, grasp the muscle to elevate the fragment outward.

if the broken end is short, deeply embedded, and impalpable, surgical removal shall be performed on-site without unnecessary movement. X-ray localization may be used if necessary.

A.3 Hemorrhage

A.3.1 Prevention of hemorrhage

A.3.1.1 The operator shall master the detailed and three-dimensional anatomy of the treatment site, and clarify the location and surface projection of surrounding blood vessels.

A.3.1.2 Inquire about the patient's condition and medical history in detail before operation, and perform bleeding and clotting time tests.

A.3.1.3 Closely observe the patient's response during therapy. If elastic resistance is encountered or the patient complains of sharp pain, slightly retract the needle-knife, adjust the direction, and reinsert. If the treatment site is on the bone surface, the blade shall not leave the bone during release, and extensive lifting-thrusting is prohibited.

A.3.2 Management of hemorrhage

A.3.2.1 Superficial vascular hemorrhage

Apply pressure with sterile cotton balls to achieve hemostasis.

In areas rich in small blood vessels (hands, feet, head, face, occipital region), routinely press the needle portal for 3–5 minutes after needle-knife release, regardless of visible bleeding.

Minor subcutaneous ecchymosis requires no special treatment and usually resolves spontaneously.

A.3.2.2 Deep hematoma

Small hematomas usually resolve spontaneously within 1–2 weeks without special management.

If local swelling and pain are severe or progressive, apply cold compression or inject etamsylate intramuscularly for hemostasis. After 48 hours, apply hot compression and topical blood-activating and stasis-resolving agents to promote absorption.

Large hematomas may be aspirated under ultrasound guidance with elastic bandage compression.

If aspiration fails or the hematoma enlarges, incision, drainage and hemostasis may be required.

A.3.2.3 Hemorrhage near vital organs

For massive or uncontrollable hemorrhage in the spinal canal, thoracic or abdominal cavity, emergency surgery shall be performed immediately.

A.4 Pneumothorax

A.4.1 Prevention of pneumothorax

A.4.1.1 The operator shall be familiar with the anatomy of the chest and back, and the surface projection of the pulmonary boundary.

A.4.1.2 Before needle-knife manipulation on the chest and back, confirm whether the patient has pulmonary diseases.

A.4.2 Management of pneumothorax

If the patient develops chest discomfort or dyspnea, discontinue the procedure immediately and transfer the patient to the respiratory ward for observation and treatment.

A.5 Infection

If redness, swelling, heat, or pain occurs at the needle portal postoperatively, perform routine blood tests and bacterial culture promptly. Administer appropriate anti-infective therapy after confirming the diagnosis.

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Annex B
(Informative)
Surface localization methods

B.1 Identification of body surface markers

Common body surface markers include:

●Bony landmarks: Bony prominences serving as attachment sites for tendons, ligaments, and other tissues. They are the most frequently used surface markers, characterized by easy identification, clarity, and accuracy, and usually correspond to lesion sites.

●Muscular landmarks: Where bony landmarks are absent, the margins of muscles may be used as body surface markers.

●Texture markers: The distinct and relatively fixed skin lines on the extremities can be used as surface markers for localizing deep lesions.

Venous landmarks: The location of deep tissues can be determined according to the course and position of superficial veins. Since the visibility of superficial veins varies among individuals, differential application is required in surface localization.

●Hairline markers: For needle-knife therapy on the head, treatment points can be determined with reference to the hairline. However, hairline height varies considerably, limiting precise localization.

B.2 Determination of surface projection

Surface markers are used to define the surface projection of deep tissues and to judge the course of blood vessels and nerves, thereby assisting needle-knife positioning.

B.3 Surface point localization

Positive points are identified and marked within the body surface area corresponding to the diseased tissues.

Annex C
(Informative)
Needle-knife grasping methods

C.1 Two-handed needle-knife grasping

C.1.1 Two-handed grasp with needle stabilization

The operator grasps the needle-knife handle with the thumb and index finger of the operating hand, and supports the needle shaft with the middle and ring fingers.
The thumb and index finger of the assisting hand stabilize the needle shaft at a point 1 cm from the cutting edge.

C.1.2 Two-handed grasp without needle stabilization

The operator grasps the needle-knife handle with the thumb and index finger of the operating hand.
The thumb and index finger of the assisting hand grasp the needle shaft at a point 1 cm from the cutting edge.
Note: The assisting hand controls the depth of the initial needle insertion to avoid unnecessary tissue injury.

C.2 One-handed needle-knife grasping

C.2.1 One-handed grasp with needle stabilization

The operator grasps the needle-knife handle with the thumb and index finger of the operating hand, and supports the needle shaft at a point 1 cm from the cutting edge with the middle and ring fingers.

C.2.2 One-handed grasp without needle stabilization

The operator grasps the needle-knife handle with the thumb and index finger of the operating hand.