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Research on Theory, Practice and Integration

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Quality Of Life
OMINEDO

A good motive creates a selfless devotion.

"I just want my customers to feel better, body and soul. Just to see their faces light up with hope and happiness, I'd do anything," remarks Masao Tsuji, President of Ominedo Pharmaceutical Industry Company. He visits various sites where raw herbs and substances for use in their Kampo products are picked. And he believes this is the tradition Ominedo had maintained for over a century now since the company was founded in 1900.

The same philosophy is applied in handling the numerous high-quality formulas created at their labs where highly advanced scientific and pharmacological researches are conducted. The company's state-of-the-art facilities that comply with GMP standards turn out various extracts to be incorporated into their pride products.

"Every merchandise is the by-product of our sincere devotion to delivering a lineup of products that not only work for the customers' body, but also bringing peace of mind as well," Tsuji concludes, "delivering the right product to customers who appreciate our knowledge and devotion is our ultimate goal."

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MISSION

To disseminate peer-reviewed information on the use of acupuncture and herbs, and integration with western medicine, based on research from an international perspective; thereby stimulating further research, application of documented therapeutic measures; and facilitating dialogue among health care practitioners worldwide.

Foreword

Kampo, Acupuncture and Integrative Medicine

Today there are three great systems of traditional medicine in the world. They are Yunani (Greco-Arab), Ayur Veda (Indian) and traditional Chinese medicine (TCM).

TCM, which originated in ancient China, has spread to surrounding countries through the ages, establishing itself as the standard system of medicine in the Chinese cultural sphere. The Acupuncture, moxibustion, and Chinese herbal medicine practiced in Japan are forms of TCM. Since this Japanese system of oriental medicine has the same origin as its counterpart in China, the two systems share many essential features. However, there are also numerous differences between them. Many of these are due to historical differences as well as differences in the ways they have been accepted within their respective healthcare systems. It is the purpose of this journal to present in the English language the most recent conditions of this medical science – possessed as it is of such a unique form – and referring to the work of researchers in other countries, to explore joint-research of the future.

In Japan acupuncture and moxibustion are practiced by acupuncturists. These acupuncturists undergo three or four years of professional training at a college or university. They are then required to pass a national examination to receive their license, after which they may begin their medical practice. In addition to the research conducted at universities and research institutes, there are a lot of interesting studies that come from acupuncturists who operate private practices.

Chinese herbal medicine, on the other hand, is practiced by medical doctors and pharmacists in Japan. Unlike China and Korea, this system of medicine is operated as part of an integrated healthcare system, similar to Europe and the United States – and its methodology can be demonstrated to the rest of the world as a model of integrative medicine. A substantial number of papers have been presented on this topic, many of which include essential elements of Western medicine. This is the reason that this journal is called "Journal of Kampo, Acupuncture and Integrative Medicine" — *Kampo* being the Japanese term for "Chinese herbal medicine". In addition observing the distinguishing aspects of acupuncture, moxibustion, and Chinese herbal medicine as practiced in Japan, readers may also discover the role of TCM in the Japanese healthcare system.

Published quarterly, each issue of this journal will present the latest research on acupuncture and Chinese herbal medicine in Japan. Also published will be three special editions – "Current Kampo Medicine," "Japanese Acupuncture" and "CAM in Japan." In addition to presenting an overall view of their respective themes, these publications will assist people in understanding the connections which have led to integrative medicine.

By providing readers with a better understanding of acupuncture, moxibustion, and Chinese herbal medicine in Japan, it is our hope to contribute to the practice of this system of medicine in other countries.

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Japanese Acupuncture - Current Research

Efficacy of Acupuncture Treatment for Headache

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1. Introduction

Headache is a symptom frequently encountered in daily practice, but many questions regarding the mechanisms of its onset, diagnostics, and therapy still remain unanswered. The classificiation,[1] first published by the International Headache Society in 1988, has been adopted by many clinicians and researchers. However, in 2003, based on recent progress in headache research this classification has been revised by the above mentioned academic society and published as the International Classification of Headache Disorders 2nd Edition (Table 1)[2].

IHS ICHD-II code	WHO ICD-10NA code	Diagnosis
Part one		The primary headache
1	[G43]	Migraine
2	[G44.2]	Tension-type headache (TTH)
3	[G44.0]	Cluster headache and other trigeminal autonomic cephalalgias
4	[G44.80]	Other primary headaches
Part two		The secondary headache
5.	[G44.88]	Headache attributed to head and/or neck trauma
6.	[G44.81]	Headache attributed to cranial or cervical vascular disorder
7.	[G44.82]	Headache attributed to non-vascular intracranial disorder
8.	[G44.4 or G44.83]	Headache attributed to a substance (2) or its withdrawal
9.		Headache attributed to infection
10.	[G44.882]	Headache attributed to disorder of homoeostasis
11.	[G44.84]	Headache or facial pain attributed to disorder of cranium, neck, eyes, ears, nose, sinuses, teeth, mouth or other facial or cranial structures
12	[R51]	Headache attributed to psychiatric disorder
Part three		Cranial neuralgias, central and primary facial pain and other headaches
13	[G44.847, G44.848 or G44.85]	Cranial neuralgias and central causes of facial pain
14	[R51]	Other headache, cranial neuralgia, central or primary facial pain

Table 1: *International Classification of Headache Disorders* 2nd Edition (ICHD-II)

When complaining about headache in Japan, the most frequent form is tension headache, as described in the classification. This can be treated with acupuncture as a characteristic form of oriental therapy, with considerable success. Conversely, the same therapeutic modality is more useful for prevention than treatment of actual migraine or cluster headache (functional) attacks. In this study, we introduce the mechanisms of the onset of tension headache as a form of transient headache and describe the effects of acupuncture therapy and its modes of action. We also describe acupuncture treatment for migraine and cluster headache.

2. Tension headache

a. Acupuncture therapy

The author used plethysmography, EMGs and thermography for an investigation of the mechanism of onset and the modes of action of the acupuncture therapy. The results of the study showed that for the mechanism of onset of headache, excessive tension of the posterior muscle, groups of the head, the posterior neck muscles as well as the suprascapular and interscapular muscle groups are more important than the muscles of the head[3]. Acupuncture therapy is performed in order to facilitate the relaxation of the excessive tension of these muscle groups and normalize the hemodynamics in these muscles.

In the posterior neck region points in the trapezius and semispinalis capitis muscles, Tenchu (BL10), Fuchi (GB20), Kankotsu (GB12) by the mastoid process (insertion of the splenius capitis muscle) the suprascapular region Kensei (GB21) within the upper fibers of the trapezius muscle; Koko (BL43) where various muscle cross each other in the interscapular region; or points in the lateral region of the neck in the splenius muscle or the levator scapulae muscle; or also in the region of the angulus superior scapulae (insertion of the levator scapulae muscle) are selected as treatment sites.

Actual acupuncture stimulation is adjusted to the patient's physical strength, general condition and severity of the symptoms. Basically, electro-acupuncture (1 Hz, 10-20 min) is performed in the regions of the various hypertonic muscles.

In refractory cases, facet joint needling is sometimes performed in the C2-3 intervertebral space (medial branches of the dorsal rami of the spinal nerves).

b. Modes of action of acupuncture therapy[3-5)]

The study also included application of the above mentioned non-invasive EMG examination that provided for repeated examinations and open loop video pupillography. This allowed for quantitative measurement of autonomic nerve function to examine the modes of action of acupuncture. These examinations provided the following results.

(1) Acupuncture therapy causes relaxation of the excessive tension of the muscles groups in the posterior neck, suprascapular and interscapular regions. It also facilitated normalization of the hemodynamics and thereby contributed to an alleviation of the headache (Figure 1).

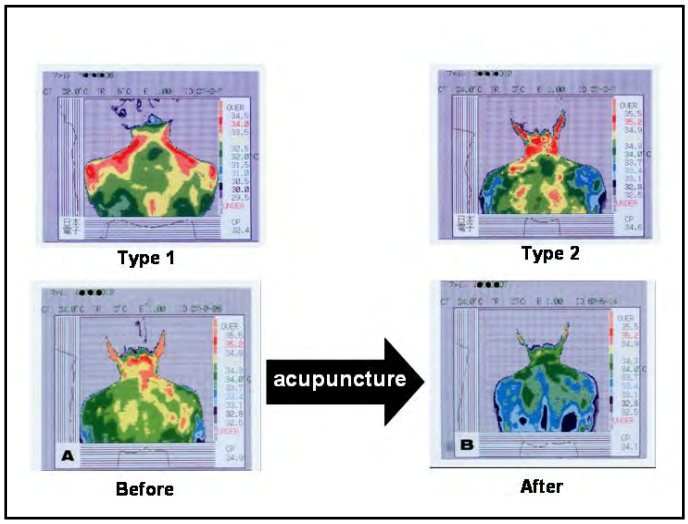


Figure 1: Thermograms of patients with tension headache before and after acupuncture treatment

Upper row: Type 1 covers the posterior area of the neck to the suprascapular region, Type 2 covers the posterior area of the neck to the suprascapular region and refers to areas of elevated temperature; thermograms of patients with tension headache can be grossly divided into two patterns.

Lower row: Improvement of symptoms due to acupuncture treatment is associated with a decrease in skin temperature in the areas of increased temperature, thus approaching the temperature of the surrounding areas.

(2) The modes of action of acupuncture partially differ from that of central acting muscle relaxants.

(3) Acupuncture treatment of the muscle groups in the posterior neck, suprascapular and interscapular regions in patients with tension headache, did not only elicit local reflexes (axon reflexes), but the evidence also indicated the possibility of an influence on higher centers.

(4) The reaction of patients with tension headache to acupuncture treatment (autonomic nervous system) differed from that obtained in healthy persons, suggesting that the acupuncture therapy apparently contributes to an improvement in the homeostasis of the body. (Figure 2a, b)

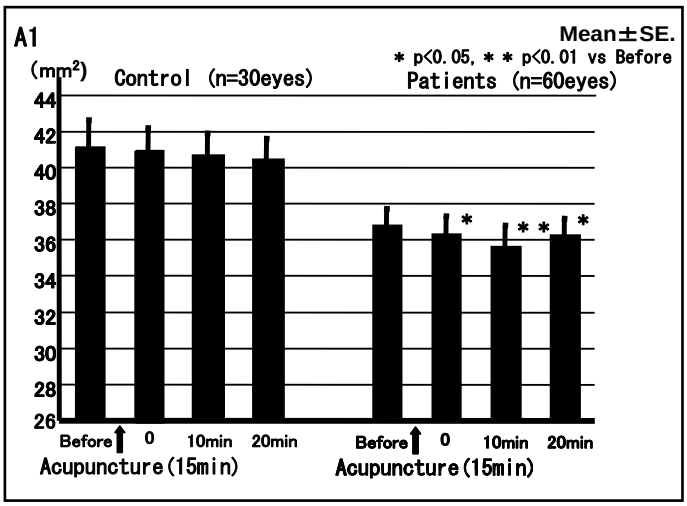
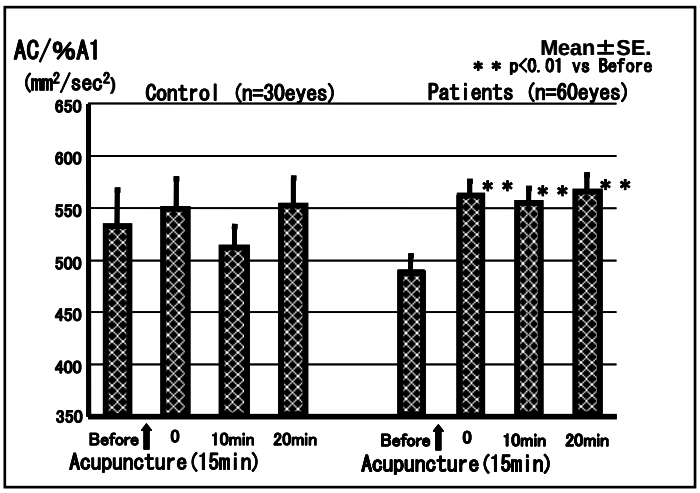


Figure 2: Variations in pupillary reactions in patients with tension headache before and after acupuncture treatment

a) Pupillary area prior to light stimulation (A1)

a: The pupillary area after light stimulation in patients with tension headache decreased immediately, 10 and then 20 minutes after the acupuncture treatment. In healthy persons no significant variations between the conditions before and after the acupuncture treatment were observed.



b) Maximal pupillary contraction velocity (AC)

b: Maximal pupillary contraction velocity following acupuncture treatment of patients with tension headache led to an immediate increase, 10 and then 20 minutes after the acupuncture treatment. In healthy persons no significant variations between the conditions before and after the acupuncture treatment were observed.

c. Effects of acupuncture treatment

Patients with tension headache were referred from departments of neurology etc. to our department for an investigation of the therapeutic effects of acupuncture. The study included 86 patients, 22 men and 64 women with an average age of 53.6±14.9 years. A visual analogue scale (VAS) and pain score (PS) were used as evaluation tools for the therapeutic effects on the patients' subjective symptoms. The improvement of symptoms was calculated in conjunction with the objective findings: improvement of more than 80% more than 60% as effective, more than 40% as slightly effective, less than 40% ineffective and an increase in symptoms as aggravation.

The results showed that in the patient group, 29.1% of the patients also had diseases of the cervical vertebra and related conditions, while 72.1% complained of neck and/or shoulder stiffness. In 17 (19.8%) of these patients acupuncture treatment was markedly effective, in 39 (45.3%) effective, and in 14 (16.3%) slightly effective; so that the overall efficacy was 81.4% (Figure 3). Acupuncture treatment and the improvement in shoulder stiffness showed an extremely high positive correlation (r=0.912; Figure 4) that resulted in some patients requiring a reduction of muscle relaxants or anti-inflammatory drugs.

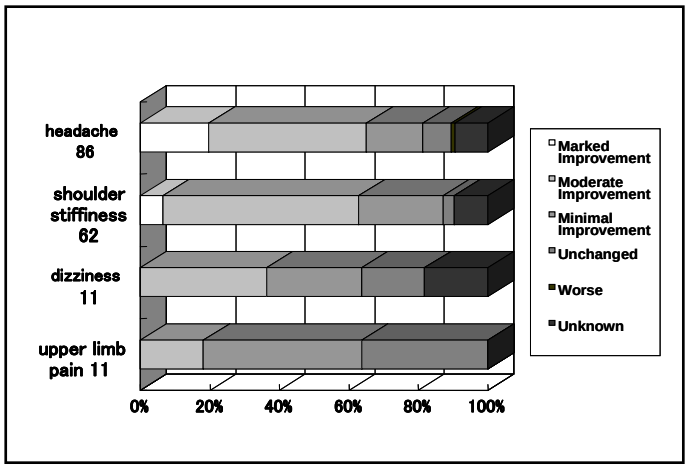


Figure 3: Results of acupuncture treatment of tension headache and associated symptoms

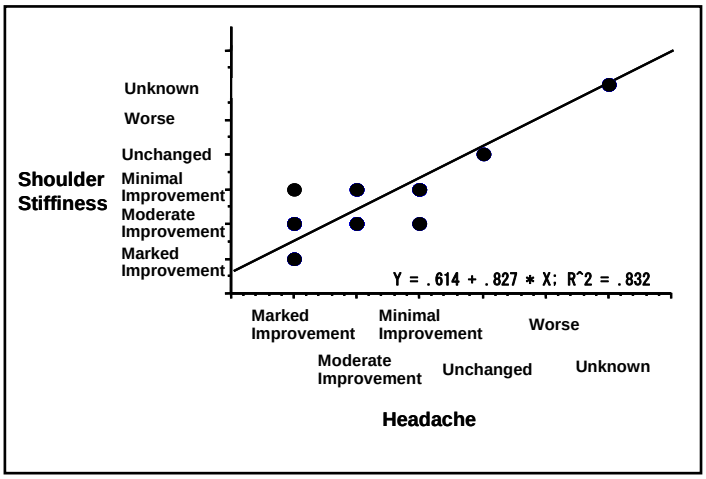


Figure 4: Therapeutic results for tension headache and shoulder stiffness

3. Migraine and cluster headache

Acupuncture treatment for migraine is performed primarily for preventive purposes mainly during remission rather than during actual attacks. During an attack, a combination therapy with triptan medications is desirable. Since the mechanism of the onset of cluster headaches differs from that of migraine, this condition is treated in the classification of the International Headache Society as an independent item; but the acupuncture treatment is, except for the attacks, approximately the same as that for migraine.

a. Acupuncture treatment

For the region in which headache occurs most frequently, namely in the vicinity of the acupoints Ganen, Kenryo, Kenri (GB 4-6) and Zui (St8); as well as for migraine, the vascular mechanism of onset of trigeminal neuralgia is considered to be likely. Therefore, points in the course of that nerve, like the supraorbital incisure or the point Gekan (St7), are selected. Moreover, for the purpose of regulating autonomic nerve functions of the circulatory system, Jingei (needling of the carotid sinus) has been added to the list of needled regions. Application of distant needling described in the classics (use of the brighter yang stomach channel of the leg, greater yang bladder and lesser yang gall bladder channels), choosing points on the legs like Taikei (KI3), Shoyo (LI1), Ichu (BL40), Konron (BL60), Yoryosen (GB34), Kyukyo (GB40), Rinkyu (GB41), and similar points are also very

important. The courses of these channels on the legs closely resemble that of the sciatic nerve, so that stimulation of distant regions presumably acts via the nervous system. Taking stimulation of the temples as the local site of the pain into account during consideration of the mechanisms of onset, suggests that a light stimulation (manual thrusting and lifting (Jakutaku) manipulation of the needles, rotation and electric stimulation of the needles at 30 to 100 Hz) inhibits triggering of attacks and aggravation. Alleviation of complicating complaints or fatigue and improvement of the general condition is also important.

4. Discussion

Recent epidemiologic studies[6] of patients with headache in Japan indicate that 8.4% of the patients suffer from migraine and 22.3% from tension headache, indicating a significantly higher incidence for the latter condition. This high incidence of tension headache makes it a good indication for acupuncture treatment and the condition may be expected to correspond well to this treatment modality.

The author used plethysmography, EMGs and thermography for an investigation of the mechanism of onset and the modes of action of the acupuncture therapy and reported that the muscle groups of the posterior neck region, as well as suprascapular and interscapular muscles, play an important role in the development of headache. These results closely resemble the findings observed during daily clinical practice and indurations or tenderness in the posterior neck and suprascapular muscles. These are frequently encountered. In the *International Classification of Headache Disorders* 2nd Edition as revised in 2004, tender spots are considered of pivotal importance. The effect of acupuncture treatment for these patients showed that wave amplitude and the electric discharge from the muscles approached those of healthy persons, indicating that the acupuncture treatment led to a relaxation of the excessive muscle tension and improvement in hemodynamics. Thermographic examinations in the same patients revealed a skin temperature distribution showing higher temperatures in the posterior region of the neck, as well as the supra and interscapular regions. The acupuncture treatment led to a decrease in temperature, observing an approximation to the surrounding skin temperature (Figure 1) and thus suggests a partially different mode of action from that of central acting muscle relaxants.

For the assessment of the influence of acupuncture treatment on the autonomic nerve function in patients with tension headache, an open loop video pupillography was employed, which permitted non-invasive, repetitive and quantitative measurements of the autonomic nerve function. The results showed that prior to light stimulation the pupillary area was decreased in size and the primary indicators of the parasympathetic nervous function, maximal pupillary contraction velocity, and maximal pupillary contraction acceleration were increased (Figure 2a, b). Yet, no significant changes were observed for the indicator of sympathetic nerve function maximal pupillary dilatation. In healthy people, significant changes were not observed for sympathetic and parasympathetic nerve function. Regarding pupillary innervation, pupillary dilatation is controlled by sympathetic nerves with their centers located in the spinal cord (C8-TH1). Pupillary contraction on the other hand, is controlled by parasympathetic nerves having their center in the Edinger-Westphal nucleus and the surrounding central grey matter. Deduction from these acupuncture treatment induced changes in pupillary reaction in patients with tension headache, suggests an increase in parasympathetic nervous function. These results indicate that acupuncture treatment does not only act on the muscle groups in the posterior region of the neck, supra and interscapular regions (via axon reflexes), but probably also has an influence on higher centers. This influence on higher centers suggests a close relationship to the mechanism of action of acupuncture analgesia.

The results of the investigation by the authors of the influence of acupuncture treatment on cerebral blood flow in patients with cerebrovascular disorders reportedly revealed that the acupuncture therapy led

in a group of patients with markedly decreased cerebral blood flow, to an improvement of the cerebral circulation[7]. Among these results, the above described acupuncture induced variations in pupillary reaction in patients with tension headache. Healthy persons, on the other hand, indicate that acupuncture treatment elicits different reactions depending on the presence or absence of symptoms and their severity. This clearly shows that the treatment contributes to an improvement in homoeostatic regulation.

5. Future prospects

Content of the new *International Classification of Headache Disorders* 2nd Edition published in September 2003 by the International Headache Society, also contained cephalagia[2]. Tension headache is classified into the following 4 types: occasional recurrent, frequently recurrent, chronic, plus a suspect form. For further subdivisions relevant diagnostic criteria have been established. Adopting these criteria for further investigations into the effects of acupuncture based on EBM principles is required. Regarding the mechanisms of onset progress in biochemical investigations of the influences on higher centers, will help to illuminate the pathophysiology and clarify the modes of action of the acupuncture treatment.

Reference

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3) Yamaguchi S, Matsuo H, Omata H, et al.: *Thermography in Patients Receiving Oriental Medical Care*: Biomedical Thermology 8 (1): 185-187, 1988

4) Yamaguchi S: *Influence of Acupuncture Treatment on Pupillary Responses*. Journal of the Japanese Association of Physical Medicine, Balneology and Climatology 58 (4): 232-240, 1995

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Kampo Medicine - Current Research

Efficacy of "Goreisan" for Headache

An epidemiological research study on the relationship between chronic headache and atmospheric depression

Hiromichi Yasui
Japan Institute of TCM Research

"*Goreisan*" has been a popular Kampo prescription in its 1,800 year history. This medicine improves abnormal water metabolism and is often used for this kind of disorder. Source: "Shang han" cold induced disease. This *goreisan* has many applications and is documented in research papers. (Refer to *Reference.) One of the most interesting studies on headache is presented below[1].

1) Haimoto H: Observations pertaining to the correlation between the clinical epidemiology of chronic headache and migratory cyclones (case-control study of patients for whom the treatment with *goreisan* had been effective or ineffective) Φυτο Vol.1 No.3 p4-9, 1998

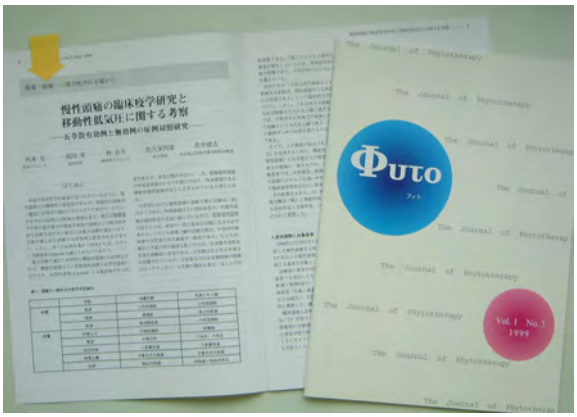

Figure 1: Φυτο Vol.1 No.3 1998

Previous studies and history of the use of "*Goreisan*" for headache

The use of *goreisan* on headaches is not popular in China. The use of this *goreisan* in Japan was developed in recent years and is documented in research and case studies. Its first use began approximately 200 years ago, documented in a thin handwritten notebook by a doctor named Kinzan Murai ("*Goreisan* is Effective on Serious Headache"[2]. Dr. Keisetsu Otsuka (1900-1982) who was one of the first persons to revive Kampo medicine in recent years, found this notebook at a secondhand bookstore. Based on the writing, he applied it for a refractory trigeminal neuralgia, made dramatic progress, and reported the results in technical journals[3].

Dr. Doumei Yakazu, who read this paper, thought that the prescription should be effective for headache, as written in Murai's note, and applied it to patients suffering from headache. Marked effects were obtained when patients with migraine at his clinic were treated with this preparation[4]. Based on these experiences, he later treated other migraine patients with this preparation and achieved very good results[5]. Considering the possibility that this may also be effective for other forms of headache, patients visiting the clinic were subsequently treated with this preparation as the prescription of first choice. Many of these case reports were published in the latter half of the 1950s and in the 1960s in the "Journal of Kampo Medicine".

Based on the results he found, he engaged in further research. From careful and detailed physical examination, he attempted to specify the types of headache for which the prescription would be effective. However, even he, who studied for several decades, could not identify definitive patterns in its use. His reports inspired other doctors to conduct research, and as a result many excellent papers were written, but none were able to definitively resolve the conditions for which it would be effective. The resolution of this problem had to wait until the revolutionary discovery by Dr. Haimoto almost 40 years after the publication of Yakazu.

The direction of smoke from a chimney pipe inspired his research

Figure 2 and 3 depict scenery from Dr. Haimoto's upstairs window. This shows the chimney of a paper mill (as seen in the left picture, from right to left) from which he deduced, that when the wind blows from west to east, it will not rain that day. On the contrary, it rains when the wind is from the east. This phenomenon is known by many women that live near this place who judge by the direction of the smoke whether they can do their laundry that day. The discussion of this phenomenon will become apparent as the discussion of headache and atmospheric pressure unfolds below.

The Paper Mill, Its Chimney, and the Flow of the Smoke

Figure 2

Figure 3

In his everyday attendance, Dr. Haimoto noticed that on days when the smoke flows from east to west, headache patients increased, and also that much of the headache can be lightened by taking *goreisan*. Therefore, he hypothesized that headaches caused by gradually lowering air pressure can be lightened by taking *goreisan*. In order to establish this hypothesis, he started research with his fellow doctors. The first step was to have the patients keep a record on the headache calendar (Table 1). It can be confirmed that the patients realized headache before the weather changes for the worse.

	SUN	MON	TUE	WED	THU	FRI	SAT
DATE	29 NOV.	30 NOV.	1 DEC.	2 DEC.	3 DEC.	4 DEC.	5 DEC.
HEADACHE	○		○	○	? ?	○	
WEATHER	FINE	CLOUDY ↓ FINE	FINE	FINE ↓ RAIN	RAIN ↓ CLOUDY	CLOUDY	RAIN

Table 1: Headache Calendar

Subject of the investigation

This study investigated patients with chronic headache as their chief complaint who visited four related medical facilities between October 10, 1988 and August 15, 1999. Among these patients, those complaining of headaches that lasted more than three months and occurred with a frequency of more than once per week served as the subjects for this study.

A consent was obtained from the patients prior to treatment. Eighty-six items pertaining to daily life and thier symptoms, 26 items pertaining to physical findings as well as other items; a total of 140 items, were examined.

The 56 patients examined in the study included 14 men and 42 women. Useable data concerning the effects was possible in a total of 42 patients, 9 men and 33 women. They were treated with *goreisan* for a period varying between 2 and 4 weeks.

A breakdown of the diseases observed included 42 patients with tension headache, 1 patient with mixed headache and 13 patients without specification (cases in which a western medical diagnosis was difficult). Coexistent diseases were observed in 40 patients (including 18 patients with neuroses, 7 with depressive moods, 9 with psychosomatic diseases, 3 with autonomic dysregulation and 3 with insomnia). Thirteen patients had cardiovascular diseases (including 11 patients with hypertension and 1 patient

with angina pectoris). Other symptoms were detected: 5 patients with dizziness, 4 patients with metabolic disorders (including 2 diabetics and 2 patients with hyperlipemia), 3 patients with skin diseases (2 patients with atopic dermatitis), 2 patients with musculoskeletal diseases, 1 patient with a gynecologic disease, and 1 patient with a hematologic disease.

Research methods and results

The physicians participating in this study instructed patients who were diagnosed with chronic headache to keep a headache calendar including frequency of their headache and observe changes in the correlation between the weather and headache as well as treatment with *goreisan*. These patients were treated with 5.0 g - 7.5 g/day of *goreisan* extract and the effects evaluated after a period ranging from 2 to 4 weeks. An almost complete alleviation of the headache was defined as "markedly effective", a reduction in the frequency of the headaches to less than half of its pretreatment incidence as "effective" and failure to fall below half of the pre-treatment incidence as "ineffective".

These results were then subjected to a statistical analysis (multivariate analysis) in order to deduce the relevant conclusions.

The following results were obtained:

Examination of the factors with a significant correlation to the effectiveness of *goreisan* for the treatment of chronic headache showed that among the 42 patients treated with this powder, the results were evaluated as "effective" in 21 patients (50.0%). Next the patients were divided into a group effectively treated with this powder and an ineffective group. The results for which a statistical analysis of the correlation between the various factors and efficacy showed a significant odds ratio are listed in Table 2.

The strongest positive correlation with the effectiveness of *goreisan* was found for "Symptoms become worse on the day before it starts raining". Here an odds ratio of 16.3 and a risk of 0.25% were statistically significant. In other words, this powder is 16 times more likely to be effective in patients who stated that "Symptoms become worse on the day before it starts raining" than in patients responding "they do not". The *Goreisan* was effective in 19 (90.5%) out of the 21 patients in whom symptoms actually exacerbated on the day before it started raining.

Item	*Goreisan* effective	*Goreisan* ineffective	p	Odds ratio
Symptoms become worse on the day before it starts raining (YES/NO)	(19/2)	(2/19)	0.0025	16.3
Easily catch cold (YES/NO)	(7/14)	(14/7)	0.045	0.26
Hands are cold (YES/NO)	(7/14)	(14/7)	0.035	0.24
Palpitation (YES/NO)	(4/17)	(10/11)	0.039	0.22
Feet are cold (YES/NO)	(13/8)	(18/3)	0.0064	0.22
Strengh of the pulse (weak/normal)	(3/15)	(15/6)	0.054	0.20
Shortness of breath (YES/NO)	(2/19)	(7/14)	0.053	0.17
Dizziness (YES/NO)	(8/13)	(15/6)	0.017	0.16
Chest dyscomfort (YES/NO)	(1/20)	(6/15)	0.073	0.13
Menstrual blood loss (profuse＋scant/intermediate)	(1/11)	(4/5)	0.083	0.12
Color of tounge fur (yellow＋dark yellow＋burnt＋gray＋black＋gree＋other/white)	(1/20)	(6/15)	0.054	0.11
Orthostatic syncope (YES/NO)	(7/14)	(17/4)	0.0031	0.10
Strong anxiety (YES/NO)	(9/12)	(18/3)	0.0055	0.093
Thumb-sized blood clots in the menstrual blood (YES/NO)	(4/8)	(8/1)	0.024	0.052

Table 2: Results and Odds Ratio

This indicated that *goreisan* is effective in patients in whom headaches develop on the day before it starts raining, much higher than in people in whom this is not the case. Regarding the correlation with the weather, the results showed clearly that the administration of *goreisan* for headaches developing when atomospheric pressure drops gradually, is effective in more than 90% of the cases.

The effectiveness of *goreisan* for patients in whom the headaches exacerbate on days preceding rain is conspicuous from this table, but examination items reveal other interesting results. Also, apart from whether *goreisan* is effective or not, examination of the signs with significant correlations to headaches on days before it starts to rain, clearly showed, for example, that the consumption of coffee or raw vegetables reduced the likelihood of the development of headaches on days before rain. This study included many other fascinating data. The reader is encouraged to review the original literature.

Haimoto et al. have deduced the following conclusions from this study.

1) *Goreisan* has a probability of 90% to be effective for headaches which occur with a frequency of 1-2 times per week with an onset days before it starts raining. It is not effective for headaches that occur daily.
2) Factors that decrease the likelihood of *goreisan* being effective include orthostatic syncopes, strong anxiety, dizziness (occurring daily), cold feet, cold hands and palpitations. These symptoms suggest a correlation to psychosomatic headache.

Reflections on the results

This study showed that *goreisan* is effective for some forms of headache triggered on days preceding rain with comparatively sudden drops in atomospheric pressure. Haimoto interpreted this with a correlation with migratory cyclones. Japan's climate has four distinct seasons and migratory cyclones are likely to pass over Japan in spring and autumn. Headache forms that are indications for *goreisan* are also likely to occur during these seasons. According to observations made by researchers, a drop in atmospheric pressure from 1013 hPa to 1000-995 hPa triggers the onset of these headaches.

At this point, the headaches in question are mostly tension headaches and not pulsating headaches (migraine). Occasionally mixed headache forms are observed. Yet, as Haimoto et al. have pointed out, *goreisan* is not only effective for headaches triggered by a drop in atmospheric pressure. It may also be effective for other forms of headache as well. For example, among the case reports published by many researchers like Yakazu, and other several have also described migraine, headaches, indicating they are suitable for the effects of this preparation.

Another factor needs to be taken into consideration. *Goreisan* is not the only preparation effective for headaches triggered by a drop in atmospheric pressure. Our experiences have clearly shown that *ryokeijutsukanto* or *hangebyakujutsutemmato* may under certain circumstances be effective.

In the former case, from a point of view of Traditional Chinese Medicine (TCM), an anomaly in water metabolism has been considered responsible, so that the three crude drugs also found in *goreisan*, namely *Cinnamomi* Cortex, *Porea* and *Atractylodis* Rhizoma probably play an important role. In the latter case, based on TCM etiologic concepts, phlegm is considered the relevant causative factor. These results suggest that similar headaches may not only be triggered by stagnant water and moisture, but also by phlegm.

Thus, there is not only one preparation for the treatment of headaches induced by a drop in atmospheric pressure, although there are as yet no clear indications as to which of the above described prescriptions should be used. Nevertheless, the research of Haimoto et al. is relevant, because it indicates efficacy of the treatment with *goreisan* in these cases.

Possible future applications

This report suggests the possibility of using *goreisan* for the treatment of various diseases triggered by changes in atmospheric pressure, in particular, drops in atmospheric pressure.

For example, headache, diarrhea or similar physical changes developing when mountaineering people reach an altitude of about 1,000-m above ground level in a comparatively short time; the obstruction of the auditory tube and ear pain due to edema developing in passengers of ascending planes after take-off; Caisson disease developing in divers or surfacing submariners, and similar conditions, may in some cases, be considered indications for *goreisan*.

Currently, some physicians who learned of this research, install a barometer in their consultation rooms in order to establish the diagnosis. Under certain circumstances they wear wrist watches with a barometer and constantly pay attention to changes in atmospheric pressure.

*Reference

Composition, dosage and indication of *goreisan* in Japan today.

Composition	Indications
Alismatis Tuber 5.0-6.0g	1. Headache, Migraine
Poria 3.0-4.5g	2. Acute gastroenteritis
Atractylodis Rhizoma 3.0-4.5g	3. Chronic subdural hematoma
Polyporus 3.0-4.5g	4. Cerebral edema
Cinnamomi Cortex 2.0-3.0g	5. Acute stage of cerebral infarction
	6. Edema generally
	7. Hydrocelle testis
	8. Ear pain during airplane flight

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Clinical Report 1 (Japan)

Acupuncture for Overactive Bladder

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Introduction

Lower urinary tract symptoms (LUTS), including increased urinary frequency, urgency, urinary incontinence, urinary weak stream, interruption and residual feeling after micturition, are common problems in elderly people[1)]. Our previous study showed that acupuncture relieved urinary incontinence, increased urinary frequency, urgency and nocturnal enuresis[2-4)].

In 2002, the International Continence Society (ICS) identified "overactive bladder" (OAB) as a symptom syndrome defined as urgenct, with or without urge incontinence, and usually with frequency and nocturia[5)].

This report presents a successful clinical case study of an individual with overactive bladder treated by acupuncture using the current definition of the symptoms associated with OAB.

Case Report

This case study is based on an 81 year-old man who underwent acupuncture treatment for refractory symptoms of increased urinary frequency (voiding 8 or more times), nocturia (awakening 3 or more times at night to void), urgency and urge incontinence due to benign prostate hyperplasia. He had previously failed alpha-1 blocker and underwent acupuncture treatment.

Acupuncture was performed using a disposable stainless steel needle (0.3mm in diameter, 60mm in length, SEIRIN Kasei, Shimizu, Japan) with the patient in the prone position. Acupuncture needles were inserted into the bilateral Zhongliao points (BL-33, as standardized by the World Health Organization), on the skin of the third posterior sacral foramina in the cranial direction (Fig. 1). The needle was inserted into each side of the foramina sufficiently deep for its tip to be placed close to the sacral periosteum (50 to 60 mm), and then the bilateral needles were maneuvered up and down manually for 10 minutes. The treatment was repeated once a week. To assess the symptoms before and after acupuncture, the International Prostate Symptom Score (IPSS) and IPSS quality of life index (IPSS QOL index) were used. The IPSS questionnaire is used by the American Urological Association symptom index[6)]. The score of each symptom of the IPSS, including 4 voiding symptoms (incomplete emptying, intermittency, weak stream and hesitancy) and 3 storage symptoms (frequency, urgency and nocturia), ranged from 0 to 5 points. A total IPSS score was obtained by summing up each score (0 to 35) and categorized into 3 groups of the severity as mild (0 to 7), moderate (8 to 19) or severe (20 to 35). Assessment of quality of life (QOL) by urinary symptoms was ranged from 0 (delighted) to 6 (terrible). Additionally, urinary frequency and voided volume were estimated from a frequency volume chart (FVC).

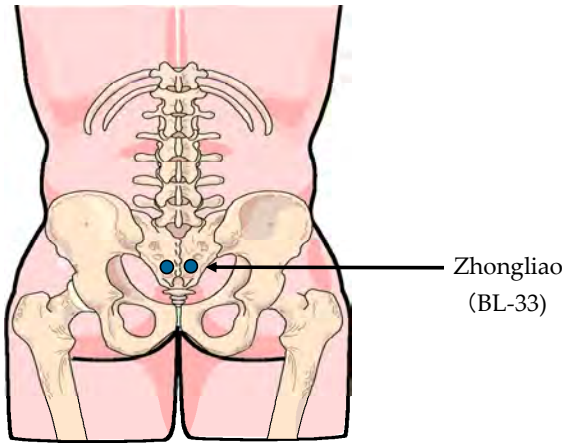

Fig. 1: Schematic diagram showing acupuncture points in bilateral Zhongliao (BL-33)

Baseline FVC showed a maximum voided volume of 120 ml with postponing micturition as long as possible. Additionally, assessment of quality of life where urinary symptoms were terrible, were assessed by the self-administered questionnaire using International Prostate Symptom Score quality of life index (IPSS QOL index) before acupuncture. After the 4th treatment a maximum voided volume was 200 ml with tolerable to postpone voiding written in FVC, however, assessment of QOL was unchanged. After the 8th treatment a maximum voided volume was 330 ml and assessment of QOL was satisfied. Urgency and urge incontinence disappeared after the 8th acupuncture treatment (see Table 1).

	Before acupuncture	After 4th acupuncture	After 8th acupuncture
daytime frequency	8	8	6
nocturia	3	3	1
maximum voided volume (ml)	120	200	330
IPSS	17 (moderate)	16 (moderate)	5 (mild)
QOL index	6 (severe)	6 (severe)	1 (satisfied)

Table 1: IPSS: International Prostate Symptom Score, QOL index: quality of life index

Comment

Overactive bladder (OAB) is a symptom complex that includes urinary urgency with or without urge; incontinence, urinary frequency and nocturia, identified by the International Continence Society (ICS) in 2002 (Fig 2) [5]. OAB is an empiric diagnosis used as the basis for initial management after assessing lower urinary tract symptoms (LUTS), physical findings, urinalysis, and the other indicated evaluations. In addition, OAB is defined based on

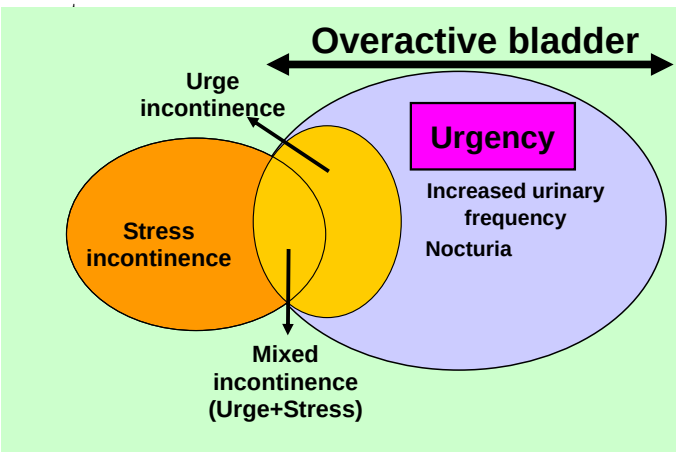

Fig. 2 Symptomatology of overactive bladder

OAB is highly prevalent worldwide. In the U.S., a study showed that the prevalence of OAB was 16.0% in men and 16.9% in women aged 18 years or older[7]. Therefore, OAB might affect 34 million individuals in the U.S. In Europe and Scandinavia, a study showed virtually the same prevalence of OAB (16.6%) in individuals, men and women aged 40 years or older, selected from the general population in France, Germany, Italy, Spain, Sweden and the United Kingdom[8]. In Japan, the prevalence was 12.4% in men and women aged 40 years or older[9]. The total cost of OAB is estimated to be $12.6 billion (year 2000 dollars) in the U.S. Still, the vast majority of OAB sufferers remain untreated.

In our previous study, it was shown that acupuncture might be beneficial in the treatment of OAB[2-3]. We applied acupuncture to Zhongliao points on the skin of the third posterior sacral foramina as in this study with 11 patients with urge incontinence or urgency and found an improvement of the symptoms in 9 (82%)[2]. The treatment induced increase in both maximum cystometric bladder capacity and bladder compliance, with statistical significance. It is therefore conceivable that acupuncture stimulation might increase bladder capacity by inhibiting bladder contraction or urinary sensation. Additionally, acupuncture has been reported to inhibit detrusor hyperreflexia in 13 patients with spinal cord injury[3]. In the study, incontinence disappeared in 2 (15%) and decreased to 50% or less incontinence volume as compared to the baseline in 6 (46%), resulting in satisfactory therapeutic effects obtained in 8 (62%). These results indicate the possible mechanism of neurological (such as spinal segmental) inhibition through which bladder contraction might be suppressed by acupuncture. In this report the patient had suffered from urgency, urge incontinence, increased urinary frequency and nocturia. Because the symptoms might be in accord with OAB, acupuncture was performed for relieving the symptoms. The urgency and urge incontinence were relived after acupuncture.

To ask the patient to record micturitions and symptoms for a period of days provided individual information. Frequency volume chart (FVC) was used for the record of the volumes voided as well as the time of each micturition, day and night, for at least 24 hours (Fig 3). The following measurements could be abstracted from FVC: daytime frequency, nocturia, 24-hour frequency, 24-hour urine production, polyuria, nocturnal urine volume, nocturnal polyuria and maximum voided volume. In particular, daytime frequency, nocturia and maximum voided volume are intimately concerned with OAB. Daytime frequency is

the number of voids recorded during waking hours and includes the last void before sleep and the first void after waking and rising in the morning. Nocturia is the number of voids recorded during a night's sleep: each void is preceded and followed by sleep. Maximum voided volume is the largest volume of urine voided during single micturition and is determined either from FVC. FVC has the advantage that the maximum voided volume is obtained without invasive procedures. In this report the maximum voided volume of the patient increased from 120 ml baseline to 330 ml after 8th acupuncture. This result supports our previous study concerning with acupuncture for urge incontinence or urgency.

time	examples	/ (Month/Day)	/ (Month/Day)	/ (Month/Day)
0:00				
1:00	150 ml			
2:00				
3:00				
4:00	100 ml			
5:00				
6:00	Waking up			
7:00	100 ml			
8:00				
9:00	150 ml			
10:00				
11:00	170 ml			
12:00				
13:00	150 ml			
14:00				
15:00				
16:00	200 ml			
17:00				
18:00	130 ml			
19:00				
20:00	140 ml			
21:00				
22:00	120 ml			
23:00	Going to bed			
Total	1410 ml	ml	ml	ml

Fig. 3 Example of frequency volume chart

Conclusion

Acupuncture could be an alternative to conventional therapies for OAB.

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Introduction of University

Meiji University of Oriental Medicine, located in the central part of Kyoto Japan, was founded in 1978 as Meiji Junior College of Oriental Medicine as a part of Meiji Institute of Oriental Medicine. The origin of the institute dates back to 1925 as the Yamazaki School of Oriental Medicine in Osaka, which developed into Meiji School of Oriental Medicine, another part of Meiji Institute of Oriental Medicine.

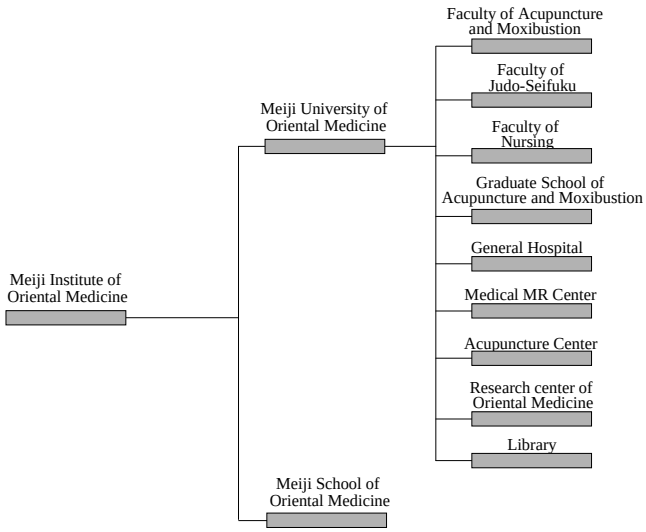
Meiji Junior College of Oriental Medicine had been accredited by Educational Ministry as the first four-year college of oriental medicine in Japan by adding a Western medical hospital in 1983. The course for doctor of science in acupuncture and moxibustion, accredited in 1994, is the one that the school can boast to the world. In 2002, the school added a course for Judo-Seifuku therapist, Japanese traditional bone fixing technique, changing the name 'College' to 'University'. A four-year course for Judo-Seifuku (2004) and the nursing (2006) was added. The school currently consists of a four-year course for acupuncture and moxibustion, a four-year course of Judo-Seifuku, a four-year course of nursing, has a clinic of oriental medicine and a western medical hospital (see diagram below). The school has also been providing postgraduate training course in the western medical hospital for over 18 years.

The mission of Meiji University of Oriental Medicine is to train therapists who are qualified to provide traditional oriental medical treatment which is supported with western medical knowledge, to provide highly qualified integrative care of western and traditional oriental medicine, and to investigate the mechanism of the effect of acupuncture and moxibustion and Judo-Seifuku therapy. The school has produced over 2,700 graduates, including 111 masters, 47 doctors of acupuncture and moxibustion for over the past 28 years, who are widely accepted as highly qualified leaders in the field in Japan.

The Western medical hospital, equipped with high quality technology including one of the most powerful MRI instruments in the world, has an outstanding medical staff of Internal Medicine, Surgery, Orthopedics, Urology, Neurosurgery, Anesthesiology, Dentistry, Otolaryngology, Ophthalmology and Gynecology to provide high quality integrative care and education. It has a primary goal, to accumulate scientific evidence on the value of traditional oriental medicine by collaborating with the professional traditional therapists.

Basic research to investigate the mechanism of traditional therapies are also made possible by collaboration with departments of Physiology, Anatomy, Immunology, Chemistry, Biology and Physics. The results are reflected in curricular decisions to ensure the program reflects the latest in medical theory and practice.

Meiji University of Oriental Medicine, Kyoto Japan



Organization of Meiji Institute of Oriental Medicine

Clinical Report 2 (Japan)

Astragali Radix Provides a Decline in Serum Creatinine in Chronic Renal Failure

Hajime Haimoto

Case: 63 years, male employee

Diagnosis: #1: hypertension, #2: chronic glomerular nephritis, #3: chronic renal failure, #4: gout

Past history: regular health checks have shown proteinuria and positive tests for occult urinary blood since the patient was in his 20s.

Present illness: At the age of 40 hypertension, gout and chronic glomerular nephritis was pointed out during a regular health check and the patient was treated for hypertension.

In May 1998, at the age of 56, the patient consulted the clinic for the first time, requesting treatment for hypertension and gout. Height was 163 cm, weight 56.8 kg, blood pressure 145/93 (already under treatment with hypotensives), pulse rate 67 bpm (no arrhythmia).

Findings obtained during the first examination included Cr 1.7 mg/dl, BUN 25.8 mg/dl, total protein 7.2 g/dl, albumin 4.2 g/dl, total cholesterol 184 mg/dl, uric acid 10.0 mg/dl, Na 144 mEq/l, K 4.7 mEq/l, Cl 105 mEq/l, antinuclear antibodies (-), serum component titer and IgA levels were within the normal range. Urinary protein (++), occult blood (++). Proteinuria was 0.80 g ～ 1.56 g/day, 24-hour CCr 57.3 ml/min, ultrasound scans showed no postrenal lesions of the bladder or prostate. Electrocardiogram and chest x-ray were normal as well.

From the first consultation, calcium antagonists, β-blockers, ACE inhibitor, ARB antagonists and similar hypotensives as well as 100 mg of Zyloric (allupurinol) for the hyperuricacidemia were prescribed. This treatment controlled blood pressure at a level of 120～135/75～90 mmHg and uric acid at 8.2 mg/dl.

Yet, Cr increased gradually, so that the levels of Cr 2.0 and K 5.1 measured in October 2002 reached by February 1, 2004 values of 2.2 and 6.3 for Cr and K respectively. At this time, treatment was initiated with *Astragali* Radix.

Kampo examination: no fatigue, restlessness or insomnia, good appetite, becomes sleepy after meals, does not sweat, no dry mouth, neither overly sensitive to heat nor cold, no particular thoracic or abdominal symptoms, bowel movements: 2/day, micturition: 7/day and 3/night

Kampo medical physical findings:

Pulse: full, wiry, pulse rate 90 bpm.

Tongue: pale-red, dark, thick, moderate dental indentations, no patchy blood stasis, superficially moist, thin white fur

Abdomen: upper abdominal region generally hard, strong resistance in the hypochondrial and epigastric regions, no tenderness, no fluid accumulation in the stomach, tense rectus abdominis muscles.

Course:

Initiation of treatment with 30 g of *Astragali* Radix (alone) on February 1, 2003 (combined otherwise with 5 mg of Norvasc, 8 mg of Blopress and 100 mg of Zyloric).

March 10 of the same year: Cr 1.7 mg/dl, K 5.6 mEq/l, addition of 10 g of *Ziziphi* Fructus, in order to make the drug more palatable.

April 7 of the same year: Cr 1.6 mg/dl, K 5.6 mEq/l.

May 5 of the same year: Cr 1.6, K 5.4 mEq/l.

September 26 of the same year: Cr 1.7 mg/dl.

December 27 of the same year: Cr 1.5 mg/dl, K 6.8 mEq/l; because of an increase in the K concentration due to excessive intake of fruits the patient was instructed in how to maintain a low potassium diet.

February 2004: Cr 1.29 mg/dl, K 4.8 mEq/l.

August of the same year: Cr 1.40 mg/dl, K 6.1 mEq/l, repeated nutritional counseling due to another rise in potassium concentration.

October of the same year: Cr 1.57 mg/dl, K 5.2 mEq/l

Until June 2005 the Cr control was good, but from June 30 to July 21st the patient discontinued his medication over the period of a stay in Germany.

July 25 of the same year: an rise to Cr 2.78 mg/dl and K 6.3 mEq/l was observed immediately after the patient's return to Japan. The *Astragali* Radix dose after the 25th of that month was increased to 30 g and treatment with *Glycyrrhizae* Radix initiated. The shift from Taiso to Kanzo was made in order to decrease serum potassium concentration.

August 20 of the same year: concentration decreased to Cr 1.76 and K 4.1 mEq/l

Currently, September of the same year: combination of 30 g of Ogi and 10 g of Kanzo with the hypotensive Olmetec 10 mg, CR 20 mg of Adalat and 100 mg of Zyloric.

Conclusion

We reported previously about a Cr lowering effect in chronic renal failure J. Phyto (Vol.7 No.1). The summary of this report is that Ogi was observed to cause in 8 out of 9 patients during the early stage of chronic renal failure a fall in creatinine ($1.6 \leqq Cr < 3.0$) by an average of 21%, while in 2 patients with uremia a decrease of 8.1→6.9 and 5.9→1.6 respectively was observed. From that time to the present day we treated a total of 13 patients during the early stage of chronic renal failure with Ogi. Excluding two patients in whom the treatment was discontinued because of side effects, like eruptions, in all 11 patients a continuous Cr lowering effect was observed. Presently, the effect of the orally applied medication continues. In some patients, long-term control over a maximum duration of 2.5 years is permitted.

When the treatment with Ogi was for some reason discontinued in this kind of patient, Cr increased, but following a restart of the treatment with Ogi the creatinine fell again in 2 of the cases. In one patient, the Cr level fell after only one month by 2.78→1.76 (35%) and in the other, over a period of 3 months by Cr 1.88→1.43 (24%).

The creatinine clearance was observed in regular intervals in some of the above described 13 patients and showed an increase in 24-hour creatinine clearance occurring simultaneously with the fall in Cr level, suggesting that Ogi probably acts directly on glomerular function. Also, these cases showed that there seems to be no potassium depleting effect, so that diet appeared to have been more effective than Ogi. However, potassium depletion is generally known to be a side effect of licorice, suggesting that combination treatment with licorice might help in patients with chronic renal failure to achieve a decrease in potassium level.

Reduction of Cr levels in patients with chronic renal failure and thus the possibility to avoid or delay the necessity for dialysis had been the most important task and the discovery of relevant effects of a treatment of with Ogi alone. In the future, this should lead to new developments in this field.

Clinical Report 3 (Japan)

Maoto Demonstrated as Highly Effective for the Treatment of Influenza (B)

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Introduction

Recently avian influenza has received a good deal of attention in the media. Currently, secondary infection among people does not seem to occur. If such a pathogenecity would be acquired, the disease would be associated with considerable mortality because the human race does not have antibodies to use against it.

In western medicine the drug Oseltamivir (brand name: Tamiflu) seems to be highly effective, so that stockpiling of the drug by the individual nations has been recommended. Yet, it must be noted that upon indiscriminate administration, side effects cannot be disregarded. Moreover, in order for the drug to be effective, it needs to be administered within 48 hours after onset and its administration has to be continued over a period of 5 days[2].

The author has 20 years of experience having treated over 1,000 patients with influenza. This has been done solely with Kampo medicine in his clinic which specializes in Kampo treatment. In January last year, the author had a chance to use Oseltamivir, providing the opportunity to compare it with Kampo preparations. His experience is presented below.

One patient with influenza who was successfully treated with Kampo is presented below.

Patient: age 32, male, employed.
Chief complaint: chills, fever, generalized arthralgia.
Family history, past history: n.p.
Description of occurrence of illness:

On January 1, 2005 the patients went to work at 9:00am, but suddenly felt chills over his back. This was followed by shaking of the entire body which the patient could not stop intentionally (shaking chills). After a short period, he started to feel feverish, developed a headache and joints and muscles throughout the body started aching. At the same time he felt drained of energy. The patient visited our clinic at 5:00pm of that same day.

Initial Observation

Inspection: pale face and appeared generally exhausted
Listening: voice was rather loud.
Reasoning: clear
History: Loss of appetite, bowel movements and micturition remained normal. Influenza seemed to be prevalent in his environment with many people being absent from work. He claimed to have a lot of work to do and thus needed to recover as quickly as possible.
Palpation (physical findings):

Physical build and nutritional status were good. Examination of the pulse showed a rate of 100/min, regular floating, tense, fast. Blood pressure was 120/78 mmHg. The throat was slightly inflammed. Auscultation of the heart and lungs did not reveal any anomalies. Abdominal examination showed intermediate abdominal tension and mild tenderness in the right hypochondrial region (these abdominal findings would be designated "fullness, tenderness or discomfort of the hypochondrium). Body temperature was 38.3°C. There was no perspiration.

Diagnosis

Western medical: quick diagnostic kit identifies type B influenza.
Kampo medical: according to the "Shang Han Lun" the condition is considered to be a cold injury excess disorder of the greater yang type.

Prescribed Course

Maoto made by Tsumura (a 7.5-g portion of the drug contains the following amount of dried crude drug extract 1.75 g (Ephedra 5.0 g, Apricot Seed 5.0 g, Cassia Bark 4.0 g and Licorice Root 1.5 g) was given in packages of 2.5 g each taken with warm water at intervals of 4 hours. The patient was instructed to cover the body until the body warmed and he started perspiring. The patient called, reporting that after taking three packages, the body temperature conversely had risen above 39°C, but he was still not perspiring. Therefore I instructed the patient to continue the medication.

On the next morning, the patient called again, reporting that 30 minutes after taking another package he started to sweat profusely over the entire body, which in turn caused a fall in his temperature and the alleviation of the joint and muscle aches. At the time he was calling, he said he was feeling refreshed. After that I instructed the patient to discontinue the medication and take a day off to rest quietly. Four days after the initial onset, he returned to work without any recurrences.

Discussion

This patient followed a typical course of patients treated during the early phase of influenza with *maoto*. The author has treated over 1,000 patients with influenza, and found that during the initial phase 90% of the patients recovered within 2-3 days following treatment with *maoto* after perspiration and defervescence. When the fever continued, even after the administration of 9 packages without perspiration, and in the presence of feverish restlessness or dry mouth, switching to the preparation *daiseiryuto* usually resulted in the onset of perspiration, defervescence and recovery within 24 hours.

In case of influenza, patients usually can tell rather precisely on "what day and at what hour" the sudden onset of chills, fever, arthralgia, general malaise, loss of appetite or the development of cough occurred approximately 1 or 2 days after the infection. This condition had in the latter half of the second century AD been described in the "Shang Han Lun" edited by Zhang Zhong Jing of the later Han period in China. In the chapter on greater yang diseases it states: "During greater yang disease, fever develops, or if it has not yet developed chills set in, the body starts aching, there will be vomiting and both yin and yang pulses will be tense." The description in this text coincides with the "Shang Han" (Shokan) pathology.

For this Shokan condition the text states *maoto* governs the greater yang condition characterized by headache, fever, body pain, low back pain, pain in the bones and joints, chills and a lack of perspiration[3]. Thus, following the instructions in the text, and taking *maoto* warm, the drug results in perspiration and defervescence and is characterized in that it simultaneously improves all the other symptoms, eventually leading to a complete cure without any complications or sequelae. Yet, *maoto* is only effective for the early phase of influenza. This means the condition described in the "Shang Han Lun" as the greater yang disease phase when it is used for the aforementioned symptoms. This resembles the provision that Oseltamivir should be administered within 48 hours after onset.

As described above, Oseltamivir should be administered within 48 hours after onset and then continued over a period of 5 days[2]. Definitely the author achieved defervescence in all 10 patients who were treated within 48 hours after onset, but in 2 out of 5 patients who discontinued the medication after 3 days a recurrence of fever and cough was observed 2-3 days later. The condition here had to be viewed in Kampo medical terms as a lesser yang condition that then required treatment with *shosaikoto*.

When *maoto* is administered for its indicated symptoms, defervescence can be achieved in most patients within a period of 24 to 48 hours. When perspiration is not observed within a period of 48 hours and the patient develops signs of (feverish) restlessness, the author prescribed *daiseiryuto*. Application of both these preparations led in almost 100% of the patients the onset of perspiration and defervescence within 72 hours. Subsequently, the course was favorable and without recurrences.

Considering financial aspects shows that 2 capsules of Oseltamivir per day for 5 days would amount to, according to the Japanese drug price in the National Health Insurance scheme, 3,780 Yen (USD31.50). The price for a 3-day dose of *maoto* is only 210 Yen per day (USD1.75). Conversely, since the *daiseiryuto* is not a ready-made extract preparation, it is prepared from two available extract preparations. When preparing it using Tsumura's extracts, the author used 7.5 g of *maoto* and 7.5 g of *eppikajutsuto* per day. In this case, the price for two days is 340 Yen (USD2.80). Applied for suitable indications, Kampo preparations are not only highly effective for the treatment of influenza, but also economically superior.

Conclusion

* One case was reported where the greater yang condition described in the "Shang Han Lun" can be viewed as a cold injury and the treatment with 7.5 g of *maoto* made by Tsumura per day and proved to be markedly effective within 2 days.
* Oseltamivir is definitively effective, but Kampo medicine, in particular *maoto* and *daiseiryuto*, when administered based on a suitable pattern identification, appear to have equivalent effects.
* Considering cost factors, *maoto* and *daiseiryuto* (combination of *maoto* and *eppikajutsuto*) seem to be economical.

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Clinical Report 3 (Japan) - continued

Efficacy of Kampo Medicine for Influenza – with Particular Focus on Maoto

Chizuno Hidaka, Hiromichi Yasui, Hideaki Yamaguchi

History records reveal that approximately 1800 years ago there was an epidemic of a condition called "Shang han (cold injury)" in China, that closely resembled what we today call influenza. Descriptions of therapies for this disease found in the book "Shang Han Lun" are actually highly effective for the treatment of influenza. In fact, more than half of the Kampo prescriptions currently used in Japan are derived from either this "Shang Han Lun (Treatise on cold-induced diseases)" or else the "Jin Kui Yao Lue (Synopsis of the Golden Chamber)". For this reason Kampo medicines are frequently used in Japan for the treatment of influenza. In particular, the early phase after the onset is often an indication for the use of prescriptions containing Ephedra like *maoto* or *daiseiryuto*.

Clinical research

Signs considered to be indications for *maoto* include chills, fever, headache, arthralgia, muscle aches, a tendency towards perspiration etc.; closely resembling the symptoms observed during the early phase of influenza. For this reason *maoto* is often used for the treatment of this condition.

Abe published detailed reports on the treatment of influenza with Kampo medicine before the introduction of antiviral agents. In these reports, he indicated that for symptomatic treatment, Kampo medicines are superior to western medications[1]. Later research comparing the antipyretic effects of amantadine and *maoto* revealed almost equivalent effects.[2]

In recent years, Oseltamivir has come into use, and thus many studies have been conducted examining the effects of a combination therapy with *maoto*. The combination of inhibition of the virus proliferation by Oseltamivir, and improvement of the body defences facilitated by *maoto,* is considered to provide an ideal therapy form. Below are several clinical studies that investigated these questions.

Kubo et al. treated a total if 49 patients (male:female = 24:25) with an age ranging from 5 months and 13 years with influenza symptoms including high fever of over 38°C. These were divided into a group of 18 patients treated with Oseltamivir, a group of 14 patients treated with a combination therapy of Oseltamivir and *maoto* and a group of 17 patients treated with *maoto*[3].

Among these patients those over one year of age were diagnosed using a quick diagnostic kit for influenza and subsequently randomly assigned into (1) a Oseltamivir (brand name: Tamiflu) group treated with 4 mg/kg for 2 days and (2) a *maoto* made by Tsumura 0.18 g/kg for 3 days) and (3) a combination therapy of Oseltamivir and *maoto*. Patients under one year, not suitable for treatment with Oseltamivir and patients in whom the influenza quick diagnostic test was negative, were treated only with *maoto* (independent therapy). Guardians were requested to supervise the actual application of the drug and record measurements of body temperature. The study then compared the differences between the individual groups until defervescence (down to 37.2°C) had been achieved. Differences in background factors like average age at the initiation of the treatment, male-female ratio, duration of the fever prior to treatment begin, degree of the fever, history of vaccinations etc. were not observed.

Regarding the time from beginning treatment until defervescence in all three groups was in the Oseltamivir treatment group, on the average 31.9 hours; in the *maoto* – Oseltamivir combination therapy group 21.9 hours; and in the *maoto* group 17.7 hours. Side effects or adverse events were observed in none of the groups.

Similar studies have also been conducted by Kuroki, Fukutomi et al. and Kimoto et al. Kuroki investigated the effects of a *maoto* – Oseltamivir combination therapy for the treatment of influenza over the three seasons from 2003 to 2005 and obtained results similar to those reported by Kubo. In the combination therapy group, improvement in clinical symptoms was reportedly superior[4].

Fukutomi et al. divided 24 patients diagnosed with influenza using the quick diagnostic kit from winter 2003 until spring 2004 into two groups and treated them with a regimen similar to that described above. The results showed that the duration of headache in days and the number of days general malaise continued was shorter with a combination therapy of Oseltamivir and *maoto* than in the group treated only with Oseltamivir (significant difference) [5].

Kimoto et al. treated patients diagnosed with influenza using the quick diagnostic kit during the period from January to March 2004 with Oseltamivir and then compared the clinical course with patients treated either with *maoto* or else ordinary western medications. Defervescence occurred in the group treated with a *maoto* combination therapy approximately 12 hours earlier than in the group

treated with a combination therapy with western drugs. They also reported a tendency toward an early recovery from fatigue, dizziness and loss of appetite. In the group treated with combination therapy with western drugs a rise in CRP was observed in 3 patients, but in the group treated with a *maoto* combination therapy this was not observed[6].

Similar to the case reports published by Oribe, symptoms were often relieved early in many patients treated with *maoto* only. Therefore specialists of Kampo medicine hold the view that Oseltamivir may not necessarily be required. In Japan, generally the diagnosis of influenza is confirmed with the quick diagnostic kit first and patients are then treated with Oseltamivir. For this purpose, case-control studies are mainly reports of combination therapies with *maoto*. Yet, the accuracy of the quick diagnostic kit in establishing a definite diagnosis is not 100%. Immediately after onset in many cases positive results are not obtained.

The Kampo preparation used predominantly during the early phase is *maoto* followed by *daiseiryuto*. It would be easy, if *daiseiryuto* were a decoction, but since there are no extract preparations, this formula needs to be prepared by combining two available extract preparations. Mitani reported obtaining good results in treating patients with influenza associated with high fever by using combinations of either *keishito + makyokansekito* or else *maoto + eppikajutsuto*[7]. These combinations contain in the first case, an excessive amount of Paeonia and in the second case Atractylodes rhizome, but reportedly were clinically effective. In the latter case, the increase in the amount of Ephedra needs to be carefully considered.

Other preparations beside *maoto* or *daiseiryuto* are also used for the treatment of this disease. Patients do not necessarily visit clinics during the early phase following onset, or else because of factors like age or due to a preexisting disposition. *Maoto* may not always be suitable. In these cases, a wide variety of other preparations are used. Kimoto et al. are conducting research on this topic.

Kimoto et al. divided 155 patients diagnosed with influenza, using the quick diagnostic kit, into an Oseltamivir or amantadine treatment group, a Kampo medicine treatment group, and a third group treated with a combination therapy. The results showed that the number of days the drugs were administered were fewer in the combination therapy group. The total of 11 drugs used here included for adults *kakkonto*, *maoto*, *keishimaokakuhanto*, *shosaikoto* and others, while for children four prescriptions including *maoto* were used[8].

Costs versus effects

Oribe pointed out that regardless of whether it is *maoto* or *daiseiryuto*, these drugs when compared to Oseltamivir are inexpensive. Regarding the cost-effect ratio, these drugs cannot compare with Oseltamivir. In Japan, seven pharmaceutical companies produce and sell *maoto*. The drug price in the NHI scheme for each of these products is around 70 Yen/day. The drug price for Oseltamivir is 756 Yen/day. That results in a price difference between the two drugs of more than 10-fold.

Since the research conducted so far appears to reveal that these two drugs (*maoto* and Oseltamivir) have approximately equivalent effects, the cheaper Kampo preparations should be made the drug of first choice. Yet, for this decision, more research is called for.

Basic research

There is basic research about the most important effective ingredient in the preparation used for the treatment of influenza, namely Ephedra.

Mantani et al. noticed that for the growth of influenza viri, an acid milieu is required within the vacuoles during the threshing process and thus performed the following experiments. They used MEM containing medium to cultivate Madin-Darby canine kidney (MDCK) cells and then infected those with the influenza strain A/PR/8/34 (H1N1 subtype) to investigate the inhibitory action of Ephedra on the proliferation of the viri. The results showed that an extract of Ephedra in dose-dependent manner, inhibited the acidification of the vacuolar fluid. Moreover, regarding the viral growth, Ephedra induced immediately after the infection during a loading period of 10 minutes a less than 50% inhibition. This suggests that Ephedra inhibits the growth of influenza viri during the early phase[9].

Ochiai conducted several other studies differing from the study of Mantani et al. described above and verified the inhibitory action of Ephedra on the growth of influenza viri[10]).

Avian influenza and new influenza types

In Japan so far, no people have been infected by, or developed, avian influenza. Accordingly, we haven't had the opportunity to treat this disease and thus cannot give definitive comments. However, China had the opportunity to treat patients with this disease and the governmental Department of Hygiene has classified the

disease into four types (four stages), suggesting therapies for these respective stages (including prescriptions). According to that information, avian influenza falls under the classification of "Wen Bing (warm diseases)" and not the "Shang han (cold injuries)"[11].

Conversely, for types of avian influenza with a potential man-to-man infectivity, meaning new influenza types, it remains obscure as to what type of clinical picture will be presented. In the past, influenza usually was classified as "cold injury", but that may not necessarily hold true for the future.

The great pandemic that occurred in 1918, and claimed many victims during the Spanish flu epidemic, has been classified based on the experience of the physician specializing in Kampo medicine (Dr. Mori) into three types. The type marked mainly by pathologic changes of the gastrointestinal tract was treated with *kososan* with added Indian Bread Exodermis, Atractylodes Rhizome and Pinellia Tuber; the type with predominantly pulmonary lesions with *shoseiryuto* plus added Apricot Seed and Gypsum; while the type associated with encephalopathies was treated with *shomakakkonto* with added Angelica Dahurica Root, Cnidium Rhizoma and Asiasarum Root. These therapies produced excellent results[12].

If new types of viri should evolve in this century, we would like to prepare as many means as possible to keep casualties among a human race without immunologic protection at a minimum. The development of vaccines against new strains will require at least 6 months, so that the number of effective antiviral drugs during that period is unknown. Under these circumstances, the experiences of Mori might prove helpful for the treatment of new forms of influenza.

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Clinical Report 4 (Japan)

Headache - Two Unique Cases

Yoshihide Yakazu, Hiromichi Yasui

Patient: 57 years, female
First visit: September 28, 1999
Chief complaint: periodically occurring headaches
Present history: onset of Menière syndrome following delivery in 1970, the condition improved later but then led to the development of periodically occurring headaches. Episodes occurred generally at a frequency of once per month. During attacks the patient first felt a stabbing pain deep behind the eye. Subsequently the pain would spread throughout the entire head. Moreover, over time shoulder stiffness also developed and eventually led to vomiting. This vomiting reportedly felt like emptying out the stomach content completely and required the patient to stay in bed for 2 days because of exhaustion. During such periods, the patient had to continue using analgesics (NSAID).

The headache was more likely to occur in summer than in winter and attacks often occurred on days preceding major weather changes.

An ophthalmologic examination performed because of a suspected glaucoma, revealed no anomalies. Neither did a visit to a neurosurgical clinic and CT examinations did not reveal any anomalies.

Present status: height 156 cm, weight 40 kg

Diet: normal
Sleep: good
Micturition: 5-6 times/day, urinary volume is not considered to be small
Defecation: once/day, normal feces
Cooling of hand and feet (+), sleeps wearing socks
Stiffness of neck, shoulders, back (+)
Dry mouth (+), constantly thirsty and drinks a lot. 2-3 cups of drinks during meals
Edema (-)
Blood pressure: 134/94 mmHg
Pulse pattern: deep and slightly wiry
Tongue pattern: pale, thin white fur, slightly greasy, moist
Abdominal pattern: nothing particular

Past history: seasonal allergic rhinitis (only in spring)
Family history: elder sister suffers from similar headaches
Diagnosis: headaches due to deficient water metabolism (water/dampness congestion)
Therapy: induce diuresis to alleviate edema, unblocking yang and mobilizing Qi
Prescription: *goreisan* extract 6.0 g in 3 portions/day. Application between meals
Course: following the beginning of treatment there was a headache attack on October 5. On 11/6 the weather turned bad with rain. On 11/7 the weather was fair. The attack lasted three days. After that the severity of headaches developing prior to worsening weather conditions decreased and attacks subsided within half a day. On those occasions, the patient used Loxonin. Nausea occurred infrequently. In May of the following year (2000), half a year after treatment began, headache attacks had become rare. However, when the patient forgot to take *Poria Powder with Five Herbs*, attacks recurred. After approximately one and a half years in, April 2001, headaches subsided completely as long as the patient took the medication. Episodes of allergic rhinitis were treated with Zaditen.

Treatment was discontinued when the patient moved to Osaka on August 6, 2001.

Additional case

On October 13, 2003, the patient, a 70-year old woman, visited the clinic complaining of headaches that had been occurring since the age of 40. In this case, headaches were related to the weather and characterized by pulsating pain in the temple regions. The patient used Cafergot, Depas, Dogmatil. Administration of *Poria Powder with Five Herbs*. After two weeks of treatment, the severity of the headaches had diminished considerably. After one month, they had almost disappeared and the patient currently continues to use this medication.

This patient was the elder sister of the above mentioned patient. According to her testament, she was completely free of headaches and leads a comfortable life.

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Clinical Report from Europe

Case Study: Classical Migraine

Ulrich Eberhard

Case study: Classical migraine

A 39-year old female patient complained about intermittent headache attacks on weekly intervals, in particular, related to weather changes (deterioration of weather). The onset came with neck and shoulder stiffness, later symptoms spread over the entire scalp and finally single-sided localization, mostly in the left parietal region; about 12 hours after the onset, sickness or nausea and frequent bilious vomiting. Generally, the attack would subside spontaneously after approximately 12 hours duration. These migraine attacks began after the last delivery (the patient has two healthy children, the first pregnancy was normal, while during the second pregnancy an EPH gestosis developed). Other diseases: allergic diathesis (drugs, see food)

Kampo diagnosis:

The anamnesis reveals that the patient typically experiences strong thirst on the day prior to an attack, but excretes in spite of a large volume fluid intake with comparatively little urine. Once the migraine symptoms subside, a marked diuresis sets in that lasts a whole day.

Findings:

Average sturdy stature, slight tendency towards obesity and cellulitis in the regions of buttock and thighs.

Tongue: moist, thin white fur

Pulse: floating, slippery and weak in the depths (disappears upon pressure)

Abdomen: fluid sound in the stomach upon palpation, relatively weak abdominal wall tonus

SHO identification:

Greater yang stage (in particular during the initial phase of attacks) and transition into lesser yang stage (over the course of the attack); condition intermittent between excess and deficiency (Qi intermedio), spleen Qi deficiency and signs of SUIDOKU*

(* suidoku: refers to a pathologic condition of the fluid metabolism, disturbed regulation - see Eberhard: Guide to Kampo Medicine, p. 95)

Kampo prescription:

Poria Powder with Five Herbs (Wu Lin San): "five ingredients mixture"

Mx:

Rhiz. Alismatis	6.0 g
Polyporus umbellatus	4.5 g
Pachyma Hoelen	4.5 g
Rhiz. Atractylodis ovatae	4.5 g
Cort. Cinnamomi	3.0 g
(amount for 7 days)	

Course:

First prescription for a period of 7 days as a decoction, 3 x daily in portions of 150 ml before meals. Important: patient was allergic, which required that she be informed about Cort. Cinnamomi, since this drug may occasionally cause skin efflorescences.

During the next visit the patient reported a good tolerance; therefore the prescription was prescribed for another period of 21 days.

The next consultation was three weeks later. The patient reported a single migraine attack during the last four weeks, which was of longer duration (appr. 24 hours), but less pain intensity (moreover in the right parietal region, while normally occurring on the left) and above all, no sickness and no nausea!

Examination:

Tongue and pulse unchanged; abdomen: no fluid sound in the stomach upon palpation, normal abdominal tonus (previously weak abdominal tonus)

Continued treatment with *Poria Powder with Five Herbs* for another 21 days, later prescriptions for 28 days each. This therapy was continued for a period of approximately 6 months with positive results. The frequency of the attacks were markedly reduced until they finally subsided completely. Sickness and nausea did not recur.

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Introduction of Japanese Acupuncture

Considering the Therapist's Hand

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1. Introduction

What characterizes Japanese style acupuncture and moxibustion? Many times I have been asked this, but it has been difficult for me to give a reply, because there are different styles of Japanese clinical acupuncture and theory.

If I try to characterize Japanese style acupuncture and moxibustion, it would have to be the importance of palpation throughout the session. During the process of examination the therapist touches the patient's skin, perceives it's condition and decides the treatment location and protocol. Then, during the treatment, the therapist continues to touch the patient's skin to grasp any changes, and according to the level of change, he can adjust or finish the treatment. I feel this process of nearly constant palpation is a very important characteristic point of Japanese style acupuncture and moxibustion.

In Japan, palpation has undergone unique changes during its long history. Unfortunately, these techniques are disappearing from Western Medicine as well as Traditional Chinese Medicine.

Japanese practitioners of acupuncture and moxibustion diagnose by palpating the skin, connective tissues, muscles and organs. Special techniques and skills are needed to distinguish stiffness or hardness in a muscle, to delicately assess apparent changes in the body surface and its connective tissues. The therapist has to understand, with the fingertips, the distinction between, so-called excess and deficiency in the skin and connective tissues. In Japan, the importance of deficiency on the body surface and connective tissues has stimulated the development of various techniques to grasp and to change the surface of the body. As a result, Japanese therapist training has included uniquely delicate palpation and acupuncture techniques.

2. Palpation in East Asian Medicine

There are four fundamental methods of diagnosis for acupuncture and moxibustion: inspection, listening/smelling, inquiry and palpation. These methods are common to the fields of acupuncture, moxibustion, massage, as well as herbal therapies in Japanese East Asian medicine. It is vital that the practitioner grasp the patient's subjective interpretation of the symptoms with one's own five senses. Despite the patient's subjective interpretation of their symptoms, the essential diagnostic methods characteristic of Japanese medicine allow the practitioner to objectively use his or her five senses to precisely grasp the patient's condition.

Roughly speaking, of the four methods, inspection, listening/smelling and inquiry are indirect methods. That is, the practitioner does not make direct contact with the patient. Only touch or palpation brings the patient and practitioner into direct physical contact.

Palpation, the foundation for touch diagnosis, represents the most important characteristic of Japanese acupuncture and moxibustion. Not only diagnosis, but actual treatment relies heavily on the art of palpation; the area of the body to treat, the treatment depth, and the level of stimulation. Palpation allows the practitioner to discern the factors essential to determining the treatment methods and protocols. A further characteristic of palpation during treatment is the quality and quantity of stimulation to the surface of the body. Further, the collaboration between the patient and the practitioner provides the chance for contacting/healing the heart of the patient.

Determining the point location with anatomical landmarks and proportional measurements represents the theoretical foundation for the practice. Then, discrete palpation for physical responses or unique anatomical features adapts the method to each individual patient and their condition.

Within the field of palpation, pulse diagnosis continues to hold great importance. Abdominal palpation has, to a limited extent, been examined. But from the point of view of clinical diagnosis and practice, research into the palpation has been insufficient.

3. Meaning of touching and developing of human hands

Throughout history, the human hand has enabled us to receive and acquire valuable resources and information, to express ourselves and to transmit and transfer various forms of information and stimuli. All in all, the human hand is an outstanding feature of our species.

Fingers can be called our second eyes、when our eyes cannot catch certain details, our fingers and hands can fill in the gaps: the sensations of heat and cold, knots, thickness, sharpness, dullness, texture, etc…

Also, an example closer to our practice, a needle of 0.2mm in diameter can be distinguished with practice. Palpation can be defined as the process of getting information about the surface of the body with the hands and fingers. In this way, our hands help us get from the object of palpation to detailed information. Also, we can assess how the object is moving and changing in response to our touch. Moreover, our will and intention can be transmitted.

In addition, in Japan, “hand” sometimes means human; “hand” sometimes means emotional state. For example, “talking hand” means “speaker”, “bitter hand” means “weak” and “poor”. Hands work, make things, transmit and accept others.

Medical History in Japan

Japanese Acupuncture and Moxibustion under the Rule of GHQ after World War II

Recommendation by the Public Health and Welfare Section for the prohibition of acupuncture and moxibustion, and the response of the acupuncture industry in Japan

Takako Okutsu

Acupuncture and moxibustion were first introduced to Japan in the 5th Century AD from the Korean peninsula and mainland China. These therapeutic techniques subsequently developed into an independent system for Japanese health care based on the Chinese view of medicine. In the 16th Century, communication between Japan and China entered a new stage, and as interaction between the two cultures increased, acupuncture and moxibustion came into wider use. When the Tokugawa Shogunate came into power in Japan, acupuncture and moxibustion played a major role in government policies regarding medical treatment. However, after the Meiji Restoration in 1868, German medicine became the norm, and traditional methods such as acupuncture and moxibustion were placed under specialized and restrictive regulations in Japan.

The new Meiji government began to issue licenses to acupuncture and moxibustion practitioners who could demonstrate a uniform and standard level of technical expertise. Acupuncture also gained protected status as an occupation for the blind, a practice begun under the Tokugawa Shogunate. For this reason, acupuncture and moxibustion came to be considered as an important pillar in the education of the blind. The attitudes and decisions regarding acupuncture at that time derived in great part from the outstanding medical and political contributions to the Shogunate that were made by Waichi Sugiyama, the gifted 16th Century blind acupuncturist.

Under the old system of small private classes and apprenticeships that was still in place in prewar Japan, it was difficult to guarantee the level of acupuncturist training. It was not uncommon for acupuncturists to focus on old ideas and to base their practice on limited knowledge and experience. However, in the 1920s a few talented acupuncturists who were exceptions to this norm began a revolutionary movement that led to the rapid modernization and systematization of Japanese acupuncture and moxibustion during the 1930s and 1940s.

In 1937, Japan began a war of aggression that developed into World War II and that ended with the unconditional surrender of Japan in 1945. During the war a number of medical schools were established to provide short-term intensive training for physicians who were then dispatched to the battlefields as military surgeons. However, the growing shortage of supplies both at home and at the front created an increasing demand for acupuncture and moxibustion, which did not require drugs as part of the treatment process.

The war ended in 1945, and the rebirth of Japan began under the direction of the Supreme Commander for the Allied Powers (GHQ). The GHQ undertook the democratization of all areas of Japanese life, including medicine.

The department that was charged with reforming the Japanese medical system was the Public Health and Welfare Section (PHW). Headed by Brigadier General C. F. Sams, the medical specialists of the PHW performed detailed surveys of every region in Japan. Their efforts were aimed at implementing a medical system based on public health principles and at reforming the educational system to improve the quality of medical practitioners. This overall reform would be highly respected later by the Japanese people, who feel a deep debt of gratitude toward Brigadier General (later Colonel) Sams.

Crawford F. Sams (1902 to 1994)

Military surgeon, American Armed Forces. Stationed in Japan from 1945 to 1951 as the director of the PHW (Public Health and Welfare Section) of the GHQ (General Headquarters), which was established in Japan in 1945. He carried out a full reform of the postwar Japanese medical system, and in later years was credited with protecting the defeated Japanese nation from starvation and disease. Retired in 1955, but continued to be active in research. Died in San Francisco in 1994 at the age of 92.

(This photo was supplied by Mainichi Newspapers.)

Among its many responsibilities, the PHW examined numerous forms of unorthodox "folk" medicine, and recommended the elimination of those that were found to be questionable. Acupuncture and moxibustion fell into that "questionable" category. The PHW pointed to a number of problems in the field of acupuncture, and suggested that, in light of those problems, such treatment should be prohibited. This recommendation came as a great shock to acupuncturists as well as to people with impaired vision and those responsible for their education. Several well-known physicians and acupuncturists spoke out on behalf of acupuncture and moxibustion, justifying the therapeutic value of this form of treatment. Protests were lodged by trade associations, including acupuncturists' associations and a federation of schools for the blind. Because of this public outcry and the dedicated efforts of some Japanese bureaucrats, traditional acupuncture mix techniques were not abolished, but were allowed to continue. Those involved with this movement to protect acupuncture and moxibustion then began to re-examine the status of this system in Japan, and to think carefully about improvements that were needed, which has led to the modernization of acupuncture and moxibustion in Japan.

This article describes the path of developments between the time when the PHW published its Recommendations for the Prohibition of Acupuncture, Moxibustion and Massage and the time when Law No. 217, the Law for Business of Massage, Acupuncture, Moxa-Cautery, Judo-Orthopedics etc., which formally established the position of Japanese acupuncturists, went into effect. Background research has been based on source documents from the period. The effects of PHW policies on the current status of acupuncture and moxibustion in Japan have also been investigated.

Named the "GHQ whirlwind" by Japanese acupuncturists, the PHW recommendation described above was a major and unforgettable landmark in the post-World War II history of acupuncture moxibustion in Japan.

Recommendations of the PHW

In Japan immediately after WWII, the field of acupuncture moxibustion was held in high regard. This was partly because that system provided medical treatment without drugs, which were in very short supply during and immediately after the war. The therapeutic techniques of acupuncture and moxibustion were not inferior to drug therapy, and since treatments could provide substantial therapeutic benefits, they gained widespread acceptance first at the upper levels of government and then throughout the country. Practitioners who earned a place for themselves within the acupuncture and moxibustion community were self-confident and proud of their jobs.

However, acupuncturists at that time were regulated under the "Regulation for the Control of Trade in acupuncture and moxibustion Businesses" (1911). This placed them outside of the ordinary medical system, and acupuncturists were generally considered to be a part of the service industry rather than the medical profession. Partly as a result, no educational system had been established for acupuncturists. Although there were some small private schools that provided a very high-level curriculum, the certification examination was open to anyone who could provide proof of having worked as a trainee for at least four years in an acupuncture moxibustion facility. The apprenticeship system was still widely practiced, and acupuncturists did not hold a prestigious position in Japanese society.

In order to move forward from that situation and to improve the social status of acupuncturists as medical practitioners, it was necessary to establish legislation for the regulation of acupuncture and moxibustion practitioners, and to reform the educational system. Meanwhile, with Japan still under occupation by the Allied Forces, the Constitution of Japan was proclaimed in 1947 to replace the Constitution of the Empire of Japan (the Meiji Constitution of 1889). Under the new constitution, the old regulations governing business became null and void as of December 31, 1947, and it was necessary to establish new laws in their place.

Those leaders in the acupuncture and moxibustion industry who had been working to improve the status of acupuncturists saw this as a golden opportunity, and began a movement toward establishing legal status for acupuncture and moxibustion practitioners.

At the same time, as part of its independent survey of Japanese folk medicine, the PHW had completed a detailed survey of acupuncture and moxibustion, and was summarizing its findings unrelated to Japanese thoughts and opinions. The PHW concluded that the traditional therapeutic system of acupuncture and moxibustion should be prohibited for reasons including "inadequate disinfecting procedures," "lack of an established educational system," and "barbaric treatment methods." These conclusions were conveyed to the Ministry of Health and Welfare as a recommendation for the Prohibition of Acupuncture, Moxibustion and Massage.

Those who were affected by this recommendation remember it as a dash of cold water in the face of Japanese acupuncture. It came as a major shock to the acupuncture industry, which had expected a bright future for acupuncture and moxibustion after the war.

This directive was prepared by the GHQ staff, whose point of view was based on Western medicine. Staff members had little knowledge of Japanese traditions, and no understanding of the theories of Eastern medicine upon which acupuncture and moxibustion are based. From the Western perspective at that time, Japan was an exotic country of the Far East, and the medical traditions of acupuncture and moxibustion seemed strange and difficult to understand, both medically and culturally. It is natural for countries and peoples to have different viewpoints, and seen in that light, it was also quite natural for the GHQ to perceive problems with acupuncture and moxibustion.

However, at that time the GHQ had absolute authority in Japan. The GHQ directive was strongly worded, apparently denying the theoretical basis and techniques of acupuncture and moxibustion and devaluing traditional elements of Japanese customs, and the Japanese government and the acupuncture industry interpreted it as an "Order for the Prohibition of Moxibustion and Acupuncture."

Those involved with acupuncture and moxibustion felt that the future of traditional medicine in Japan was at risk, and a movement arose to prevent the loss of this medical resource. The Japanese government, caught between the requirements of working with the GHQ and the need to respond to the acupuncture industry, concluded that "Without changes in the laws that provide the basis for the acupuncturist system, it will be difficult for acupuncture and moxibustion to continue." From that point on, governmental efforts focused on legislative reform.

Predictions and strategy of Professor Ishikawa

Professor Hidetsurumaru Ishikawa, Professor Emeritus of Kyoto Imperial University and President of Mie Prefectural Medical School (now Mie University School of Medicine), was one of the first to recognize the risk to acupuncture moxibustion.

At Kyoto University School of Medicine, Professor Ishikawa had taught physiology, and at Mie Prefectural Medical School, he continued his study of the autonomic nervous system, which led him to acupuncture research. As a young man, Professor Ishikawa had studied in Germany and Russia, and from his perspective as a physician, he predicted early on that "Acupuncture is far removed from Western medicine, and includes procedures that will be seen as barbaric," and that the GHQ would raise questions regarding "inadequate disinfection procedures," "lack of uniformity in acupuncturists' knowledge base and technical proficiency due to the lack of an established educational system," and "ambiguity and vagueness of the method's scientific foundations, which are considered to be the most important element of Western medicine." He also predicted that the future of acupuncture and moxibustion could be at risk, depending on how the Japanese government and the acupuncture industry responded to these issues.

Immediately after the war ended, Professor

Ishikawa began to tell the acupuncturists with whom he worked, "With Japan's defeat, there is a risk that acupuncture and moxibustion may be prohibited. However, fortunately the American people have a particularly high regard for science. Acupuncture has a much better chance of surviving if we can show that it has a scientific basis. We need to begin preparing for that now. So if you are interviewed or investigated by any of the Occupation forces (GHQ), I want you to say, Ask Dr. Ishikawa at Mie Prefectural Medical School.[1)] With this, he began to build a rational strategy for responding to the GHQ.

Professor Ishikawa's statements appear to have been founded on two premises. First, was his rather egotistical view that, with his mastery of both Western medicine and acupuncture, he was the only person who could protect acupuncture and moxibustion from the GHQ. The second was the very real fear that acupuncture and moxibustion could be prohibited immediately by the GHQ because of some naïve demonstration or explanation of techniques by a practitioner who was not versed in Western medical thought.

Hidetsurumaru Ishikawa (1878 to 1947)

Physiologist. After graduating from the Faculty of Medicine, Tokyo Imperial University, he traveled to Germany, England, and Russia for further research beginning in 1908. At the age of 36 he was appointed as a professor in the Second Department of Physiology, Faculty of Medicine, Kyoto Imperial University. Accomplished researcher in the area of the autonomic nervous system. Served as President of Mie Prefectural Medical School (currently Mie University School of Medicine) from 1944, directing considerable energy into scientific research on acupuncture and moxibustion. Died in 1947 at the age of 69.

Professor Ishikawa's Demonstration to the Mie Military Government

On July 1, 1947, Professor Ishikawa was called in by the Mie Military Government of the GHQ, and was handed a list of 15 acupuncture-related questions. On the following day, he responded to those questions before First Lieutenant P. A. Weizmann, a military surgeon, and concluded his presentation by outlining "plans for the reeducation of current practitioners and the raising of quality standards, to culminate in college-level training."

The Military Government started that day by citing acupuncture-related issues regarding "inadequate disinfection procedures," "the lack of an established educational system," and "barbaric treatment methods", and announced that regulations and restrictions would be applied to current practitioners of acupuncture and moxibustion. However, after the conversation with Professor Ishikawa, they asked him to pursue further research and to quickly provide them with a comparison of acupuncture and modern medicine.

On July 7, Professor Ishikawa and one of his most talented acupuncturist assistants, Mr. Higuchi, provided the Mie Military Government with a demonstration of an actual acupuncture treatment. In front of six military personnel led by Surgeon Lieutenant Weizmann, Ishikawa and Higuchi scrubbed and disinfected as if they were preparing for surgery. During the actual demonstration of moxibustion, they explained that treatment was performed with extremely small amounts of moxibustion, and that burns from moxibustion could be avoided by using the combustion ash.

Ishikawa and Higuchi then suggested that Surgeon Lieutenant Weizmann try an acupuncture treatment. The lieutenant agreed, and confirmed that the treatment was painless and that he experienced changes in sensory perception. Acupuncture was then performed on other members of the audience, some of whom reported with considerable enthusiasm that "It didn't hurt, and the tension in my shoulders is gone!" That day's demonstrations achieved Professor Ishikawa's objectives quite successfully.

Next, on September 7, Professor Ishikawa took Mr. Higuchi and other acupuncturists to Tokyo, where they met with the Medical Affairs Office of the Ministry of Health and Welfare (now the Ministry of Health, Labor, and Welfare). Professor Ishikawa explained that the office would soon need to respond to queries from the GHQ. He bolstered the confidence of individual staff members by describing the data from his years of acupuncture research, which provided a scientific basis for acupuncture. He also demonstrated the safety and effectiveness of acupuncture treatment, using Ministry staff members as his subjects.

This was how physicians, acupuncturists, and those involved with acupuncture kicked off their "defensive war" against the "GHQ whirlwind."(To be continued)

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1. Sugihara M: The footsteps of Mr. Naofumi Yamazaki, *First President of Our School and Pioneer in Acupuncture and Moxibustion Education*. Publication of the Alumni Association of Meiji School of Oriental Medicine

Surgeon Lieutenant **Philip A. Weizmann**

Book Review

"Japanese Acupuncture: A Clinical Study" written by Stephen Birch and Junko Ida

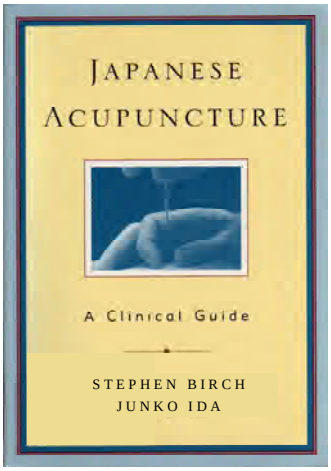
Reviewed by Emily Katai
L.Ac., CA, U.S.A.

Japanese Acupuncture: A Clinical Guide is the "foundation volume" in a series on the Japanese clinical practice of acupuncture. This exciting text brings many highly relevant, yet heretofore largely unknown, 'materials and methods' to life for the Western practitioner. The purpose of this volume is clearly stated: to set the stage for the next level of development in the field of (English language) acupuncture. Skills and techniques common to the Japanese acupuncturist have been translated and presented in a very practical and informative style. Just as the West begins to accept acupuncture to a larger degree, Japanese approaches will enjoy an overdue boom.

The process of assimilation, integration and development of Oriental medicine in Japan is very important to understanding where Chinese medicine has been altered to fit Japan's unique culture. The unique subtlety and delicacy of Japanese acupuncture, the "less is more" style, common to so many Japanese traditions, receives special attention

The initial chapters present a historical overview and an assimilation of Oriental medical theory familiar to most Western trained practitioners. An overview of Japanese acupuncture systems concludes this section. Systems representative of Japanese practice are defined and explained. The work of Dr. Yoshi Manaka, Kodo Fukushima and Denmai Shudo are briefly discussed under the topic of Keiraku Chiryo (meridian treatment).

The main body of the text covers palpation, needles and needling, moxibustion (kyu), intradermal needles (Hinashin), press-tack needles, (empishin), press-spheres (ryu), cupping (kyukaku), bloodletting (shiraku), Manaka's wooden hammer, and needle and case studies from the Japanese literature, including the authors' experience. This extensive collection, complete with illustrative photos, provides a very comprehensive overview of Japanese techniques and the discipline required to administer them. Where appropriate, information about actual Japanese clinical situations makes this volume very comprehensive.



[**Paradigm Publications**
Brookline, Massachusetts 1998]

Acupuncture education and practice in Japan are the subjects of Appendix 1. This information will be very useful for educators and those practitioners organizing study groups and professional organizations. The presence of Appendix 2 is somewhat dubious as there is no obvious connection to Japanese clinical practice. Chinese studies using seeds taped to auricular points presents interesting information but adds nothing to the discussion of elucidating Japanese practice.

In conclusion, this text is worthy of attention and will undoubtedly find a place in the libraries of many a Western practitioner. That said, one wonders why, given the optimal timing for bringing this information to Western practitioners, there is not a single Japanese Kanji or Chinese Character. The authors' clearly relied on their hard earned skills in reading and speaking Japanese, yet make absolutely no effort to extend this knowledge to practitioners in the West. As practitioners of a traditionally Oriental body of medical wisdom, is there no imperative for the Western practitioner to make even the most rudimentary efforts to read or recognize the original kanji? Lists of acupuncture points identified only by number, Romanized transliteration of Japanese terms like *sotai* exercises and *oshide* for moxibistion reveal nothing of the wisdom hidden in the terms and instead reinforce the Westerners belief that Kanji are too complicated and numerous to bother considering. Until Western practitioners begin to master the language of the medicine we will be mere technicians, exquisitely skilled perhaps, but in the long term, limited by the translation on which we depend.

Birch and Ida have done us a great service, providing a necessary window into an elite world of dynamic practitioners. But at the same time they are keeping our perspective limited. Surely their practices involve reading and speaking Japanese. Open dialogue with Japanese practitioners will be the real key to transforming the Westernized approaches to acupuncture from largely symptomatic point recipes to well organized reproducible root treatments. To that end, Japanese Kanji, as well as romanization of terms and point names must appear hand in hand.

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