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Reviewed by Hirokimi Matsuda

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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

Four Seasons Provide the Foundation for Oriental Medicine

Japan enjoys four distinct seasons during the year.

The trees and flowers that have hardened themselves against the cold during the winter wake up to the warmth of spring, and new buds and shoots appear naturally. This coming forth of new life is one of nature's incredibly beautiful events. Human beings love spring in particular because energy that has been stored is suddenly released, and there is a true sense of liberation.

The season of new greenery that comes at the end of spring is not showy or spectacular, but in the sunlight the new leaves glow gently, and day by day the green color grows deeper and richer. This reminds us of the crazy enthusiasm of youth and the human heart contains a mixture of powerful strength and immense pain.

The June rains signal the arrival of summer. Under the heat and the sunlight, shade and coolness dwell together. Boisterous noise and stillness are close neighbors at this time of year, the warp and woof of summertime.

Fall brings the season of fruit, each piece a concentration of sun, earth, wind, rain and time, and our hearts dance as we participate in the harvest. Perhaps we are trying to forget the cold of winter that must follow.

But where is it that fall ends and winter begins? Looking for an answer, we realize that spring grows out of the winter solstice, and that nature shares the joy of searching for signs of spring even in the middle of winter.

These four distinct seasons experienced by the nations on the eastern seaboard of Asia add richness to the lives of people in the small island nation of Japan, and contribute greatly to a quiet and tranquil heart.

The Japanese people like to contrast human beings and nature, and to describe how we overlap and are identified with the world around us. The changes of the seasons profoundly influence people's lives, and although the Japanese way of thinking also has a major effect, it seems possible that nature chooses this way to tell us about herself. That is because the beauty and strength of nature come into true existence for the first time in the process of being seen by our eyes and described by our voices.

People who lived on the islands of Japan were attracted to the system of Oriental medicine that was written down 2000 years ago in China and brought to Japan from China through Korea about 1500 years ago. Oriental medicine helped Japanese people understand that human beings and nature are truly inseparable, forming a close relationship, and that humans are merely part of nature. Oriental Medicine made the people of the Japanese islands aware of the seasons, the self, and the relationship between the seasons and the self. Japanese people were able to subjectify nature, and this helped them identify it with the self.

The four seasons became clearly present within the Japanese people, while at the same time, the people grew aware of the dark side of nature which is Yin. Nature that includes this dark side is deeply respected by the Japanese people.

From another perspective, perhaps by working through a country like Japan, Oriental medicine can demonstrate nature within human beings and define the medical relationship between nature and people.

The transitions of the four seasons offer another opportunity to reacquaint ourselves with this viewpoint of Oriental medicine.

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Japanese Acupuncture - Current Research

Current Acupuncture Treatment for Acquired Lumbar Canal Stenosis in Japan

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Tsukuba College of Technology Clinic

1. Introduction

Spinal canal stenosis can be caused by hypertrophy of the vertebra forming the spinal canal themselves or the ligamenta flava, by protrusion of intervertebral discs etc. and thus lead to compression of the cauda equina or spinal nerve roots encased within the spinal canal, producing compression symptoms of these nerve structures. Acquired lumbar canal stenosis (LCS) is characterized by neurogenic intermittent claudication and morbidity types divided into an external form marked by pain and numbness of the affected leg and weakness (nerve root type) and a bilateral internal form, in which the patients complain in addition to the symptoms of the lower extremity, bladder and similar symptoms (cauda equina type).

The anteroposterior diameter of the spinal canal of the Japanese is narrower than that of white and colored persons, so that this is one of the frequently encountered diseases among the Japanese. Moreover, with the advancing age of the Japanese population, the number of patients with this condition is expected to increase still further. Thus, elucidation of its pathology and development of effective therapies are tasks that await solution in Japan. Therapeutically, the surgical procedure of posterior decompression permits alleviation of the symptoms in many patients, but long-term postsurgical observation has revealed that relief is reportedly not long-lasting. In the elderly, concomitant presence of vascular diseases often increases the risk of surgery. Improvement of surgery results and development of effective and safe conservative therapy for LCS are pressing issues at hand and attempts have been made to use acupuncture and moxibustion treatment for this purpose.

During the 2 years from April 1992 to March 1994, the chief complaint of 841 (40.2%) of the 2,093 patients who visited the Department of Acupuncture and Moxibustion at the Tsukuba College of Technology Clinic (TCT-Clinic) was low back pain. Among these patients 15 (0.7%) suffered from LCS. This shows that LCS is a condition often seen among patients undergoing acupuncture and moxibustion treatment in Japan. Although a number of research papers have been published in Japanese, a search for acupuncture treatment of LCS on "Medline" or the representative database for EBM, "The Cochrane Library", gives almost no hits. In the Japanese medical reference database “Igaku Chuo Zasshi (Japana Centra Revuo Medicina) “web version” a total of 27 Japanese papers can be found. Among these 15 references are case reports. There is only one randomized controlled clinical trial pertaining to neurogenic intermittent claudication, so that the current evidence for the acupuncture treatment of LCS rests almost entirely on the information gathered through case series studies. Below we would like to introduce the clinical picture of acupuncture treatment for LCS in Japan based on the representative literature.

2. Representative clinical reports

1) Fujinuki, R. 1989-90

Mr. Fujinuki is a practicing acupuncturist and has reported about the treatment of LCS in his acupuncture clinic from a western medical point of view. Practicing acupuncturists in Japan are at a disadvantage regarding the western medical evaluation of the pathology of this condition because they cannot use any accessory diagnostic procedures. Yet, most of Fujinuki’s patients who opted for acupuncture and moxibustion treatment had already been diagnosed and undergone appropriate treatment at mainstream medical facilities. Previous diagnoses could be referred to and specialized physicians consulted, which clinically compensated for these problems.

Examination of 28 patients (15 men and 13 women; age range 46 to 80 years) in whom a cauda equina

intermittent claudication was suspected based on the anamnesis and physical examination, showed that almost all of these patients had already consulted an orthopedist. The claudication distance ranged from 13 to 310 m (average 102 m) and only a few patients presented obvious bladder or rectal symptoms.

The treatment consisted of 2-3 treatment sessions per week during which electroacupuncture was performed in the vicinity of the intervertebral joints surmised to be responsible for the symptoms appearing when walking. Tender points in the buttocks and legs were also needled.

Based on the Takayama Medical and Pharmaceutical University score, the evaluation results showed in 7 patients a ratio of more than 75% improvement, in 6 patients a ratio of 50-74%, in 2 patients a ratio of 25-49%, in 11 patients a ratio below 25% and 2 patients dropped out of the study. Breakdown of LCS type showed that the improvement ratio was highest in patients with the monoradicular type (69.7%). When classified by symptoms, the study showed that there was some improvement in the low back and leg pain as well as the claudication, but effectiveness for numbness, feeling of coldness or weakness was not less pronounced. Pain as the predominant symptom of the monoradicular type was comparatively well relieved regardless of the claudication distance. However, according to recommendation by Fujinuki, for patients who have had a long history and clear neurologic disturbance, the limit of this treatment should be identified early and the patient be referred to the relevant specialists for consultation.

Moreover, Fujinuki also reported a randomized comparative clinical trial performed in order to evaluate the appropriateness of the acupuncture treatment for LCS[3]. In this trial, the 23 patients with LCS were randomly assigned into an electroacupuncture treatment group inserting the needles toward the intervertebral joints as well as a single insertion group (the needle is inserted and removed immediately). A comparison of the claudication distance prolongation before and after each treatment showed for the electroacupuncture group, an average value of 136% and for the single insertion group a ratio of 7%, thus representing a significantly better improvement in the former.

2) Kasuya, D. 1989-99

Mr. Kasuya is an acupuncturist employed in a university hospital, and like Fujinuki, conducts western medically orientated clinical research. Using the functions of a university hospital, he performed research to more accurately identify the pathology. He used thermography for an objective evaluation of the clinical results.

A total of 62 patients with LCS (36 men and 26 women, age range from 22 to 83 years, average age: 67 years) with LCS presenting a chief complaint of intermittent claudication. Diagnosis rested on the findings of diagnostic imaging. A breakdown into clinical types showed 27 patients with radicular type, 5 patients with cauda equina type, and 30 patients with a mixed type.

The vicinity of the lumbar intervertebral joints or intervertebral foramina served as insertion points for the treatment. The needles were either retained (inserted needles are removed after a short retention period) for about 15 minutes, or else electroacupuncture or the thrusting and lifting technique (inserted needles are manipulated vertically to apply mechanical stimulation) were applied. Patients were treated at a rate of one session per week and the results evaluated 3 months after treatment began.

Among the 62 patients, excellent results were observed in 14 patients, the treatment was effective in 17 patients, slightly effective in 19 patients and ineffective in 12 patients. The evaluation criteria for the results of back pain profile recommended by the Japanese Orthopaedic Association (JOA score) showed a marked improvement in the subjective symptoms and movements within the activities of daily living in patients with the radicular type, but no significant

differences in the cauda equina and mixed type. Neither were there any marked differences in the other findings observed.

The claudication distance increased in all types, but while the improvement (from 449 to 1,110 m) in the radicular type was statistically significant, the differences in the cauda equina (on the average 225 -> 512 m) and mixed type (on the average 281 -> 525 m) were not statistically significant.

Observation of lower extremity skin temperature with thermography revealed abnormal findings like cool regions in 8 out of 12 patients (62.5%) that were later found to improve during the acupuncture treatment[7]. Moreover, observation of LCS patients using thermography showed also abnormal lower extremity skin temperature recovery patterns after a standing load shifting test. These anomalies reportedly improved in parallel with the acupuncture treatment induced improvement in clinical symptoms[8].

3) Inoue, M. 2000

In a patient (age: 70 years, claudication distance: 100 m) that had been almost unresponsive to 20 acupuncture treatments of paravertebral (intervertebral joint regions) points, dramatic improvements were reportedly obtained in leg pain and claudication distance after electroacupuncture stimulation of the pudendal nerve. Later, 3 more patients were described in whom this technique had been employed. Moreover, this author argued that experimental evidence showed that pudendal electroacupuncture stimulation induced an increase in sciatic nerve blood flow and thus verifies the hypothesis that improvements in the intermittent claudication are due to an improved circulation of peripheral nerves.

4) Watanabe, A. 1994

Five treatment sessions, applying mainly electroacupuncture on the paravertebral muscles, were administered in a patient (48-year old male) with LCS, presenting leg pain and intermittent claudication, but did not produce any marked changes. For this reason, application of electroacupuncture along the course of the sciatic nerve was tried, upon which the leg pain and activities of daily living reportedly improved. In rats, not only electrical stimulation of the lumbar region or the pudendal nerve, but also electric stimulation of the sciatic nerve, reportedly led to an increase in the blood flow of the sciatic nerve[9].

The most commonly used acupuncture treatment described in Japanese literature appears to be needling in the vicinity of the intervertebral joints above the level of the segment responsible for the affection. Also, in patients where needling in the vicinity of the intervertebral joints did not produce any improvements, electrical stimulation of acupuncture needles inserted through the buttocks in order to stimulate the sciatic and pudendal nerves reportedly produced better results. Although we found only one classic text that described a traditional approach to the basic condition, this may simply indicate that acupuncture and moxibustion treatment based on a modern medical understanding of the pathology, is easier to publish, but in clinical practice either treatment form can be applied.

Improvements can be achieved for the clinical symptom intermittent claudication with pain since it tends to be more responsive to treatment than numbness. Moreover, acupuncture treatment results as classified by the type of morbidity appear on the one hand to be better for the radicular type (external) than the cauda equina type (internal), and on the other hand, better for the monoradicular type than the multiple radicular type.

3. Needling techniques

1) Needling in the vicinity of the intervertebral joints

Needling of the vicinity of the intervertebral joints comprises techniques called needling of "paravertebral points" and "intervertebral spaces", which both represent roughly the same concept. The paravertebral

points (from L3 to S1) are located 20 mm lateral from the spinous processes, while the "intervertebral spaces" are located 20-25 mm lateral from the spinous processes. The below outlined needling techniques have been described for the intervertebral spaces.

a) Needle insertion 20 mm lateral to the posterior edge of the lumbar and sacral spinous processes (or the interspinal process spaces)[9]. In this case a propagated needling sensation should be felt in the buttocks or down into the legs.

b) Needle insertion immediately lateral to the lumbar and sacral spinous processes. From the paravertebral muscles, the needle tip is pointed slightly outward into the spaces between the transverse processes. Stimulation of a deeply situated, rubber-like resistance and confirmation that this elicits a propagated needling sensation resembling the clinical symptoms is achieved.

Apart from the vicinity of the intervertebral joints, needling has also been tried on the paravertebral muscles[10] or the region adjacent to the foramina nervosa (needle insertion at approximately 30 mm lateral of the posterior edge of the lumbar and sacral spinous processes elicits a propagated sensation that spreads into the symptomatic region[6]).

Needling of reactive regions in the buttocks or legs (symptomatic regions or areas in which tender points were found) is often combined with needle insertion in the vicinity of the intervertebral joints.

The length of stainless steel needles used varies between 40 and 60 mm and their thickness ranges from 0.24 to 0.3 mm. References specifying the depth of the needling give it as varying between 20 to 40 mm. Many references state the use of low frequencies of 1-2 Hz for the electrical needle stimulation. The frequencies used in Japan for the electroacupuncture stimulation are often lower than those used in Europe and America. The level of stimulation intensity is chosen in such a way that the patient does not feel any pain and the stimulation is thus performed within a comfortable intensity range. It should be noted that this differs from the "maximal intensity tolerable by the patient". Apart from electrical stimulation, needle retention and manipulation, such as the thrusting and lifting technique are also performed. The duration of the stimulation often ranges between 10 and 15 minutes.

2) Electroacupuncture stimulation of the sciatic nerve

Needles are inserted three fingerbreadths lateral of the fourth sacral foramen with the needle tip slanting slightly inward. The needle enters the infrapiriform foramen and is then manipulated in such a way that it elicits a stimulus spreading through the innervation area of the sciatic nerve. Upon electrical stimulation rhythmical muscle contractions within the innervation area of the sciatic nerve can be observed[10].

The length of the used stainless steel needles is 80 mm and their thickness 0.3 mm. The needles are stimulated with frequencies between 1-2 Hz and stimulation intensity is chosen so that the patient does not feel any pain. The duration of the stimulation often ranges between 10 and 15 minutes. This is often combined with needling of the low back region.

While this technique is considered to be effective, pain develops occasionally after the needle insertion that spreads to the leg and can make the patient very uncomfortable. Nevertheless, this technique seems to be more widely used than the below described electroacupuncture stimulation of the pudendal nerve.

3) Electroacupuncture stimulation of the pudendal nerve

Needles are inserted at a point 50-60% away from the posterior superior iliac spine on the line connecting the posterior superior iliac spine and the ischial tuberosity. Insertion depth is 50 to 60 mm and the needles are manipulated until a propagated sensation spreading through the pubic region is obtained. Stainless steel needles with a length of 60-80 mm and a thickness 0.3 mm are used, that are then electrically stimulated with a frequency of 2 Hz for 10 minutes[9]. This is often combined with needling of the low back region.

While this technique is considered to be effective, pain occasionally develops during or after the needle stimulation in the buttocks, that can make the patient extremely uncomfortable in addition to the already intensive sensation produces by the stimulation in the perineum, and thus requires appropriate attention[9].

4. Examples of treatments for LCS in the TCT-Clinic

Below we would like to give a brief overview of the concrete acupuncture treatment for intermittent claudication performed in the TCT-Clinic for patients thought to suffer from LCS.

Patient: 65-year old male (self-employed). First visit: December 17, 1998.

Chief complaint: intermittent claudication (after walking for 200 m development of left low back and leg pain)

Present illness: onset of the condition approximately 1 year ago, diagnosis of LCS based on MRI findings, two different orthopedists recommended surgery, but the patient visited our clinic, because he wanted to try acupuncture before deciding on surgery. Pharmacotherapy using mainly analgesics and hypotensives.

Findings: SLR test, negative at 90 degrees. Other neurologic physical examinations were also normal.

Acupuncture treatment course: Four treatment sessions within one month, electroacupuncture in the lumbar and gluteal regions (Figure 1) and manual thrusting and lifting stimulation were performed, but did not lead to any improvement. Subsequently, direct moxibustion (placing moxa directly on the skin and burning it there) was performed in both gluteal regions (BL25 + BL26) as well as on tender points in the left gluteal region, burning 7 moxa cones consecutively on each point (Figure 2). Following that day the symptoms gradually started to improve and by March 1999 the patient could walk a distance of 2 km in one stretch. The third orthopedist in the university hospital then said that an operation would not be necessary. Currently, in June of the same year, the condition is maintained with the patient receiving two treatment sessions per month while continuing his medication.

Because electroacupuncture (Figure 1) was ineffective in this patient we tried moxibustion. Some patients improve with electroacupuncture alone, in others both acupuncture and moxibustion are performed, but failure to obtain improvement with either of these modalities represents an indication for surgery.

5. Conclusion

The above introduced Japanese literature allows one to conjecture that the radicular type (external type) could respond best to acupuncture, while symptoms in cases with marked deformities of the vertebrae or neurologic symptoms effects may be difficult to obtain.

Currently, because comparisons of acupuncture treatment and untreated control groups, or comparative trials with the addition of acupuncture to a conservative therapy have not yet been performed, no definite information on the scope of the merits of acupuncture treatment is available. Further, no information has yet been obtained pertaining to the effects on long-term prognosis.

Yet, appropriately performed general acupuncture treatment is considered to be a comparatively safe procedure, and in our opinion, is worthy for consideration as a possible choice in the conservative therapy of LCS.

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Kampo Medicine - Current Research

Treatment of Chronic Renal Failure with Kampo Medicine

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This used to be a disease unknown in our field, but is now encountered due to the advances in modern medicine in daily practice. Hypertension, chronic liver failure, hyperlipidemia and similar conditions are recognized as some of many currently problematic pathologic conditions. Among these, often only the terminal stages are recognized as diseases and thus subject to treatment. Examples are the collection of ascites due to liver cirrhosis or the development of uremia caused by chronic renal failure.

Famous physicians of the past have diagnosed such diseases during stages where they "are not yet manifest" and seemed to have contrived a variety of therapeutical means for curing them before reaching the terminal stage. Or else these physicians tried to extend the time required to reach the terminal stage as much as possible. Again, occasionally they may have initiated treatment in some cases after certain aspects of the terminal stage became manifest.

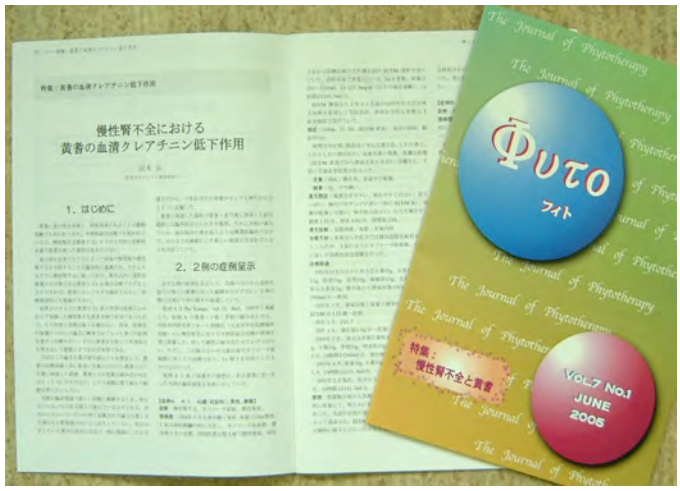
Today, due to advances in modern medicine, we are able to infer the prognosis and course of almost any disease. Yet, even though that may be possible, it still does not allow us to stop the progression of the disease. This often leaves us without any therapeutical means for its treatment.

Chronic renal failure is a classical example of such a disease. Modern medicine is making efforts to achieve its cure and new procedures like dialysis, substituting for the lost renal function, have been developed and currently benefit many people. Yet, for both therapists and patients, dialysis compares to being chained and leaves both parties wishing for more freedom. However, even though the gradually declining renal function and simultaneously gradually increasing BUN and creatinine concentrations can be controlled to some degree by rigorous diet and the application of Kremezin (spherical carbonaceous absorbent), the disease relentlessly destroys these therapeutic efforts and pushes the patient towards dialysis.

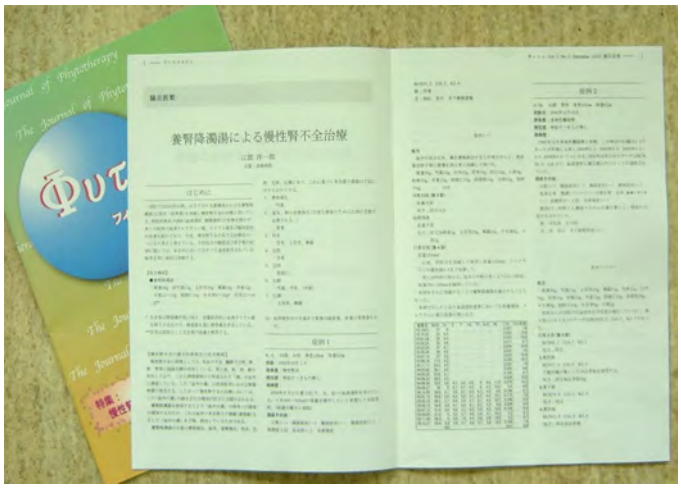
Modern Kampo medicine has become able to treat several renal diseases that will lead to chronic renal failure from the stage "where they are not yet manifest". The question now is, whether there are also therapeutic tools and techniques applicable to the terminal stage of chronic renal failure.

The answer to this question has recently been provided by two Kampo specialists who have published two outstanding reports:[1,2)]

Picture 1: Hajime Haimoto, Serum Creatinine Level Lowering Effects of *Astragali* Radix in Patients with Chronic Renal Failure Φυτο Vol. 7, No. 1, p4-9, 2005



Picture 2: Yoichiro Ebe, Clinical Experiences Using the *yojinkodakuto(Nourishing the Kidney and Depressant Turbid Dampness Decoction* in Patients with Chronic Renal Failure Φυτο Vol. 7, No. 2, p4-11, 2005



1. Dr. Haimoto's work

Haimoto, at the beginning of his work, describes clinical examples he experienced himself. Based on two specific cases, he is now convinced that *Astragali* Radix is capable of lowering the creatinine concentration.

In the first patient, in whom the chronic renal failure was due to membranous nephropathy, administration of *Astragali* Radix resulted in a drastic increase in urine volume that led to a decrease in creatinine. The second patient suffered from uremia caused by chronic nephritis. When treatment with Kampo medicine did not produce any improvements at all, addition of *Astragali* Radix to the prescription also resulted in an abrupt decrease in the creatinine concentration (within one month from 8.8 mg/dl to 7.4 mg/dl.)

Based on these results, Haimoto thought that the use of *Astragali* Radix alone might be able to induce a decrease in creatinine concentration and thus started the following research.

Serum creatinine level lowering effects of *Astragali* Radix in patients with early chronic renal failure.

Ten patients (one of these dropped out of the study because of the development of efflorescences) with early chronic renal failure who consulted his clinic between February 2002 and February 2005, were treated with a combination of 3-4 crude drugs centering on *Astragali* Radix. Observations of the patients showed that underlying diseases of the patients varied widely.

This treatment resulted in a decrease in creatinine concentration by 0.3-0.9 mg/dl and the effect continued over a prolonged time. The effects of *Astragali* Radix appeared after a rather short period (within 2 months) and a gradual decrease of the initially high creatinine levels continued even over an observation period of more than 2 years. In patients with initially low values, the concentration fell to the upper limit of the normal range, but subsequently did not improve any further. Changes in serum potassium levels were not observed.

Among the nine patients observed, one presented a particularly interesting case. The patient was a 62-year old man with an initial creatinine level of 1.3 mg/dl. From the age of 56, the value started to increase gradually and reached 1.7 mg/dl by the age of 61. At that stage, treatment with *Astragali* Radix and several other crude drugs, did not produce any improvement; but when *Paeoniae* Radix Rubra was added to the prescription, the concentration decreased after one month to 1.21.
Based on this experience this researcher concluded that a combination of *Astragali* Radix + *Paeoniae* Radix Rubra would be even more effective.

Summarizing the above described results shows that Haimoto proposed the following protocol for the treatment of patients with early chronic renal failure: "In patients with chronic renal failure first administer *Astragali* Radix (15-30 g) (where even the administration of *Astragali* Radix alone is effective, as Haimoto's case report presented in the previous issue clearly shows[3]). However, when the administration of *Astragali* Radix alone does not induce a decrease in the creatinine level, *Paeoniae* Radix Rubra (10-15 g) is added. If the creatinine concentration still does not fall, *Rhei* Rhizoma is added."

Table 1 shows the variations in serum creatinine and potassium(K) observed in 9 patients who were treated with Kampo medications by Haimoto. The underlying diseases in these patients included a variety of diseases like chronic nephritis, IgA nephropathy, diabetic nephropathy and unknown causes (suspected drug induced nephritis). The prescriptions used for these patients all contained 15-30 g of *Astragali* Radix. For patients for whom an improvement in proteinuria is imperative, 10-15 g of *Imperatae* Rhizoma and 15-35 g of *Houttuyniae* Herba were added. In patient No. 4, *Astragali* Radix alone did not produce any improvement, but after addition of *Paeoniae* Radix Rubra a successful reduction of the creatinine concentration was

achieved.

Table 1 Variations in serum creatinine and potassium(K) in 9 patients receiving Kampo treatment

No.	Sex	Age	Cr/K before medication	After 2 months	After 6 months	After 9 months	After 12 months	After 24 months
1	F	65	1.9／5.7	2.0／5.6	—	1.6／4.2	1.6／4.3	
2	M	76	2.8／4.9	2.2／4.7	2.1／	—	2.1／4.6	1.9／5.0
3	M	61	1.9／6.7	1.7／5.6	1.7／5.2	1.5／6.8**	1.3／4.8	1.5／5.6
4	M	61	1.7／4.7	1.9／4.5	1.8／4.8	1.5／5.2	1.4／	
5	M	56	1.6／4.7	1.1／	1.1／	1.2／4.5	1.2／4.5	
6	F	59	2.3／4.1	2.1／4.3	1.9／4.4	1.8／4.9	1.7／4.5	
7	M	72	1.7／4.8	1.3／4.8	1.3／4.1			
8	M	39	1.6／4.8	1.4／4.3	1.4／4.4	1.3／4.4	1.2／4.9	1.9*／4.8
9	M	61	2.9／5.3	2.6／5.6				

* Patient discontinued Kampo medication on his own initiative

** Start of rigorous low potassium diet

New applications of old methodology

In the dawn of the Kampo medical age, prescriptions did not exist right from the beginning, but the effects of each individual crude drug were doubtlessly confirmed separately. Records of such activities of ancient people may still be found in the "Shen Nong (Shinno) Legend", describing a legendary forefather of pharmacotherapy who allegedly tested 100 plant species per day on himself to confirm their effects. Kampo preparations are composed of individual crude drugs whose effects are well known. Haimoto also discovered that *Astragali* Radix lowers creatinine concentration through confirmation of the effects of each individual crude drug.

The process of this discovery was a dramatic one and reading through that work is very rewarding. This discovery not only represents a great blessing for patients with chronic renal failure, but will also make a major contribution to the research in this field. In a field where diseases are considered to be incurable by modern medicine, this finding may represent the appearance of a new therapeutic drug. This circumstance can only be described as the emergence of a new research field.

2. Ebe's new preparations

Yoichiro Ebe, who is also known as the developer of the classical formulation theory, has discussed chronic renal failure from a point of view of this classical formulation theory, "*yojinkodakuto (Nourishing the Kidney and Depressant Turbid Dampness Decoction)*" for the treatment of intractable diseases. Theoretically one of the active ingredients of this preparation is *Astragali* Radix. Ebe's approach differs completely from that of Haimoto, but the conclusions reached resemble each other very closely.

Ebe with his joint researchers, Hashimoto, et al., has reported improvements achieved with the use of this preparation in three patients with chronic renal failure in the Clinical Journal of Chinese Medicine Vol. 25, No. 4, (2004), later 7 other patients in Vol. 26, No. 1 (2005) and finally introduced 13 cases in the『Φυτο』Vol. 7, No. 2, (2005). The underlying diseases in these patients included such diversified conditions as chronic nephritis, gouty nephropathy, diabetic nephropathy, multicystic renal cysts etc. regardless of whether they were of renal or postrenal nature. Moreover, the course of the individual conditions in these patients closely resemble those described by Haimoto, although they included more severe cases

than the patients described by Haimoto. These reports also describe patients in which the creatinine concentration did not rise even after 3 years of treatment, but on the contrary tended to decrease and the condition did not progress for more than a year, although the patients had already been in the preparatory stage for dialysis. In patients who were already on a dialysis regimen, an increase in urine volume led to improvements in the creatinine concentration, so that it was in some cases even possible to decrease the frequency of the dialysis.

In order to comprehend this preparation it is necessary to master the classical formulation theory. Since this theory represents a very detailed system, it is difficult to represent it here in a simplified form. Here I would like to restrict myself to the presentation of my conclusions. People who do no know the entire theory will be able to obtain certain results using the below described formula.

Yojinkodakuto(Nourishing the Kidney and Depressant Turbid Dampness Decoction)

Astragali Radix	30 g
Paeoniae Radix Rubra	15～30 g
Smilacis Rhizoma	30 g
Dioscoreae Hypoglaucae Rhizoma	10 g
Salviae Miltiorrhizae Radix	12 g
Pinellia Tuber	12～15 g
Trichosanthes Semen	10 g
Glycyrrhizae Radix	6～15 g*
Poria	12～30 g**

* In addition to the renal protective activity of *Glycyrrhizae* Radix there is also a dose dependent serum potassium lowering effect, so that its dose should be determined based on the laboratory values.

** *Poria* is basically used in twice the amount of raw licorice.

Ebe lists the following precautions pertaining to the use of this preparation.

1. *Imperatae* Rhizoma (bai mao gen) may aggravate the renal failure and its effect may last in some cases up to 3 months. Since the pharmacologic actions of *Imperatae* Rhizoma are heat clearing, detoxification and draining damp, this drug is frequently used in Chinese medicine for the treatment of chronic renal failure. Yet, based on past experiences, it has become clear that this drug may aggravate chronic renal failure. Even though founded on known Chinese medical drug effects, new crude drugs should be added to this preparation very carefully.
2. Since Kremezin absorbs ingredients compornents of herbs, a combination therapy with this preparation may obscure the effects of the Kampo preparation.
3. In case of dermal efflorences caused by *Astragalus membranaceus* Bunge or Astragalus mongholicus Bunge is said to range generally between 1 and 3%. In patients with renal failure this ratio reached approximately 10% (4/38), indicating that the said incidence may increase. (Author's note: in the case of astragalus induced efflorences, it might be beneficial to switch the prescriptions to Hedysarum polybotrys Hand.-Mazz.)
4. *Yojinkodakuto* apparently does not affect renal anemia. Conversely, in patients with severe anemia marked by a hemoglobin value of less than 7.0 g/dl, it may induce nephrocyte apoptosis or necrosis and thereby further aggravate the renal failure. With the use of this drug under these circumstances, improvements in creatinine concentration or similar parameters are not observed. Accordingly, it is essential to treat anemia with erythropoietin.
5. Generally, when treating renal failure with Kampo medicines there is a fear of increasing potassium uptake. Yet, raw *Glycyrrhizae* Radix has a dose dependent serum potassium lowering effect allowing control of the potassium level based on serum potassium concentration.
6. In dialysis patients, the use of this preparation induces a decrease in creatinine concentration, an effect that is even observed in almost anuretic

patients. In some cases, it may further increase urine volume.

Above, I introduced the treatment patterns of Haimoto and Ebe for chronic renal failure. As stated at the beginning of the paper, there are no other actively pursued treatment alternatives apart from dialysis and so far nobody believed in the existence of drugs or preparations that might improve the creatinine values. However, the work of these two researchers has clearly shown that preparations centering around *Astragali* Radix are apparently capable of producing at least a certain degree of improvement, the effects of which continue for prolonged periods of time. Although these practitioners used completely different approaches, the conclusions they arrived at were remarkably similar.

These two dissertations provide good news for patients suffering from chronic renal failure.

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Clinical Report 1 (Japan)

Acupuncture for Painful Diabetic Neuropathy

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Key words : painful diabetic neuropathy, low frequency electroacupuncture stimulation, current perception threshold, diabetes mellitus

Abstract

In the present study I investigated the effects of acupuncture treatment on the pain of diabetic neuropathy and parsesthesia as well as the duration of the morbidity and treatment results. Acupuncture treatment induced variations in the current perception threshold (CPT) were also examined. The study examined subjective symptoms associated with diabetic neuropathy (like spontaneous pain and parsesthesia) in 38 patients (divided into a 20-patient group treated with acupuncture and an 18-patient drug treatment group) were treated both for one month with either one acupuncture session per week or pharmacologically. The results showed that the duration of the morbidity was on the average rather short, namely approximately 8 years. In patients during the hyperalgesic period, changes in subjective symptoms (VAS) was significantly better in the acupuncture treatment group than in the drug treatment group. Moreover, threshold measurements using CPT revealed a decrease in the threshold of C fibers (5 Hz), resulting in a comparatively early treatment induced increase of this threshold.

Introduction

Acupuncture has usually been performed in our facility for patients with rheumatism or diabetic neuropathy and effects like improvements in pain, range of motion as well as alleviation of the paresthesia are observed. Many reports have already shown that acupuncture treatment effectively can alleviate pain and paresthesia, but very few reports deal with the mechanisms of these effects. Improved blood flow or elevated pain thresholds are conceivable foundations for these effects, but research into common features are still yielding no clear results.

In recent years the current perception threshold device has been developed for the objective measurement of sensory thresholds[1]. This current perception threshold device does not cause the patient any pain and separates between Aß, Aδ and C fibers and can analyze hyperesthesia, hypoesthesia, pain and other abnormal perceptions simultaneously. The absolute values of the relevant parameters may serve as evaluation criteria etc. They allow observation of the course of disorders of perception and permit an easy evaluation of the conditions before and after treatment. While in the past it was necessary to rely entirely on the patient's subjective assessments, this device allows accurate evaluation of the therapeutic effects. We believe that the reliability of its application in pain clinics has been verified[3-4]. Since this technique utilizes the fact that nerve conduction velocity varies among the different types of nerves, it is possible to selectively stimulate and measure large caliber myelinated nerve fibers (mainly Aß fibers), intermediate myelinated nerve fibers (mainly Aδ fibers) and unmyelinated nerve fibers (mainly C fibers) by applying alternating currents with specific frequencies to the measurement sites. This permits evaluation of the degree of pain, prognosis, establishment of treatment policies, observation of the therapeutic course and evaluation of the results.

In the present study, I investigated the correlation between acupuncture effects on pain and paraesthesias in patients with diabetic neuropathy as well as the duration of the morbidity and treatment results. Acupuncture treatment induced variations in the current perception threshold (CPT) were also examined.

I. Materials and methods

1. Subjects

The study examined subjective symptoms associated with diabetic neuropathy (like spontaneous pain and parsesthesia) in 38 patients (divided into a 20-patient group treated with acupuncture and an 18-patient drug treatment group). Both were treated for one month with either one acupuncture session per week or pharmacologically. All 38 patients were treated with orally applied insulin in order to control blood sugar and the subjects of the comparison in this

study were pharmacologic and acupuncture treatments. A written informed consent was obtained from all patients.

2. Acupuncture treatment

(1) Treatment purpose

Changing pain threshold and improving peripheral circulation

(2) Acupuncture treatment

Diabetic neuropathy is often associated with symptoms like pain or numbness in peripheral innervation areas and acupuncture treatment provides mainly a stimulation of peripheral nerves. Needles are inserted into acupoints in the periphery and are then either quietly retained or else electrically stimulated in order to stimulate the peripheral nerves. For this purpose, the needles are inserted in the vicinity of nerves and then electrically stimulated using a pulsed current with a frequency of 1 Hz. This treatment provides selective stimulation of nerve tissues. Whether the nerves in question are correctly stimulated is confirmed in praxis by observing contractions of the muscle groups innervated by that particular nerve. During the treatment of real patients, it was assured that they (1) understood the fact that upon needle insertion a feeling of numbness at the insertion site or a propagated sensation ("de qi") may spread along the course of the nerve. (2) Prior to applying the electrically current the patients are instructed that the treatment will result in muscle contractions.

The acupoint Naikan (PC6) on the arm is used to stimulate the median nerve, the point Kousai (LU6) to stimulate the radial nerve, and the point Shokai (HT3) to stimulate the ulnar nerve. On the legs the acupoint Ichu (BL40) is used to stimulate the tibial nerve, the point Yoryosen (GB34) to stimulate the superficial peroneal nerve and the point Ashi Sanri (ST36) to stimulate the deep peroneal nerve, while the points Shofu (BL36) and Inmon (BL37) can be used to stimulate the sciatic nerve. Specifically, for patients complaining about numbness of the soles of the feet, stimulation of the tibial nerve via Ichu elicits a feeling of "de qi" along the posterior aspect of the lower leg and into the soles. Later, application of electrical stimulation leads to contractions of the tricips surare muscle, observable as plantar flexion at the ankle. Currently, knowledge obtained through basic research into the mechanisms of electroacupuncture stimulation suggests that this treatment modality improves the blood circulation in the nerves as well as peripheral circulation, which is reportedly also associated with the release of chemical mediators (substance P, CGRP)[4-5]. Clinically improvements in local dermal as well as intramuscular blood flow are observed[6-7]. Paresthesias like the pain and numbness of diabetic neuropathy are hard to bear and thus significantly impair the QOL of the patients. Thus, the improvement in symptoms non-invasive treatment modalities like acupuncture and moxibustion or electroacupuncture can provide is considered to be of great significance[8].

(3) Evaluation methods

Table 1 shows that the evaluation methods are based on scores for spontaneous pain and numbness, providing evaluations for each disease stage. For variations in the subjective symptoms, the visual analogue scale (VAS) was used, simultaneously observing variations in blood sugar and HbA1c. In the 20 patients of the acupuncture treatment group, changes in current perception threshold (CPT) were also examined.

Moreover, based on the natural history of diabetic neuropathy, the disease stages were classified according to the state of the superficial perception. According to this classification the period of 10 years from the initial changes until appearance of symptoms, during which hyperesthesia developed, was defined as stage 1. The emergence of changes during an intermediate period from 10 to 20 years characterized by a decrease in pain perception associated with an increase in pressure pain sensitivity was designated stage 2. Changes occurring later, characterized by a decrease in pressure pain perception, were designated stage 3. Changes from hypersensitive pain perception to a decrease in pain perception are followed by similar changes from hypersensitivity of pressure pain perception and a subsequent decrease. From a point of view of functional anatomy, these phenomena are considered

to reflect changes ranging from dysfunction to hypoactivity that develop due to functional disturbances of the thinnest sensory nerve fibers (Aδ, C fibbers) of the free nerve endings and a decrease in the functionality of the thick sensory nerve fibers (Aß fibers) of sensory receptors. In the present study the differences in therapeutic effects for painful diabetic neuropathy were examined classified according to the above described disease stages.

II. Results

(1) Background factors

Table 2 shows the background factors for the 20 patients in the acupuncture treatment group and the 18 patients in the drug treatment group. A written informed consent was obtained from all 38 patients. The age in both groups was the late 50s, duration of the morbidity approximately 8 years, and the degree of obesity (BMI) in both groups 23-24. A breakdown of disease stages in the acupuncture treatment group showed 8 patients with stage 1, 4 patients with stage 2, and 8 patients with stage 3. A similar breakdown for the drug treatment group showed 7 patients with stage 1, 3 patients with stage 2, and 8 patients with stage 3, revealing no particular bias in the two groups. Blood sugar and HbA1c also showed about the same values.

(2) Results

1) Table 3 shows the ratio of improvement in subjective symptoms after one month of treatment. Regarding spontaneous pain and numbness of the legs, the ratio of results better than "improvement" (an improvement of more than 2 scores) was in the acupuncture treatment group for the spontaneous pain 50% (10/20) and in the drug treatment group 44% (8/18). Classified by disease stages, the results showed that in the acupuncture treatment group a marked improvement was found in 4 out of the 8 patients with stage 1, improvement in 2 patients and slight improvement in 2 patients. In patients with stage 2, a marked improvement was observed in 1 out of 4 patients, improvement in 1 and slight improvement in 2 patients. In patients with stage 3 an improvement was observed in 2 out of the 8 patients, a slight improvement in 2 patients, while the condition remained unchanged in 3 and worsened in 1 patient.

In the drug treatment group on the other hand, a marked improvement was observed in 3 out of the 7 patients with stage 1, improvement in 2 patients and slight improvement in 2 patients. In patients with stage 2, an improvement was observed in 1 out of 3 patients and a slight improvement in 2 patients. In patients with stage 3 an improvement was observed in 2 out of the 8 patients, a slight improvement in 1 patient, while the condition remained unchanged in 4 and worsened in 1 patient. No significant differences pertaining to the efficacy were observed between the two groups. Comparison of the efficacy classified according to disease stage showed that effects were better in patients with stage 1 than in patientswith stages 2 or 3. In patients with stage 1, therapeutic effects during the hyperalgesic phase could be achieved comparatively early, while many patients with stage 3 tended to be rather resistant to acupuncture therapy due to a decrease in nociception and progressive neuropathies during the phase of sensitization of pressure pain.

2) Regarding changes in subjective symptoms, the VAS (Figure 1) showed for the drug treatment group a reduction in the score from 5.1±1.3 prior to the treatment to 4.2±1.4 after the treatment. The corresponding values in the acupuncture treatment group was a score of 4.8±1.5 prior to the treatment, falling to 3.3±0.9 after the treatment. This represents a statistically more significant improvement in the acupuncture treatment group.

3) Regarding variations in blood sugar and HbA1c values (Table 4) no differences were found between the two groups.

4) The incidence of adverse reactions observed in the acupuncture treatment group was 15% (3/20: local bleeding in 2 patients, dull pain in 1 patient), and 24% in the drug treatment group (4/18: digestive tract symptoms in 3 patients and vomiting in 1 patient).

5) Regarding the variations in the current perception threshold of the second digit of the foot in acupuncture treatment group (CPT, 18 patients, Figure 2) a decrease in the 5-Hz threshold (C-fibers) was observed and thus a significant acupuncture treatment induced increase in threshold was found. This change was not

observed at 2,000 Hz (Aß fibers) or 250 Hz (Aδ fibers) and showed that the increase in threshold occurred only at 5 Hz. The electric stimulation applied through acupuncture decreased the threshold of the damaged thin, unmyelinated C fibers, suggesting that it may be effective during this state of decreased threshold.

III. Discussion

In the present study, the effects of acupuncture treatment on diabetic neuropathy were examined and compared in a comparative clinical trial with anti-inflammatory drugs, vitamin B preparations and similar pharmacotherapies. The diabetic neuropathies are considered to be due to the demyelination of remaining myelinated nerve fibers caused by a continuous insulin insufficiency induced hyperglycemia. Thus, the condition is characterized by a variety of symptoms depending on the state of diabetes control, duration of the morbidity and severity of the impairment.

In the present study, the duration of morbidity with 8 years was comparatively short and the results of acupuncture treatment, as manifested in the subjective symptoms (VAS), for complaints of peripheral numbness were found to result in significantly better improvement than with drug treatment. Moreover, threshold measurement with a CPT device revealed a decrease in the threshold of C fibers (5 Hz) and a comparatively early rise in threshold after initiation of the treatment. In patients with prolonged morbidity, often a decrease in Aß and Aδ fiber threshold was observed, suggesting that large and intermediate caliber myelinated nerve fibers were affected, which in turn also tended to result in a variety of paresthesias and delayed healing. Yet, performance of electroacupuncture produced, although only temporarily, an increase in the threshold of the Aß and Aδ fibers. This suggests that the described phenomenon might help to explain the pain mechanisms. As one of these mechanisms, the relevant peripheral nerves and sections in the spinal cord, are inhibited by substance P, where the decreased pain is due to an increase in sensitivity threshold.

IV. Conclusions

In addition to the above described diabetic neuropathies, the condition is aggravated by acute changes due mainly to demyelination during the different disease stages, which then conceivably lead to the development of various forms of pain and paresthesias. For this reason, it is necessary to choose the appropriate treatment form for each individual disease stage. The present study revealed that acupuncture treatment can possibly alleviate symptoms associated with decreased pain sensation and hypersensitive pressure sense caused by progressive neuropathies encountered during stages 2 and 3, but not necessarily for symptoms mediated via the limbic system. However, effects of the treatment for hyperalgesia during stage 1 can be elicited comparatively early. This could possibly contribute to an improvement in the QOL of patients with painful diabetic neuropathy and thus suggests that this could be the treatment modality of first choice.

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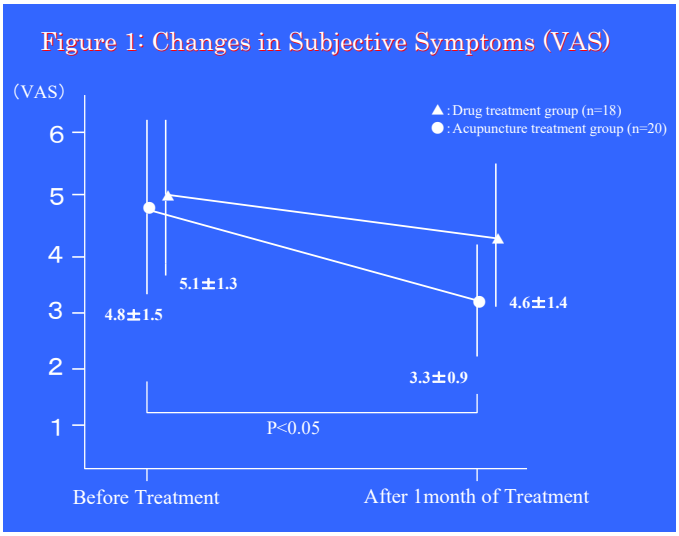


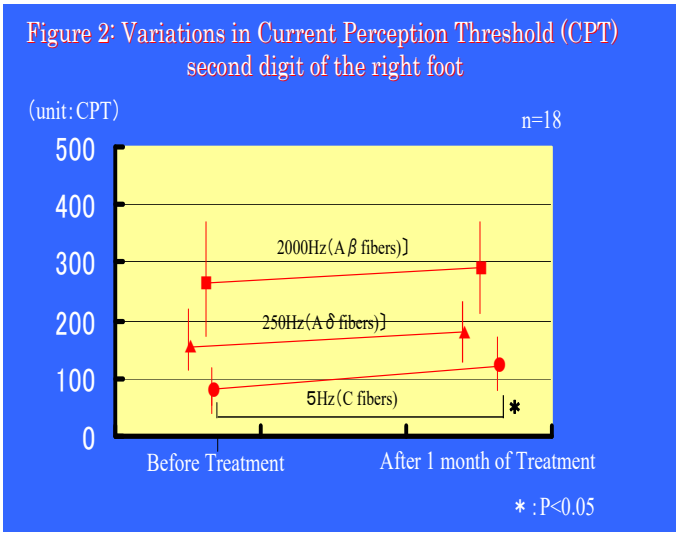


Table 1 Score criteria for spontaneous pain and numbness

Score	Severity	Symptom
6	+ + +	Extremely severe
5	+ + +	Severity between 6 and 4
4	+ +	Strong
3	+ +	Severity between 4 and 2
2	+	Weak
1	+	Severity between 2 and 0
0	-	None

Score Criteria:

The improvement in spontaneous pain at the time the medication was completed (including cases when treatment was discontinued) was evaluated according to the following five evaluation criteria as "marked improvement", "improvement", "slight improvement", "unchanged" and "aggravation".

Marked improvement: when the score decreased from 6,5,4,3 -> 0

Improvement: when the score decreased from 6,5,4,3 -> 1,2, or else a change from 6->3

Slight improvement: when the score decreased in other increments than the above described by 1 or 2 steps

Unchanged: no change in score

Aggravation: when the score increased.

Table 2 Patient backgrounds

	Acupuncture treatment group	Drug treatment group
Number of Patients	20	18
Classified by sex	13 men, 7 women	11 men, 7 women
Age	58.7±10.7	55.9±14.4
Height	159.9±11.1	162.4±12.8
Weight	61.2±12.1	65.7±15.6
Obesity (BMI)	23.8±3.2	24.1±4.2
Classifiation of pathology	NIDDM (20)	NIDDM(18)
Duration of morbidity	8.7±4.8	8.1±5.3
Disease stage 1	8	7
Disease stage 2	4	3
Disease stage 3	8	8
Disease stage 4	0	0
Fasting blood glucose	157.1±56.5	161±73.6
HbA 1c (%)	7.6±2.5	8.0±2.4

Table 3 Improvement in spontaneous pain and numbness of the leg

Variations in the severity of symptoms (score)					
	Marked improvement	Improvement	Slight improvement	Unchanged	Aggravation
Acupuncture treatment group (20 patients)					
Disease stage 1 (8 patients)	4	2	2		
Disease stage 2 (4 patients)	1	1	2		
Disease stage 3 (8 patients)		2	2	3	1
Drug treatment group (18 patients)					
Disease stage 1 (7 patients)	3	2	2		
Disease stage 2 (3 patients)		1	2		
Disease stage 3 (8 patients)		2	1	4	1

Table 4 Variations in blood glucose and HbA1c values

		Before treatment	After 1 month
Drug treatment group (18 patients)	Blood glucose (mg/dl)	161±73.6	152±88.2
	HbA1c (%)	8.0±2.4	8.3±3.1
Acupuncture treatment group (20 patients)	Blood glucose (mg/dl)	157±56.5	150±69.9
	HbA1c (%)	7.6±2.5	7.9±2.1

Acupuncture treatment performed at the University of Tokyo Hospital

1. History of acupuncture and moxibustion treatment at the University of Tokyo Hospital

Research into acupuncture and moxibustion started at the University of Tokyo Hospital in the 1960s in the Department of Rehabilitative Medicine (usually: iatrophysics). Dr. Yoshiaki Oshima, at that time a professor in the department, took the lead in the research and published numerous papers pertaining to the electrical resistance at acupoints. At that time, there was not yet a department treating patients using this modality. All activities were performed strictly for research purposes.

The Department of Rehabilitative Medicine (usually: iatrophysics) was established in 1926 and thus can look back on a long history. As a department conducting physical therapy, it was a unique department in that it used physical energy forms for its therapies to trigger natural healing powers. Clinical studies about acupuncture and moxibustion as a form of oriental medical physical therapy were initiated later. Treatment of outpatients started around 1980.

In 1996, a reorganization of the Department of Rehabilitative Medicine led to a division into departments of allergology and rheumatism, respiratory diseases, digestive diseases and cardiovascular diseases. The division performing acupuncture and moxibustion treatment was affiliated with the Department of Allergology and Rheumatic Diseases, because many of the treated patients presented with rheumatic diseases. It started its operation in March 2002. From April 2002, occupational therapy performed for the Department of Orthopedics and Psychiatry provided by the central rehabilitation service was combined with the section of physical therapy of the Department of Allergology and Rheumatic Diseases. Currently, the Department of Rehabilitative Medicine, division for physical therapy (acupuncture and moxibustion section) has a staff of 5 full-time employees, 5 acupuncture and moxibustion clinical trainees and 2 foreign students and is thus involved in clinics, research and education.

2. Acupuncture and moxibustion treatment

The acupuncture and moxibustion outpatient treatment in the Department of Rehabilitative Medicine, division of physical therapy of the University of Tokyo Hospital is offered from Monday to Friday from 9:00 in the morning to 3:00 in the afternoon and in-patients are treated similarly from 3:00 to 5:00 in the afternoon.

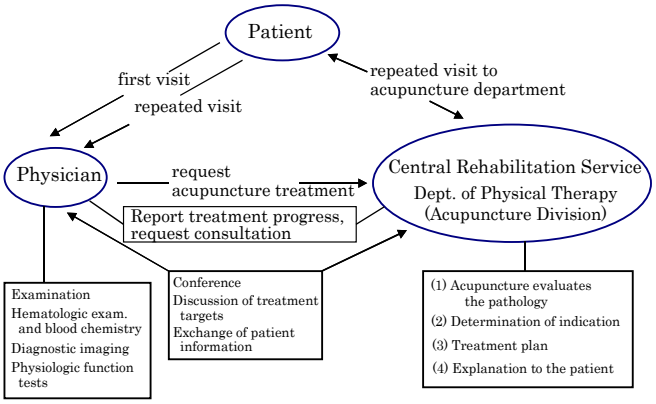
Patients are first seen by the relevant physician in charge at this hospital. Based on the judgment of this physician and the wish of the patient, the division of physical therapy in the Department of Rehabilitative Medicine receives a request for treatment and an acupuncturist initiates the therapy by conducting an interview with the patient and performs physical examinations (Figure 1).

Later, our department reports the results to the physician in charge and requests consultations if indicated. During conferences with the physician(s), treatment policies are decided, the acupuncture treatment discussed and information exchanged. The merit of performing acupuncture and moxibustion treatment in a university hospital is based on discussions of the hematologic, diagnostic imaging and similar data by specialized physicians and a comparison with other treatment modalities. Such an opportunity to discuss all the symptoms and other diseases of the same patient with the specialized physician is highly valued.

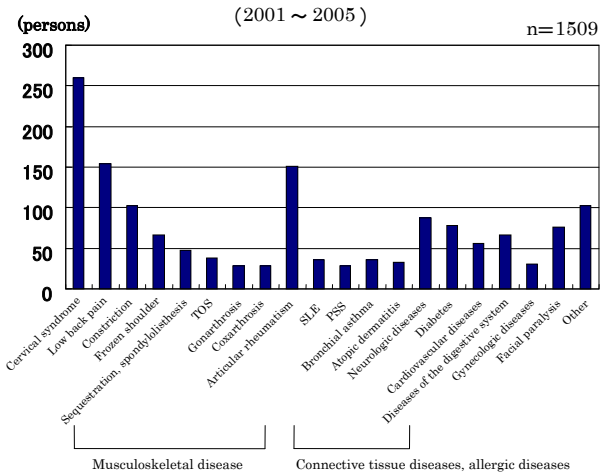
The number of outpatients visiting the facility is about 40 per day. A breakdown of the complaints shows a ratio of about 60% for diseases of the locomotor system (cervical spondylosis, low back pain, periartheritis humeroscapularis and similar rheumatic diseases), a ratio of about 20% for allergic and rheumatic diseases and beside those conditions neurologic diseases, diabetes, cardiovascular disease etc. Recently, an increasing trend has been observed for the number of patients presenting with diabetes, gynecologic and obsterical diseases (Graph 1).

Among the stationary patients, articular rheumatism is the most frequent condition, followed by cancer pain or the pain after a compression fracture due to osteoporosis. The Department of Allergology and Connective Tissue Diseases is also the leading department regarding the number of filed requests for manual acupuncture and moxibustion treatment (50%), followed by the Department of Gynecology and Obstetrics with requests for patients with cancer pain and the Department of Rradiology (Graphs 2, 3).

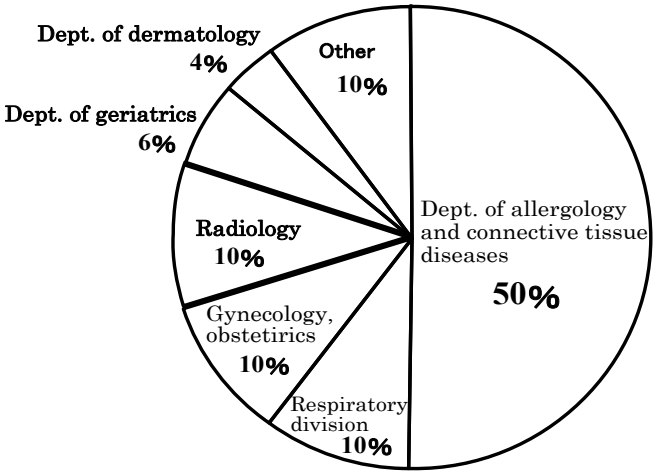
Figure 1: Overview of acupuncture treatment perfomed in the University of Tokyo Hospital



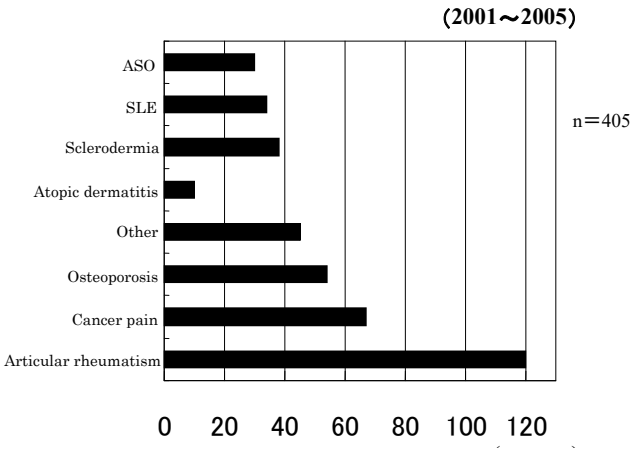
Graph 1: Breakdown of outpatients by diagnosis



Graph 2: Department requesting admission



Graph 3: Diseases of admitted patients



Clinical Report 2 (Japan)

Effective Treatment of Gouty Nephropathy Induced Chronic Renal Failure with the "Yojinkodakuto(Nourishing the Kidney and Depressant Turbid Dampness Decoction)"

Yoichiro Ebe
Takao Hospital

Patient: 51 years, male
First visit: October 28, 2004
Underlying disease: gouty nephropathy
Anamnesis: hyperuricemia
Present illness:

The patient had been treated for gout at a different clinic for about 10 years and approximately 4 years ago renal failure had been pointed out. In December 2003, the serum creatinine level was 4.8 mg/dl, but had increased to 5.1 mg/dl by October 27, 2004, when the patient visited our clinic. Treatment in the other clinic consisted of diet (protein restriction to 30-40 g protein per day) and treatment with Espo (epoetin alfa) injections, 4 g of Kremezin (spherical carbonaceous absorbent) per day), Norvasc (amlodipine besilate), Persantin (dipyridamole) and Zyloric (allopurinol).

Current condition, others: height 170 cm, weight 66 kg
Dry mouth (-), cranial symptoms (-), thoracic symptoms (-), gastric symptoms (-), abdominal symptoms (-), cold feet (-), easy fatigability (-), normal stools, small urine volume.
BUN 32.3 mg/dl Cr4.8 mg/dl K4.4 mEq/l
Pulse: thin, slippery; left-sided wiry and slippery
Tongue: faint pale red, white fur

Prescription:

Astragali Radix	20g
Hedysarum Radix	12g
Paeoniae Radix	15g
Smilacis Rhizoma	30g
Dioscoreae Hypoglaucae Rhizoma	10g
Atractyrodis Rhizome	15g
Poria	15g
Ostreae Testa	15g
Pinellia Tuber	15g
Trichosanthes Semen	10g
Salviae Miltiorrhizae Radix	12g
Zingiberis Rhizoma Processum	6g
Rhei Rhizoma	2g
Aconiti Radix Processa	3g

Treatment for 14 days
Continued treatment with Kremezin.

Course: On November 11, 2004: BUN 32.9 mg/dl、Cr4.9 mg/dl、K3.7 mEq/l
No marked changes. Constipation
Prescription: same prescription (excluding *Ostreae* Testa and *Aconiti* Radix Processa, adding 10 g of *Polyporus*, 12 g of *Stephania tetrandra* Radix, 6 g of *Glycyrrhiza* glabra); modified to use 30 g *Astragali* Radix and 1 g of *Rhei* Rhizoma.
BUN 43.9 mg/dl; Cr4.2 mg/dl K3.9 mEq/l
Heavy feeling on the stomach (+), decreased appetite (+)
Prescription: same prescription (adding 6 g of *Foeniculi* Fructus, 10 g of *Tritici* Fructus)
Treatment for 14 days
Considering the possibility that the Kampo medicine may be adsorbed to Kremezin, the 2 g of the drug is taken before sleep.
December 17, 2004
BUN 46.7 mg/dl Cr4.2 mg/dl K3.5 mEq/l
Prescription: same prescription (excluding *Stephania* tetrandra Radix); modified to use 4.5 g of *Glycyrrhizae* Rhizoma and 0.5 g of *Rhei* Rhizoma.
Treatment for 7 days.
Discontinued Kremezin.
December 24, 2004
BUN 44.4 mg/dl Cr3.8 mg/dl K4.0 mEq/l
After that the patient came once every two weeks for consultation and examination, but each time both creatinine and BUN levels, 3.3 – 3.5 mg/dl and 35 – 40 mg/dl respectively, remained stable (as of May 25, 2006) (see Table 1)
Prescription on May 25, 2006

Astragali Radix	30g
Paeoniae Radix	15g
Smilacis Rhizoma	30g
Dioscoreae Hypoglaucae Rhizoma	10g
Salviae Miltiorrhizae Radix	12g
Glycyrrhizae Radix	6g
Pinellia Tuber	15g
Atractyrodis Rhizoma	10g
Poria	10g
Salviae Miltiorrhizae Radix	12g
Tritici Fructus (Malt)	10g
Foeniculi Fructus	6g
Silkworm Excrement	10g

Discussion

This was a patient with gouty nephropathy and an underlying chronic renal failure treated with "Nourishing the Kidney and Depressant Turbid Dampness Decoction". The amounts of component crude drugs in the formula were modified as required and the patient observed over a period of more than 1.5 years, during which time the serum creatinine concentration could be decreased form 4.8 mg/ml to 3.3 - 3.5 mg/dl. This preparation is effective regardless of the underlying disease, but here it could be confirmed that it is also effective for renal failure caused by gouty nephropathy. When the Kremezin used up to that time was discontinued during the course, a decrease in the creatinine level was observed. Based on these results I believe that Kremezin may have adsorbed the Kampo medicine and thus weakened its effects. These results clearly indicate that serum creatinine levels can be sufficiently lowered even without the use of adsorbents.

Table 1: Fluctuations in laboratory values of this patient

Number of visits	Examination days	BUN	Cr	K	P	UA	TP	ALB	Hb	1/Cr	CCr
0	04.10.28	32.3	4.8	4.4	3.9	9.5	8.0	4.6	12.1	0.208	17.0
14	04.11.11	32.9	4.9	3.7	4.4	9.4	7.2	4.1	10.9	0.204	16.6
42	04.12.09	43.9	4.2	3.9	4.8	8.3	7.6	4.3	10.7	0.238	19.4
50	04.12.17	46.7	4.2	3.5	3.9	7.9	7.5	4.3	0	0.238	19.4
57	04.12.24	44.4	3.8	4.0	4.5	7.6	7.7	4.5	0	0.263	21.5
80	05.01.16	41.5	4.1	3.8	3.9	7.3	7.6	4.4	10.9	0.244	19.7
84	05.01.20	34.2	3.9	4.2	4.6	6.8	7.5	0	11.0	0.256	20.7
98	05.02.03	26.0	3.8	4.1	4.1	7.1	7.4	4.4	11.1	0.263	21.2
112	05.02.17	34.7	3.9	4.3	4.2	7.2	7.1	4.3	10.7	0.256	20.7
126	05.03.03	30.5	3.8	3.8	3.9	6.9	7.0	4.2	10.9	0.263	21.2
140	05.03.17	32.7	3.8	4.1	4.7	6.5	7.2	4.2	11.4	0.263	21.2
154	05.03.31	37.2	3.6	3.9	4.9	6.8	6.7	3.8	11.0	0.278	22.4
168	05.04.14	33.1	3.5	3.9	4.2	6.9	6.3	3.8	11.1	0.286	23.0
182	05.04.28	32.2	3.6	4.1	4.2	6.5	6.0	3.6	10.7	0.278	22.4
196	05.05.12	36.2	3.5	4.2	3.6	7.0	7.0	4.1	10.8	0.286	23.0
210	05.05.26	34.7	3.5	4.2	4.1	6.5	6.9	4.1	11.1	0.286	23.0
224	05.06.09	37.9	3.7	4.0	4.2	7.7	7.1	4.2	11.2	0.27	21.8
238	05.06.23	35.4	3.8	4.3	4.0	6.8	7.0	4.2	11.2	0.263	21.2
252	05.07.07	41.1	3.1	4.0	3.4	6.5	6.2	3.7	10.3	0.323	26.0
247	05.07.02	39.4	3.5	3.9	3.5	6.6	6.8	3.9	10.6	0.286	23.0
280	05.08.04	38.1	3.6	4.3	4.0	8.0	7.0	4.1	11.6	0.278	22.4
294	05.08.18	35.6	3.4	3.8	2.7	7.1	6.8	4.0	11.0	0.294	23.7
308	05.09.01	34.4	3.2	3.9	3.2	6.3	6.9	4.0	10.8	0.313	25.2
322	05.09.15	35.9	3.4	3.7	2.8	6.7	6.7	4.0	10.4	0.294	23.7
336	05.09.29	38.1	3.4	4.0	3.4	6.7	6.8	4.0	10.8	0.294	23.7
350	05.10.13	37.4	3.5	4.3	3.4	6.7	6.9	4.0	10.2	0.286	23.0
364	05.10..27	34.4	3.3	4.2	3.2	6.9	6.6	3.9	10.2	0.303	24.4
378	05.11.10	34.0	3.4	3.9	2.6	6.2	6.8	4.0	10.1	0.294	23.7
385	05.11.17	29.7	3.3	3.9	2.0	8.5	7.1	4.2	10.3	0.303	24.4
399	05.12.01	34.1	3.5	4.5	3.3	7.1	7.5	4.4	11.2	0.286	23.0
413	05.12.15	31.9	3.4	3.8	3.1	5.9	6.9	4.0	9.6	0.294	23.7
441	06.01.12	35.9	3.6	3.7	2.9	6.1	6.8	4.0	9.9	0.278	22.2
455	06.01.26	35.8	3.3	3.5	3.3	5.2	6.8	4.0	10.1	0.303	24.2
469	06.02.09	36.0	3.4	4.1	3.4	6.0	7.5	4.3	10.3	0.294	23.5
483	06.02.23	36.9	3.3	3.7	3.2	6.5	7.0	3.9	10.1	0.303	24.2
497	06.03.09	36.3	3.3	4.2	3.2	6.8	7.5	4.4	10.2	0.303	24.2
511	06.03.23	38.1	3.4	3.8	3.0	6.5	6.9	4.0	9.9	0.294	23.5
525	06.04.06	39.6	3.3	3.9	3.8	6.5	7.0	4.0	9.9	0.303	24.2
539	06.04.20	41.0	3.4	4.1	4.0	6.5	7.2	4.0		0.294	23.5
560	06.05.11	43.6	3.5	4.1	4.6	6.8	7.4	4.3	10.1	0.286	22.8
574	06.05.25	40.1	3.5	3.7	3.1	6.1	6.8	3.8	9.9	0.286	22.8

Clinical Report 3 (Japan)

Mood Disorder Successfully Treated with Kamishoyosan

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Introduction

The Asian expression "oneness of mind and body" provides a good summary of the powerful relationship between the body and the mind (both cognitive and emotional elements), which is a fundamental principle of Kampo medicine. Modern Western medicine focuses primarily on treatment by medical specialists who focus on a specific organic area. This perspective makes it difficult to understand the relationship between mood disorders and physiological symptoms. In contrast, Kampo medicine looks at mental and physical symptoms that might appear initially to be completely unrelated, and treatment is routinely founded on a unified interpretation of those symptoms. This medical paradigm, which is based on the functions of the five Zang-organs and the six Fu-organs, provides a system of organic unification of mind and body.

The present article describes the clinical course of a patient who presented a primary complaint of emotional instability, accompanied by multiple physical symptoms including dizziness, fatigue, and cold feet. The patient was treated with a preparation of *Modified Back to the Spleen Decoction*, which produced marked improvement. Results are reported below.

Case Report

First visit on January 27, 2006.

The patient was female, 42 years of age and 155.5 cm in height. Body weight was 55.9 kg, and blood pressure was 112/74 mmHg.

Primary complaints:

#1: emotional instability; #2: dizziness; #3: fatigue; #4: cold feet

Medical history:

Appendicitis at age 8, gastric polyps at age 40. Sometimes noticed upper abdominal pain during times of mental stress.

History of present illness:

This patient was married at 26 years of age at which time she moved a considerable distance from her childhood home to live in this region. After her marriage she began to notice occasional episodes of irritation, dizziness, fatigue, and cold feet. From the summer of 2005, these symptoms increased both in frequency and in severity, and were particularly pronounced when the patient was experiencing mental stress. She was not willing to discuss the details of that stress and only mentioned continued mental fatigue from work.

Current symptoms:

Frequently experiencing both irritation and melancholy, easily angered, brooding, unable to make decisions. Reduced activity level, frequent sighing. Stool generally softer than usual, with frequent bouts of diarrhea. Goes to bed at midnight, gets up at 6:30 AM. Without use of sleeping pills, does not usually feel that she has slept well. Stiffness in neck, shoulders, and upper back. Dull pain in right elbow. Cold feet, dislikes air conditioning in summer. Some spasming of facial muscles. Frequent development of aphthae (mouth ulcers). No prior drug therapy.

Menarche at 14 years of age. Menstrual cycle irregular (40 to 90 days). No menstrual pain. Menstrual blood mixed with a small amount of clotting.

Findings from the perspective of Kampo medicine:

<<Observation of the mind>>

Somewhat lacking in liveliness, expression stiff.

<<Observation of the tongue>>

Tongue proper: Somewhat pale

Tongue fur: Thin white, thin

Shallow teeth marks, pattern of shallow fissures.

No overswelling of the sublingual vein.

<<Pulse diagnosis>>

"Taut" pulse, somewhat thready. Pulse 66 bpm, regular.

Analysis of pathology from the perspective of Kampo medicine

The pale tongue with the pattern of fissures and the thin pulse reflect blood deficiency. Years of staying up

late at night and stress-related fatigue had made this patient prone to mental stress. Of the five viscera, the liver in particular showed blood deficiency. Stress caused ki flow to stagnate in the liver, resulting in mood swings. Therefore, the patient became angry easily and noticed feelings of irritation. She also experienced feelings of melancholy and had difficulty in making decisions. The sighing and reduction in activity level reflect the reduced level of ki flow through the liver. The liver has the attribute of wind which causes physical symptoms characterized by movement such as dizziness, facial muscle spasm, and tremor. The experience of cold, limited to the feet and not involving the torso, reflected the failure of ki energy to reach the extremities.

Aphthae and upper abdominal pain due to mental stress reflected the effects of ki energy stagnation in the liver, extending to the spleen. The mouth is thought to reflect the condition of the spleen.

Treatment:

To augment blood to the liver, improve the flow of liver ki, and balance the functions of the liver and spleen.

Prescription:

Kamishoyosan 7.5 g/day (ordinary adult dose), taken in the form of 2.5 g before each meal, a total of 3 times daily, for 11 days.

Clinical Course

Second visit on February 7, 2006.

The patient reported improvement in dizziness, emotional instability, fatigue, and cold feet.

<< Observation of the tongue>>

Tongue proper: Slightly pale.

Tongue fur: Thin white. Shallow teeth marks and pattern of fissures still in evidence.

<<Pulse diagnosis>>

Moderate pulse, somewhat thready. Pulse 66 bpm, regular.

The patient's progress was satisfactory, so the *kamishoyosan* dosage was reduced to 6.0 g/day for the next 21 days.

Third visit on February 28, 2006.

The patient noticed that she continued to experience dizziness when she had insufficient sleep. However, her irritability was markedly reduced. She tired less easily, and when fatigued because of work or for some other reason, she recovered with a good night's sleep. She did not notice any particular experiences of cold feet.

<<Observation of the tongue>>

Tongue proper: Slightly pale

Tongue fur: Thin white, shallow teeth marks remained as noted previously, but pattern of fissures no longer visible.

<<Pulse diagnosis>>

Moderate pulse, somewhat thready. Pulse 72 bpm, regular

Kamishoyosan 6.0 g/day continued for 1 additional month, at which point treatment was concluded.

Discussion

Kamishoyosan was developed from the original *shoyosan* (shoyo-san in Japanese, Xiao-Yao-San in Chinese), a traditional Chinese formulation described in the Chinese national formulary during the Sung Dynasty (960-1279 AD). It is called "Xiao-Yao" in Chinese, which literally means "to wander" or "to stroll with no particular location in mind." (The name reflects the many and varied complaints for which this formulation is indicated.) Medical texts from approximately one thousand years ago note that the preparation was already being used to treat a wide range of symptoms at that time. Basically, the indicated medical conditions are congestion of liver ki, blood deficiency, and lack of spleen fortification and movement.

Moutan Cortex and *Gardeniae* Fructus were added to *shoyosan* to produce *kamishoyosan*. Japanese national health insurance covers *kamishoyosan* rather than unmodified *shoyosan*, and the *kamishoyosan* formula has been a favorite of Kampo physicians in Japan for many years. In the last half of the 18th Century, a well-known physician, Tokaku Wada

(1744-1803), wrote in one of his books that this prescription "relieves fire due to excessive yang in the liver and kidneys"[1]. In this case, the patient's angry tendencies, such as irritation and a ready temper, corresponded to Wada's "fire due to defficiency", so the modified prescription containing *Moutan* Cortex and *Gardeniae* Fructus are indicated.

Dr. Domei Yakazu (1905-2002), who used *kamishoyosan* in a large number of cases, authored a number of case reports regarding the use of this formulation in the treatment of organic disease such as hepatic cirrhosis, as well as for the treatment of a wide range of conditions that include psychiatric symptoms, such as climacteric disorder and senile depression. For the beneficial effects of this formula in psychosomatic complaints, he coined the term, "Kampo tranquilizer"[2].

Summary

This article describes a case in which *kamishoyosan* was efficacious in treating a mood disorder that included physical symptoms. Since Kampo medicine can offer a unified view of illness in some cases where modern medicine would consider psychiatric and physiologic symptoms to be unrelated, and since the forms of modern life and the complexity of our society have immeasurable effects on both the minds and bodies of modern people, it is fortunate that Kampo therapy, initially developed for the people of ancient and medieval times, can also bring impressive health benefits to patients today.

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Clinical Report 4 (Japan)

Treatment of Both Mother and Child with Yokukansan

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Introduction

Yokukansan is a preparation intended to calm an upsurge of liver Qi and the classics contain instructions to treat "both mother and child" (use the preparation for both the mother and the child). In this study we observed a case of improvement induced by treating the mother with *yokukansan*. Later, the child started to crave the mother's Kampo medicine, so that we had no choice but to accept the mother's request for consultation. Observation of the child revealed night crying, fretfulness and other symptoms suggesting that *yokukansan* would be effective. For this reason, both the mother and that child were treated simultaneously with *yokukansan* upon which we observed improvements in both of them. This is an extremely interesting case, since the child apparently had expressed its interest in the treatment with Kampo medicine by herself. We report this experience here as an example of treating both mother and child.

1. Mother: 28 years

Chief complaint: depressive mood, irritation, insomnia, shoulder stiffness etc.

Present illness: At the age of 23 the stress at work and love affair related problems led to a loss of appetite and the development of depressive moods. The patient consulted a psychiatric outpatient clinic, receiving a prescription of psychotropic agents based on the diagnosis of depression, but discontinued the treatment after about one year due to developing side effects. She married at the age of 26, became pregnant the following year and delivered her first child by caesarean section. Since then, the depressive moods and irritation grew worse. The patient consulted our clinic because she was looking for a treatment other than the psychotropic agents.

Anamnesis: At the age of 19 years Guillan-Barré syndrome. Nothing remarkable in the family history.

Western medical findings: Height 160cm, weight 47kg, blood pressure 110/70 mmHg, chest auscultation and percussion: no anomalies.

Results of laboratory studies: peripheral blood count, biochemical and general urological examinations were all normal.

Kampo medical findings: The tongue body was of faint red color and had a thin white fur. Sublingual veins were engorged. The pulse was thin and wiry. The abdominal pattern showed an intermediate abdominal tension, increased resistance and tenderness in the epigastric region, left-sided fullness, tenderness or discomfort of the hypochondrium, tense abdominal skin, supraumbilical pulsation, paraumbilical tenderness and pressure pain in the ileocecal area.

Oriental medical findings: Cold hands and feet, general malaise, vertigo, dizziness, stiff shoulders, palpitations, anxiety, anorexia, edema of hands and feet, irritation, depression, bitter taste in the mouth, insomnia (difficulties falling asleep and profuse dreaming), constipation, menstruation (irregular, associated with strong pain), copious mentrual flow, abundant fluor genitalis).

Observation of the course

Initial visit: Deficiency of both Qi and blood, associated with stagnation and sluggishness of liver Qi and blood stagnation were considered and therefore 7.5g of *yokukansankachimpihange* extract (divided into 3 portions) administered.

Two weeks later: There was some improvement in the irritation, but constipation and abdominal bloating worsened, so that a Lactobacillus preparation and magnesium oxide were added to the prescription.

Four weeks later: There was some improvement in the irritation, but now constipation and diarrhea occurred alternatingly. For this reason, the Lactobacillus preparation and magnesium oxide were discontinued and the prescription switched to 6.0g of *yokukansan*, 4.5g of *Cassia Twig Decoction plus Peony* + 3.0g of *daiokanzoto* (mixture, administered divided into three portions).

Six weeks later: Improvement in mental status and

bowel movements. At this time we were consulted about the female child. According to that consultation, the child grows angry and develops a hot-red face when it does not like certain things, so that the parents are not able to control it. The question was whether this situation could somehow be improved with Kampo medicine. Since the child was eager to take the mother's Kampo medicine, it was given a mouthful to try and did not show any aversion at all. Rather on the contrary, the child seemed to crave the drug.

Eight weeks later: Improvement of the symptoms continued. The child accompanied the mother during her visits.

2. Child: 1 year 8 months, female

Symptoms: Once she started to cry, she began to throw things around, hit things and could not be controlled. She fell easily asleep, but on days in which she encountered certain things or situations she did not like, she started crying at night like she was screaming. She had an active character and did not show any fear of strangers. She tended to be constipated and in particular would not have any bowel movements when away from home. She had an aversion to heat.

Development: Since she was in a breech position, she was delivered through ceasarean section (2800g). Fed on artificial milk. Examinations did not reveal any anomalities. Her height was 80cm and her weight 11kg.

First visit and course: Prescription of 2.0g of *yokukansan*.

Two weeks later: The crying at night stopped from the day she started taking the medicine. She did not get sleepy during the day. The drug was mixed with milk or administered during meals dissoloved in warm water which she drank with pleasure instead of tea. Later, the course was favorable and she visited our clinic regularly. After the child entered Kindergarten at the age of 4 year, gradually tapering the drug did not lead to any problems, so the therapy of both mother and child was discontinued.

Discussion

The original text describing *yokukansan* was the "Bao-Ying Cuo-Yao" (Essentials for the Care of Infants; 1555). This text states: "*yokukansan* heals deficiency-heat of liver meridian, the occurrence of convulsions, or development of fever with grinding the teeth, or palpitations with anxiety; clinically irritability manifests in the form of chills and fever, or else a condition where wood overcontrols earth and the patient discharges phlegm and saliva, the abdomen is distended, the patient eats little and has difficulties with sleep. Use 5 fen (about 1.9g) of soft Bupleurum root (Saiko), 8 fen (about 3.0g) of Cnidium rhizome (Senkyu), 1 qian (about 3.8g) of Chinese Angelica root (Toki), Largehead Atractyrodes rhizome (Byakujutsu), Tuckahoe (Bukuryo), Gambirplant Hooked Stems and Branch (Chotoko) each and 5 fen (about 1.9g) of Licorice root (Kanzo) prepared in water. This decoction was given simultaneously to both mother and child."

Yokukansan contains the following ingredients and their respective actions are detailed below.
*ingredients (action)

* Uncariae Uncis cum Ramulus
  (Calmes the Liver and Extinguishes the "Wind")
*Bupleuri Radix
  (Spreads Liver qi and relieves constraint)
*Cnidii rhizoma
  (Invigorates the blood)
* Angelicae Acutilobae Radix
  (Nourishes the Liver)
  (Tonifies the blood)
*Poria
  (Calm the spirit)
  (Promotes urination)
* Atractyrodis Rhizoma
  (Promotes urination)
* Glycyrrhizae Radix
  (Harmonizes the other herbs)

A modified form with added Citri Unshiu Pericarpium and Pinellia tuber is used for worse conditions where the loss of gastric and splenic functions leads to the formation of phlegm. Tokaku Wada (1744-1803) frequently used *yokukansan*, not only for children, but applied it also to adults. For example, in the "Shoso-Hoi-Kai (Medical Formulary

written beside the window shows through Basho Tree)" he exerts: "Cures severe symptoms of excessive anger, insomnia, rash and impatient nature. These symptoms are signs of an upsurging liver Qi. (That means, severe forms of getting easily angry and being irritated because of poor sleep etc. represent the main symptoms. These symptoms are caused by an upsurge of liver Qi.) Moreover, Sohaku Asada (1814-1894) wrote in his "Hutsugo-Yakushitu-Hokan-Kuketsu (Knack of the Formularies of "Don't mistake the Pharmacy" Chamber), "Inquire about anger. When there is anger, this preparation never fails to be effective. (Ask questions as to whether the patient is easily angered. If he/she is, it is unlikely that this formula will work)." Generally speaking, this formula is effective for mental and physical symptoms associated with anger and irritation, night crying, fretfulness not only in infants, but it is also widely effective in adults with neuroses, depression, headache, chronic pain, hemiplegia, demented aggressive elderly and the elderly adult population in general.

In the "Bao-Ying Cuo-Yao (Essential for the Care of Infants)" (1555) it says: "In the care of the infant, treat the nurse as long as diseases have not yet developed, but once the child has already fallen ill, carefully examine and treat the child. Furthermore, it would be best, if both mother and child were treated together." Generally, it is common practice that "the mother is also treated for the purpose of treating the child", but in this case rather the reverse situation applied. Moreover, since the child described in this case report strongly disliked vegetables, we expected the formula to be difficult to administer, because *yokukansan* has a distinct smell of Senkyu (resembling the smell of celery). Yet, in spite of this smell the child even tried to take the medicine from its mother, which makes the case very intriguing.

The mechanisms of action when treating both mother and child include first direct effects and second effects induced through the mother's milk. That means, there are conceivably two psychological effects. Regarding the direct effects, there are the following two well-known case reports in the section on infant diseases of the "Wan Bing Hui Chun (Restoration of Health from Myriad Diseases); 1587, Vol. 7.

"When small children of less than one month develop convulsions and nasal obstruction, that means they are suffering from common cold. Use the *rikkunshito* with added Platycodi Radix and Asiasari Radix and administer this to both mother and child. (… omission …) It will clear the nose and stop the convulsions."

"When an infant of less than a month develops convulsions, vomits milk, has a distended abdomen and diarrhea, the cause is adverse effects of milk on the spleen and stomach. Use the *gomiikosan* (*Miraculous Effect Powder with Five Herbs)*, add Raponticum uniflorum Radix and give this to the mother. Administration of the drug to the child with a children's spoon eventually leads to a cure."

The mechanisms responsible for improvement in the child when both mother and child are treated, are considered in case of common cold or mastitis, the transfer of antibiotic components through the mother's milk. In case of *yokukansan*, there are naturally direct effects, but the psychological effect of "relaxation of the child through relaxation of the mother" is probably also of major importance. The synergism with this psychological effect does not only apply to parent-child relationships, but could probably also be applied to married couples or the relationship between caregiver and the person being cared for. *Yokukansan* has fewer side effects when compared to western psychotropic agents and thus could conceivably find wide application in our modern, so-called "stressed society".

Summary

When a mother complaining of irritation was treated with *yokukansan*, alleviation of the symptoms had been observed. Moreover, when the child craved to take the mother's medicine, treatment of the infant with the drug improved symptoms of night crying. Since even in the original text describing *yokukansan* treatment of both mother and child is recommended, this was a highly intriguing case.

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Clinical Report (Europe)

Case Report (1) Arthritis – Yue Bi Decoction for Relieving Edema plus Atractylodes / Coix Seed Decoction

Ulrich Eberhard

Female Patient, 37 years, housewife

Diagnosis: Primary chronic polyarthritis (PCP), mainly wrist and finger joints (interphalangeal and intercarpal joints of both hands) affected; intermittent course during the last 10 years; both shoulder joints have also been affected for the last 2 months.

Clinical findings:

Morning stiffness of all the joints, spindle-shaped tumefaction of interphalangeal joints with restricted and painful movement on either side (inability to close the fist), painful bending of the wrist joints; muscular atrophy of both hands and forearms, restricted and painful movements of both shoulder joints.

Laboratory findings:

Blood sedimentation 28/56mm, C-reactive protein 3,6 mg/dl, no leucocytosis, dysproteinemia, rheumatoid factor negative.

Therapy (until present):

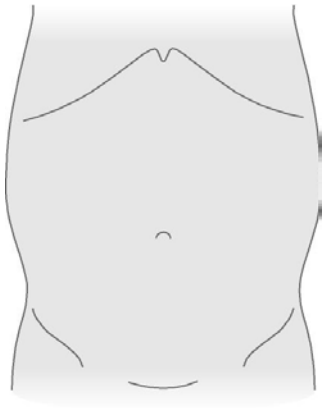
Physiotherapy for many years (active and passive kinesitherapy, local application of frigotherapy on the joints, kinotherapeutic baths etc.); several acupuncture treatments by different acupuncturists have been performed without improvement; a specialist in rheumatology initiated a basic therapy with Resochin some years ago, but the treatment had to be interrupted as serious side effects occurred. Since then she has taken non-steroid-anti-inflammatory-drugs regularly.

Kampo-Shô-determination:

Kampo specific questioning (*monshin*) reveals that the patient suffers from herpes zoster infections and subsequently intercostal neuralgies, chronic conjunctivitis and recurrent urinary tract infections; furthermore she complains of insomnia (difficulty in falling asleep or waking up with a heat sensation of the entire body), she doesn't tolerate heat of any kind (sleeps mostly uncovered) and sweats frequently; she feels constantly thirsty and prefers cold drinks; her urine is mostly concentrated and of dark yellow colour with a pungent odor. She gave birth to a child 12 years ago by a natural delivery and shows absence of menstruation for about 5 consecutive years until present.

The examination reveals a strong stature with a clear tendency towards obesity and a red (flushed) face. The affected joints (hands and shoulders) show hyperthermia and some are of red colour. The tongue inspection (*zesshin*) reveals a dry tongue with a thin white fur. The pulse (*myakushin*) is slippery.

Abdominal examination (*fukushin*): no specific signs besides an obese abdomen with a slight tendency to fullness



Kampo-Therapy and proceedings:

The patients Kampo-sho is one of yang-heat (*yônetsu)* in the exterior (*hyôbyô*). According to the Shang Han Lun her state reflects the first stadium called *daiyôbyô* or Greater Yang Desease.

I prescribed her the famous Kampo prescription „Maidservant from Yue Decoction with Atractylodes“ ***Yin Nourishing Real Treasure Decoction*** for 7 days (starting quantity).

On the sixth day of the treatment she phoned and informed me that she tolerated the decoction without negative reactions and that her sleep was improving as the nightly heat sensations had disappeared. I therefore repeated the prescription for another two weeks.

On the following visit to my clinic the patient reported an improvement in her painful joints in general and that she hadn't had to take anti-inflammatory drugs for the last 2 weeks. No more signs of feeling thirsty, the urine had become clearer, but the tongue fur had changed and became thick white and slightly greasy.

I therefore decided to adapt the prescription to the new situation and changed to ***Coix Seed Decoction*** which I gave her for two weeks.

The follow-up consultation revealed further improvement. There was no morning stiffness any more and the mobility of the joints was considerably better. I repeated this prescription for another 4 weeks. The patient reported a general improvement, especially of the joints. There was no more signs of swelling or heat. Besides that she hasn't suffered from urinary tract infection ever since (which had not been the case for a long time...)

Introduction of Japanese Acupuncture

Considering the Therapist's Hand (2)

Shuichi Katai

4. Palpation in Japanese Acupuncture and Moxibustion Treatment

One of the characteristics of Japanese acupuncture and moxibustion treatment is palpation, which forms part of the four diagnostic methods and is of enormous significance among these methods. For Japanese acupuncture and moxibustion treatment, palpation is not just a diagnostic method, but also an important means for gathering information. The practitioner can then determine the depth of the therapeutic target area, stimulus quantity, as well as basic aspects of the acupuncture and moxibustion treatment.

Acupuncture and moxibustion treatment centers essentially on stimulation of the body surface, so palpation of the physical body naturally has to play an outstanding role. Further, as therapists spend a long time with their patients, another characteristic of the Japanese acupuncture and moxibustion treatment may well be described as their ability also to "touch the heart" of their patients.

A certain amount of research into palpation has already been published. This research focuses in particular on abdominal diagnosis. Yet, considering the importance of palpation as a diagnostic method for acupuncture practitioners, the amount of conducted research is not sufficient. Here I would like to explore why more sufficient research has not yet been performed.

5. Placing too much emphasis on visual and auditory information

Japanese acupuncture and moxibustion treatment is a traditional form of medicine that was transmitted to Japan from China (currently called Chinese medicine), modified during the Edo period in a characteristically Japanese manner, and is still used in this form today. The development of the delicate and highly refined senses of the hand developed in the Edo culture may definitely be described as an important therapeutic tool. Yet, the emergence of the modern 'machine culture', and the changes it induced following the Edo culture, may have unavoidably put an end to this unique aspect of our culture.

One of the reasons for this development has been the progression of the extremely high technical specialization that is associated with the basis of modern science and our mechanically oriented civilization. It has become very difficult to get a perspective on the entire field of technology, which in turn may render comprehension of the current state of society very difficult. We have created a society relying not only on a high degree of specialization, but also a reliance on other people and services for all our basic needs (food, clothing and shelter, etc). This trend has resulted in an estrangement in self-recognition. The emotional status of individuals rooted in their feelings as well as physical phenomena based on essential life events like birth, aging, disease and death, awareness of fatigue and one's own mental state, have slipped out of view.

Generally, in Japan, medical care is established so that patients entrust themselves both physically and mentally to the therapist (therapist – patient relationship) and it is a matter of general understanding that the function of hospitals, medical care or drugs and physicians is to cure patients. In this society the "power to heal oneself" is underestimated and the significance of "healing oneself" has been lost. The result is that efforts made by patients are not properly appreciated and, comparatively, even the original role of the therapist, namely healing powers, are not sufficiently evaluated and recognized. This may eventually lead to the misconception that physicians merely have the function of providing a bridge between the patients and pharmaceutical companies.

It also needs to be pointed out that in this modern era, vision and hearing are assigned much more importance than touch. In this kind of society and within the framework of medical care, it can be difficult to identify the significance of body contact.

6. Insufficient research of and training in palpation

There is a tendency to place too much emphasis on vision and hearing among the five senses, while touch receives too little attention and any research into the

latter proves to be difficult. In the field of oriental medicine only pulse and abdominal diagnoses rely on touch and little research has been conducted . The subject of palpation in its entirety has not been investigated. Within the field of traditional acupuncture and moxibustion in Japan following World War II, in particular, pulse diagnosis has become a primary diagnostic method. Since the significance of pulse diagnosis has tended to be overemphasized, developments in research related to other areas of palpation, in general, have received little or no attention.

Accordingly, unenthusiastic and poorly planned research into palpation leave many standards still to be established. The result is that the education pertaining to acupuncture and moxibustion places too little importance on palpation skills. Thus, one of the characteristics of Japanese acupuncture and moxibustion treatment, namely the determination of stimulation sites through palpation, can hardly be said to be accurately taught.

Moreover, the state examinations for acupuncture, moxibustion and Anma (massage) do not include practical examinations, so that the practical training is entrusted to the individual teaching institutions (that is schools authorized by the state). In practice, this means a trend towards a certain degree of neglect of practical skill in favor of emphasis on lectures.

7. Significance of palpation for acupuncture and moxibustion – from the perspective of palpation –

1) Information gathering through palpation (From the perspective of the therapist)

First, considering the question from the perspective of the therapist, the patient's account of their own symptoms can not be accurately assessed by inquiry alone. Instead, the practitioner must directly (demonstratively) verify the condition based on the information obtained through the hands. In this way even regions and subtleties of symptoms that lie outside the patient's scope of self-recognition can be identified, brought to the patient's attention and highlight an overall picture of the patient's physical condition.

(2) From the patient's perspective

If the therapist is capable of directly perceiving the patient's subjective discomfort and pain, the patient may sense the practitioner's skill and knowledge. If the patient can feel confidence in the therapist's skills they may become able to share his or her pain to assist in the healing. Perhaps more importantly, is the practitioner's ability to detect conditions that are completely asymptomatic for the patient. These unconscious processes necessarily influence the patient's physical condition and healing path. I believe this is one important role of the therapist, to alert the patient to their own unrecognized potential, disease and resistance to their own condition. Springing from modern customs and habits of convenience and specialization, many people have been deprived of their innate capability to recognize their own physical condition and thus their awareness of their place in society and the natural environment.

8. Information required for the treatment is gathered through palpation

Naturally, the information obtained through palpation is very important for the determination of the treatment target areas, the type of stimulation and quantity of the stimulus etc. The palpation performed in Japan does not only serve to determine the medical examination and treatment principles, but also allows us to comprehend and monitor the constantly changing physical condition in response to the acupuncture and moxibustion therapy and thus finally determine the quantity of the required stimulus. Palpation is an extremely important means to decide when the treatment should be adjusted or discontinued.

Therapists thus use palpation-derived information and are guided by experience to decide the stimulus strength and method. To make palpation a common examination method in the future, these individual pieces of palpation information should be organized into a system. Therapists could then share and contribute to a dynamic common body of knowledge.

For this purpose the establishment of quantifications of palpation and unification of palpation techniques, as well as methods suited for the acquisition of palpation skills, should become a task for future efforts.

Medical History in Japan

Japanese Acupuncture and Moxibustion under the Rule of GHQ after World War II (2)

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

Takako Okutsu

When acupuncturists across Japan heard of the interactions between Dr. Ishikawa, who was concerned about the continued existence of acupuncture and moxibustion under the occupational forces, and the Mie Military Government, they began to work together. Their first action was to organize and implement self-regulation for acupuncturists. Meeting on June 20 at Ito City in Shizuoka Prefecture, acupuncturists founded a national organization called the League of Moxacautery Acupuncture, and Massage Practitioners (LMAMP). That initial meeting was attended by Deputy Director, Katsuji Kuge from the Medical Affairs Bureau of the Ministry of Health and Welfare. His forward-looking initiative toward self-regulation did much to stabilize the future of the acupuncture industry in Japan.

However, the Ministry of Health and Welfare (MHW) had already notified the local prefectural Public Health Departments that moxibustion and acupuncture might be prohibited by the GHQ. The well-known acupuncturist Tsutou Hanada of Miyazaki Prefecture heard about this from the director of the regional Public Health Department after the LMAMP meeting, and traveled immediately to Tokyo to spread this alarming news. Meanwhile, the acupuncturist and Diet member Katsuma Kobayashi had also heard from Deputy Director Kuge that acupuncture might be at risk. Storm clouds were gathering for acupuncture in Japan.

Opposition to the GHQ proposal from the visually impaired

On September 23, 1947, staff members at the Medical Bureau of Ministry of Health and Welfare were summoned to GHQ. There they received the following announcement from a GHQ staffer.

"Drivers of automobiles must be knowledgeable about the capabilities and mechanical structure of their vehicle. In the medical treatment of human beings, also, injuries are likely to occur unless the practitioner is fully knowledgeable about the body. Although some forms of treatment in ancient Asian medicine can be effective, the injuries that occur during treatment can be attributed in part to the low level of understanding of human physiology among modern-day acupuncture practitioners. If this is difficult for sighted practitioners, it must be even more difficult for practitioners with impaired vision. We would thus like to request that this practice be discontinued. What does the Japanese government think?"[2)]

The GHQ, based on the results of their own survey, offered the following proposal for the future of moxibustion and acupuncture in Japan. The contents of that proposal were divided broadly into the following two categories.

1. The visually impaired should be completely barred from the practice of acupuncture, moxibustion, and traditional amma massage.
2. At this point, all practice of therapeutic techniques such as acupuncture, moxibustion, Anma-massage, and Judo Orthopedics Therapy should be prohibited[3)].

The proposal closed with the statement, "If the Japanese government wishes to retain these treatment procedures as part of the current medical system, reasons are to be submitted in writing by October 2." Although this proposal did provide a little time before an actual conclusion would be reached, the people of the occupied Japanese nation interpreted it as an order that moxibustion and acupuncture would be prohibited.

In February of 1947, the Ministry of Health and Welfare had created a six-person board of inquiry, the Council for the Medical System, to investigate the postwar medical system in Japan, and that council was already reviewing issues and reaching decisions.

Questions related to acupuncture had been a major point of discussion, and on receiving the communication from GHQ, the council acted independently to establish self-regulation by acupuncturists. This was an unforeseen development for the Ministry of Health and Welfare, which had been working to establish a form of self-regulation that would take into account everyone who was currently practicing moxibustion and acupuncture. From the perspective of the Japanese government at that time, the views of the GHQ were absolute. In addition, some of the criticisms by the GHQ regarding current acupuncture practice were accurate.

The biggest problem was that acupuncture was one of the few major occupations available to people with impaired vision. If the Japanese government acted on this warning from the GHQ, it would take away the livelihood of numerous acupuncturists throughout the country and snatch the future from those studying acupuncture at schools for the blind and visually impaired, leaving them lost and without hope. In the tumult and confusion of postwar Japan, such a development would have a very serious negative impact on the society as a whole.

At that time the Medical Affairs Bureau of the Ministry of Health and Welfare had a number of staff members who were well-informed about acupuncture and who also had a good understanding of therapeutic techniques performed by the visually impaired. The Minister of the MHW, Sadayoshi Hitotsumatsu, also had personal experience of being restored to health through acupuncture, so he appealed directly to the GHQ to allow the continuation of moxibustion and acupuncture. However, the absolute authority of the GHQ meant that if acupuncture was prohibited by the occupation forces, the Japanese government would have no alternative but to comply. Despite their desires to the contrary, the MHW could see no way out of the dilemma.

When they heard about the situation, acupuncturists across Japan began looking for ways to avoid this negative outcome. They focused on the time limit of October 2, set by the GHQ proposal, and organized a movement in support of acupuncture.

Representatives of the LMAMP called upon Colonel Harry G. Johnson, chief of the PHW Medical Service Division, and pleaded for the continuation of acupuncture. General Johnson responded that the situation was being discussed with the Japanese government, and no decision had yet been made to ban this method of treatment.

Meanwhile, across Japan schools for the blind that were training visually impaired students for occupations as acupuncturists came together to form an independent movement. This actively involved the directors of schools for the blind throughout the country, as well as Takeo Iwahashi, the Founder of Nippon Lighthouse, known for his correspondence with Helen Keller. These educators pointed out that prohibition of the practice of acupuncture would not only deprive their students of hope for the future and deprive many visually impaired practitioners of their livelihood, but would also undermine the social structures supporting the visually impaired in Japan, and would endanger the existence of the schools for the blind that focused on acupuncture education. This movement for the continuation of acupuncture was thus based on the desire to protect the occupations of the visually impaired, and also to protect the schools for the blind themselves. On September 28, the Acupuncture Continuation Committee was established within the Tokyo Metropolitan School for the Visually Impaired. On September 29, that committee paid a visit to the Ministry of Education, where they met with Minister Tatsuo Morito. On September 30, committee members visited the MHW and the House of Councilors of the National Diet of Japan to plead for the continuation of acupuncture.

Submission of response by the Council for the Medical System

On October 2, as scheduled, a response prepared by the Council for the Medical System of the MHW was submitted to GHQ. Its contents were as follows.

1. All treatment involving acupuncture, moxibustion, amma massage, other forms of massage, or Judo Orthopedics must be carried out under the supervision of a physician.
2. In general, no new licensing of the visually impaired will be performed for the occupations of acupuncture and moxibustion. However, those persons who are currently working in this field or who are studying acupuncture at a school for the blind will be vested to continue under the old licensing provisions.
3. In general, no new licenses will be provided for the practitioners of Judo Orthopedics Therapy.
4. All quasi-medical practices will be prohibited.[4)]

Two of those provisions, in particular, were suggested by the MHW as a last resort to ensure the survival of acupuncture and maintain the right of currently licensed visually impaired practitioners to continue their livelihood. Those two provisions specified that treatment must be carried out under the supervision of a physician and recognized the right of current practitioners and students to practice under the old licensing system while ceasing to issue new licenses. If that response had been approved without modification, Japanese acupuncture would have been greatly restricted, and could hardly have become the thriving medical practice that it is today.

When this response was submitted, Department Chief Hiroyuki Takata of the Medical Administration Department, Medical Affairs Bureau, MHW, informed the GHQ that acupuncture was supported by the majority of the membership in the National Diet. Takata said that there was considerable opposition to any legislation that would impose financial hardship on acupuncturists, and he explained that laws eliminating the occupation of acupuncturist would have a harshly negative impact on the many practitioners of acupuncture, including numerous visually impaired practitioners, and would also work to the disadvantage of the many Japanese people who needed acupuncture treatment. Because acupuncture was a fundamental element of Japanese society at that time, and because it was one of the few occupations available to the visually impaired, the MHW was focusing on establishing a system of self-regulation. It seems likely that this point of view was frankly presented to the GHQ by Department Chief Takata.

Along with this, Dr. Takeshi Itakura of the Council for the Medical System provided an explanation of moxibustion and acupuncture from an academic and scientific perspective. During his tenure as a researcher in the Ministry of Education, Dr. Itakura had conducted research in the United States and Europe. In 1943 he became the first director of the newly established East Asian Institute of Medical Treatment, where he carried out research on acupuncture and Asian medicine. Extremely knowledgeable in both Asian and Western medicine, Dr. Itakura had the background and the ability to describe acupuncture objectively in the language of Western science. He discussed the effectiveness of acupuncture, based on data from his own ongoing research, and was able to explain the scientific basis for those effects. He also pointed out that there are fundamental differences in perspective between Asian medicine, which provides the theoretical basis for acupuncture, and Western medicine. The study of disease, pursuit of the essential nature of disease, and prevention of disease through medical treatment have been central to the development of Western medicine, which is fundamentally a "Science of Diseases". In contrast, Asian medicine has developed out of therapeutic techniques that with progressive research can culminate in a "Science of Indications"[5)]. Asian medicine is a well-established form of medicine, and Dr. Itakura predicted that in the future a fusion of Western and Asian medicine would lead to the birth of "true medicine".

The GHQ staff indicated their clear understanding and appreciation. Brigadier General Sams, the head of

the Public Health and Welfare Section (PHW) of the GHQ, offered his hand to Dr. Itakura and said that he would like to see continued research in this area for medical development.

National movement for the visually impaired

The signs were now favorable for establishing self-regulation of acupuncturists by acupuncturists. However, the acupuncture industry and the schools for the blind, the two groups that had developed the movement for the continuation of acupuncture, faced new restrictions on their practice because of the provisions that treatment must be carried out under the supervision of a physician and that no new acupuncture licenses would be issued to the blind. These two groups thus continued their activities for the withdrawal of those restrictions, even after the initial response was submitted to the GHQ on October2.

On October 4 a group of well-known acupuncturists from Osaka traveled to Tokyo to meet with the MHW. They discussed future responses with a number of well-known acupuncturists in the Tokyo area on October 5, and from that point on acupuncturists from Tokyo and Osaka coordinated their activities.

The Acupuncture Continuation Committee also discussed responses. Their representatives visited the MHW and the Ministry of Education, and exchanged information with the LMAMP and the Japan Teachers Union (JTU) section for special schools. In order to prepare materials for submission to the appropriate government agencies, the Acupuncture Continuation Committee asked the Tokyo Metropolitan School for the Visually Impaired to perform a survey that would scientifically demonstrate that acupuncture could be performed by the visually impaired, and educators at the school hurried to comply. At this point some voices began to suggest that this flurry of protest activity might irritate the GHQ, having an effect opposite to the one desired, and that moderation would be wise. This proposal for moderation provides what is probably an accurate insight into the impressions of the Japanese people toward the GHQ at that time.

On October 7, at the invitation of MHW Minister Hitotsumatsu, a public hearing was convened that was attended by staff members from the MHW Medical Affairs Bureau and by representatives from the world of acupuncture, from schools for the blind, and from the Ministry of Education. At this hearing, leaders within the acupuncture/moxibustion community discussed the theory and therapeutic effects of acupuncture, testified to the safety of acupuncture treatment as performed by visually impaired practitioners, and explained that acupuncture was deeply rooted in the daily lives of the Japanese people. Future needs were also discussed, including the need to establish research facilities that would be able to explain acupuncture from a scientific perspective, and the need to reform the system for acupuncture education and training. This public hearing was significant because it provided an opportunity for all interested parties to meet under a single roof and engage in productive dialogue.

Subsequently a number of conferences were held by the LMAMP and the Acupuncture Continuation Committee, which had been formed by schools for the blind throughout the country, and numerous petitions were submitted to Japanese government organizations and the GHQ. Summaries of those discussions and petitions were reported in acupuncture publications such as *The Journal of Acupuncture and Moxibustion*, the *Imperial Journal of Acupuncture and Moxibustion*, and *The World of Acupuncture and Moxibustion*. Acupuncturists from Tokyo also shared this information in visits to their colleagues from more rural areas, so that soon the movement was not limited to the Tokyo area, but was spreading across Japan.

GHQ was censoring the mail and parcel post during that period in Japan, and there was no true freedom of speech, so in that context the emphasis that these practitioners placed on sincere and truthful communication was a particularly remarkable accomplishment. The censorship procedures also

meant that a great deal of information was communicated to the GHQ about the current status of acupuncture in Japan. The University of Maryland's Gordon W. Prange Collection, an archive of Japanese publications that were collected by the GHQ during the censorship process, includes acupuncture journals of the time, and a review of those materials shows that news on the acupuncture continuation movement was being closely monitored by the censors.

The GHQ used censorship of the mail and parcel post not only to limit freedom of expression, but also as an important source of information for determining how fully Occupation policies were being absorbed into Japanese society and ways of thinking, and for learning about the daily life of the Japanese people. Within the PHW, General Sams and his staff in particular used these materials for information in reforming Japanese medical care. In this way, it seems likely that the acupuncture journals influenced the GHQ plans at least to some extent.

It was at this point that the movement originated to allow the continuation of acupuncture by visually impaired practitioners, a movement that had considerable impact on subsequent GHQ policy.

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Explanation of illustration

Takeshi Itakura (1888 to 1958)

A physician in internal medicine and a pharmacologist, Dr. Itakura graduated from the Faculty of Medicine, Tokyo Imperial University. From 1923 to 1925 he worked as an overseas researcher with the Ministry of Education, conducting research in countries including the United States, England, France, and Germany. Well-trained and knowledgeable in both Western and Asian medicine, in 1943 he became the first director of the East Asian Institute of Medical Treatment, where he conducted ongoing research in acupuncture and other forms of Asian medicine. After World War II, in February of 1947, he joined an MHW board of inquiry (the Council for the Medical System), where he contributed to establishing policy for the postwar medical system and worked for the continuation of acupuncture in Japan. He subsequently continued to contribute to the development of medical therapeutics, including in the area of Asian medicine. Dr. Itakura died in 1958, at the age of 70.

Note: Part one of this history appeared in the Spring, 2006 issue of KAIM, pp. 27-31.

Book Review

"Traditional Japanese Acupuncture: Fundamentals of Meridian Therapy"

The Society of Traditional Japanese Medicine, 2003

Is there such a thing as Traditional Japanese Acupuncture? The spirit of acupuncture is permeated by Japanese naturalism

Reviewed by Hirokimi Matsuda
Acupuncture journalist and member of the Japan Society of Acupuncture and Moxibustion

The question of "What is Traditional Japanese Acupuncture (TJA)" contains a built-in paradox. After acupuncture was brought to Japan from China more than 1000 years ago, the Japanese developed deep respect for the elements of Chinese classical acupuncture theory, including meridians, acupuncture points, and yin-yang five phase metaphysics. Viewed solely from this angle, it would seem that there is truly no such thing as "traditional Japanese acupuncture" (TJA), but only "traditional Chinese acupuncture" and its imitators. But is this really the case?

The Chinese classics included a high-level philosophical system on the basis of theories such as yin-yang five phase metaphysics, as well as the art of divination and the perspective of fatalism. TCM grew out of that context. As can be seen from the TCM perspective on life and from theories regarding the human body, the meridians, the organs and entrails, and the etiology of disease, this Chinese system was complex and had many elements that were formalistic, mechanistic, and metaphysical.

In contrast, located on the fringes of Asia and molded by a warm and moderate climate, Japanese culture developed a preference for simplicity over complexity and for intuition over theoretical systems, with a strong tendency toward naturalism and a highly valued sense of unity with nature. In the area of acupuncture, although Japanese practitioners made use of the graphs and illustrations from China of the meridians and acupuncture points, they also developed an experiential approach based on palpation and relying primarily on sensory experience and hands-on practice to confirm their findings.

This book was compiled from classical Japanese and Chinese acupuncture literature and from acupuncture techniques hidden within the folk wisdom of the common people in 1930's Japan, systematized under the title of "Meridian Therapy." Made widely available at the time of its publication, it became quite popular within "society". The title, *Traditional Japanese Acupuncture*, has been criticized by other schools of acupuncture for being overbearing. However, the text succeeds both in providing good theoretical points based on TCM and also in revealing the experiential and sensory characteristics of Japanese acupuncture that establish TJA as an acupuncture form separate from TCA.

The reader is encouraged not to simply conceptualize the meridians and acupuncture points as something to be memorized from a book, but also to verify these points experientially by feeling with the fingers for depressions, pain on pressure, and indurations. This experience, acquired from the surface examination of patients' bodies over many generations, is summarized in statements such as the following. "When there is a problem in the Spleen or Stomach, the points ST-19 to ST-25 tend to show pain on pressure, resistance, or depressions. Particularly, ST-21 will always show deficiency when there is a gastric ulcer." (p. 65) "The Spleen channel on the lower limbs tends to exhibit pain on pressure. Healing will be slow if there are depressions along the Spleen channel here." (p. 69) Similar information is reported throughout the book. Secrets of Japanese acupuncture are revealed that are not available in any TCM textbook, but are specific to TJA.

This subtle awareness of small changes in the surface of the body also shows up in pulse diagnosis, which is performed differently than under TCM. Pulse diagnosis to diagnose sickness in the entrails and meridians, and to determine which acupuncture points

to select, is specific to Japanese-style acupuncture and is not used in modern TCM. In the process of taking a detailed reading of the body surface and the pulse, the practitioner talks with the patient, which builds communication and encourages the patient to cooperate and participate in the healing process. Japanese-style acupuncture is characterized not only by the use of very fine needles that do not hurt, but also by a feeling of comfort. There is a heightened sense of connection between the practitioner and the patient, which contributes to a strongly beneficial healing environment.

At the end of this book, there are some interesting statements that reveal the spiritual posture of Japanese acupuncturists.

"This is hard to understand without experiencing it firsthand, but in short, a feeling of "now", or "it's better", or "this is enough" will just come to you. This feeling will come without a clear reason when you earnestly perform treatment with an empty or clear mind." (P.331)

The key words here are "without a clear reason" and "perform treatment with an empty or clear mind". Many Japanese acupuncturists would agree that there is an area held in common among all of the different Japanese acupuncture schools within TJA, which is similar to the experience of Zen meditation. The closer we approach this area, the more we see the expressions of naturalism and the Japanese heart that permeate acupuncture.

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Excerpted from National Park Service