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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

The Melancholy of Acupuncture Researchers

In the context of modern medicine, acupuncture is often placed in the same category as superstitions or supernatural phenomena[i]. The statement of the National Council Against Health Fraud[i] (NCAHF) is a typical sample of the skeptical attitude to acupuncture. One of the major complaints has been that quality of clinical trials of acupuncture have been poor for proof of specific effects of acupuncture.

In Japan there has been recognition since the early 1960s, the importance of randomized controlled trials (RCTs) to demonstrate the effectiveness of acupuncture. Despite the early implementation of RCT, the goal of determining specific effects has not been actively pursued. Clinical trials began somewhat later in the West, but focused on specific effects from the beginning of Acupuncture RCT.

Importance of randomization was recognized by both Western and Japanese researchers. However, Western researchers developed several types of sham acupuncture method as a self-evident placebo equivalent. The suitability of the methods used is an issue that should be addressed separately. This meant that no major adjustment of the clinical pharmacological research model was required fundamentally. Since 1975, it has been possible in those countries to test propositions regarding the specific effect of acupuncture therapy within a clinical trial context.

In drug studies, it is relatively easy to conceal the active ingredient that provides the drug's pharmacological effects, and to create a placebo tablet that is completely indistinguishable from the active drug. This is very different from the situation facing non-pharmacologic methods of medical intervention.

There is a dogmatic view that the methodology of clinical pharmacology should be applied to non-pharmacologic interventions as well. But it seemed that this idea be accepted a priori without exposing to the skeptical scrutiny that was being applied to acupuncture itself. It is impossible to gain an accurate understanding of acupuncture and moxibustion while ignoring the physical interaction between practitioner and patient. This is particularly a problem for Japanese acupuncture and moxibustion, in which palpation play important role on diagnosis..

It may be obvious to anyone that acupuncture treatment is realized through a process of physical interaction between the hands of a practitioner and the patient's skin. The concepts of Japanese acupuncture and moxibustion have been widely discussed in Europe and America in recent years, but Japanese acupuncture is not simply characterized by the use of finer needles and the application of lower levels of stimulus. Emphatically, the process also builds on the physical contact between the practitioner and the patient. We need consideration of such relationship in order to understand concepts and practices of Japanese acupuncture.

i. National Council Against Health Fraud. Acupuncture: the position paper of the National Council Against Health Fraud. *Clin J Pain*. 1991:7(2):162-6

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Japanese Acupuncture - Current Research

Clinical Practice and Studies on Acupuncture for Lumbar Disc Herniation in Japan

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1. Introduction

Our research showed that in Japan the annual utilization rate of acupuncture treatment was 6.1%, whereas the life time utilization was 32%[1)]. Data did not show what percentage of patients with lumbar disc herniation (LDH) were included among these users. It is conceivable that since musculoskeletal problems are generally motivational to receive acupuncture treatment[2)], the acupuncture treatment may often have been used for this disease. In fact, we have often performed acupuncture treatment for LDH patients classified as within conservative treatment.

As with the generalization of the Evidence-Based-Medicine (EBM) in the present health-care arena, acupuncture treatment is no exception. In recent years, randomized controlled trials (RCT) have increasingly been conducted in Japan to demonstrate clinical evidence for effectiveness and safety of acupuncture treatments[3)]. As for the acupuncture treatment specific for LDH patients, sufficient clinical studies have not been carried out in Japan. This report provides the summarization of the current status of clinical studies in Japan on the use of acupuncture for LDH and explanation of the detailed methods of our acupuncture treatments.

Acupuncture is not a direct approach to LDH, a morphological abnormality. Rather, it is a treatment for pain in the low back or lower extremities caused by such abnormality. Therefore, this report presents, in the strict sense, "acupuncture treatment for lumbar radiculopathy or sciatica due to LDH".

2. Case series studies on acupuncture for LDH in Japan

Although only a few RCT reports have been published so far on acupuncture treatment on patients with LDH[4,5)], RCT's in the relevant area have yet to be carried out in Japan. However, in Japan there are three case series studies in which changes in subjective symptoms and clinical findings before and after the acupuncture treatment on patients with LDH were compared.

The first was the analysis performed by Maruyama[6)] of 47 cases (male 29, female 18, mean age 34.2). Acupoints were selected from BL40, BL54, BL36, BL57, BL60, GB34, BL23, Ex36 (Huatuojiaji), Ah-shi points and others and electroacupuncture (1-5Hz, 15-20 min per session, 2-4 times per week) were given. The treatment results were classified in 4 grades: Excellent、Good、Fair、Poor. Fair and above or a certain degree of improvement was observed with a rate of 72% in the single acupuncture treatment group and 83% in the combination group of acupuncture and conservative therapy. Patients at a younger age, or with a shorter duration of the disorder, tended to show favorable results, whereas patients with a longer duration of the disorder had a tendency to show better results by the combination therapy. Objective findings of the report indicated a high rate of improvement in a straight leg raising (SLR) test and a low rate of improvement in sensory disorder and abnormalities in deep tendon reflex.

The second was the analysis performed by Yamashita et al.[7)] of the data on 22 cases (male 14, female 8, mean age 37. accumulated at Tsukuba College of Technology Clinic (current Center for Integrative Medicine, Tsukuba University of Technology). Points used were BL25 on the affected side, 2cm lateral to BL25, BL26, center of

buttocks, BL37, GB34, and electroacupuncture (1Hz, 15 minutes) and manual needling were given. The course after the acupuncture treatment showed a 68% improvement. In the third week improvement was assessed with the Japanese Orthopaedic Association Score (JOA Score)[8]: subjective symptoms 39%、clinical signs 31%、activity of daily living (ADL) 52%, SLR-positive angle 75.5° from 59.3°, pain score 3.8 from 10 of an initial level (all are average values). Patients who already had a long history of the disorder at the initial treatment, or the patients who had not been responsive to nerve blocking, tended not to show favorable treatment results.

The third was the analysis by Nakazawa[9] on 29 cases (male 14, female 15, mean age 54.8), from which data were gathered at the Department of Oriental Medicine, Saitama Medical School. The needling was performed in the proximal areas of nerve root, facet joint, upper buttocks, and piriform muscle and electroacupuncture or needle retention method was applied. Assessments were made on the basis of pain score, visual analogue scale, sensory and manual muscle test, pain in motion, and SLR test. The rate of improvement after the treatment was 82.7% and the patients who reportedly had weakness in the lower extremities or developed the sickness after a traffic accident remained unchanged.

The above three case series studies reveal the following characteristics in the acupuncture treatment on LDH:

1) About 70-80% of the patients showed improvement.

2) Patients with shorter duration of the disorder tended to be easily healed.

3) Younger patients showed better results.

4) Improvements in deep tendon reflex or muscle weakness were slower than that in subjective symptoms or ADL.

These tendencies however, may not be limited to "the cases of acupuncture treatment" and will generally be seen in the physical treatment or conservative treatment. Case series study is not a method of study to prove the specific effects of acupuncture and moxibustion treatment (whether getting better due to acupuncture and moxibustion). It should be noted that the cases that showed improvement due to natural course or placebo effect were included. In the future, pragmatic RCTs[10] that compare effects of different treatments such as traction and drugs should be conducted.

3. Case reports[11),13)]

Case 1

Age 26, Male, Height 172cm, Weight 70kg, Pain in right lumbar and lower extremities

History: The patient was a postgraduate student who would sit on a chair while typing his thesis on his computer for 5-6 hours every day before the onset. Six days ago when he sneezed in a semi-crouching position, pain in the right lumbar and lower extremities and a sensation of numbness appeared immediately. He was given transcutaneous electrical nerve stimulation, traction, and medication by his neighboring physician (orthopedic surgery) and was instructed to wear a corset. Although the pain was slightly relieved, dull pain and numbness feeling remained and his first visit was made with a desire for the treatment of acupuncture and moxibustion. In his daily life, he could neither drive nor keep sitting on a chair for long hours due to the pain.

Findings: In keeping the standing position / sitting position, dull pain and numbness in the lateral surface of the right lumbar / buttock, posterior and lateral surface of the right leg became more intense. Neuralgic scoliosis was observed. SLR was 60°(+) in the right, 90°(−) in the left. Manual muscle testing (MMT) : Right

long extensor muscle of thumb 4、left 5. Patellar tendon reflex (PTR) and Achilles tendon reflex (ATR) were normal without difference between the right and left. Cutaneous sensory perception: Hypalgia was observed in the region from the lateral surface of the right leg to the lateral surface of the right foot (S1 region). Tenderness was prominent in the bilateral BL23 and the right BL25.

Examination: MRI examination revealed posterolateral lumbar disc herniation between L4/5.

Treatment and course:

Until the third visit (5th day), electroacupuncture (1Hz 15 min.) was continued on both sides of BL23 and BL25 with the needle of 60mm No. 25. After this treatment, the patient could have almost a full day of relief. However, since the analgesic effect did not last long, the level of the tenderness was re-assessed on the 4th visit or the 8th day and electroacupuncture (1Hz 15 minutes) was given in the 4 acupoints proximal to the right BL25 where tenderness was most pronounced. After this treatment, the pain subsided and only the sensation of numbness was left. On the 5th visit, or the 11th day, the neuralgic scoliosis disappeared. Numbness in the foot region still existed so that the treatment was continued once a week on average. On the 14th visit, or the third month, the condition returned nearly to the one before the episode. Then the treatment was discontinued.

Comments: Pain was relieved right after electroacupuncture was practiced in the point of maximum level of tenderness proximal to the surrounding of the right BL25. Since this experience, I have sensitively been trying to find tenderness points surrounding BL25 in lumbar radiculopathy cases also in an attempt to test repeatability. I have the impression that in case tenderness is prominent at the proximity of BL25, especially at the location slightly outward, and the tenderness is diffused upon pressure. Needling into these points immediately provides an analgesic effect, although it depends on cases.

Case 2

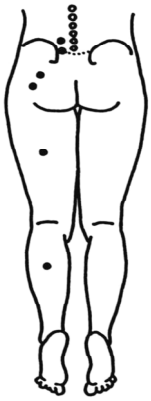
Age 55, Male, Height 165cm, Weight 79kg, Pain in the left lumbar and lower extremities

History: For two weeks the patient felt lumbar pain without any trigger. Poultices relieved the pain gradually. However, five days ago, a tense sensation and pain in the left lower extremity were added. The patient visited the orthopedic surgery department of a general hospital, and was diagnosed with disc space narrowing by plain roentgenography and prescribed transcutaneous anti-inflammatory gel. However, since no improvements in the symptoms were obtained, the patient visited our hospital to have treatment with acupuncture and moxibustion. The patient had been using medication for high blood pressure for the previous 10 years. For much of his working time, he was sitting or driving.

Findings: The patient had a tense sensation in the posterior surface of the left thigh and leg and sometimes awoke during the night time due to pain. No numbness sensation was present. Standing on tiptoes: Right capable, left difficult. Standing on heels: Right and left capable. SLR test: Right 80° (−), left 70°(+). ATR: Right (+), left (−). PTR: Both right and left (+). Cutaneous sensory perception in the lower extremities: Pain sense and tactile sense – right and left no difference. MRI examination identified disc herniation posterolateral in L5/S1.

Treatment and course: Electroacupuncture (1 Hz 10 min.) was performed with the stainless needle of 60mm No. 25 at the points connecting left BL25 and left BL26 where tenderness was marked; upper and lower regions of the center of the left buttock; and left BL37 and BL57 (Figure).

Figure:
Points frequently used in electroacupuncture for LDH



From the initial treatment the pain score was reduced from 10 to 1. Treatment was continued once a week. After three weeks, pain disappeared although a heavy sensation remained. Standing on the left toes was enabled on the 27th day from the initiation of the treatment or about a month after the onset of symptoms in the lower extremities. At the time, the left ATR, however, was (-). On the 40th day, i.e. the 7th visit, the patient was instructed to reduce weight and the treatment was completed.

Comments: This case can be considered as S1 radiculopathy due to LDH. Electroacupuncture at the acupoints of the bladder meridian or those along with the distribution of the sciatic nerve remarkably reduced pain. However, recovery of objective findings such as muscle strength (standing on toes) and ATR was slow compared to subjective symptoms. This tendency will be the common course in treating radiculopathy.

Conclusions

Currently, sufficient volumes of clinical evidence of acupuncture treatment for LDH patients have not been presented. Evidence confined to case series studies suggest that acupuncture treatment can be applied at least as an analgesic means for lumbar radiculopathy. We have the impression that as the above two cases typically demonstrated, acupuncture treatment is characterized by an analgesic effect that lasts for a certain period of time immediately after the treatment. Although the action of pain relief does not necessarily mean a cure of lumbar radiculopathy, the characteristic of pain relief effect right after the treatment merits clinical attention when compared to other conservative treatments. Judging from case series studies conducted so far and case reports released, there are sufficient reasons that more RCTs on acupuncture for radiculopathy due to LDH need to be conducted in Japan.

Reference

1. Yamashita H, Tsukayama H. Nippon no Seijin Shinkyu Juryo-sha ni kansuru Zenkoku Kibo Denwa Chosa 2005, J Jpn Soc Acupunct Moxibust 2006; 56: 503. [Japanese]
2. Yamashita H, Tsukayama H, Sugishita C. Popularity of complementary and alternative medicine in Japan: a telephone survey. Complement Ther Med 2002; 10: 84-93.
3. Tsukayama H, Yamashita H. Systematic review of clinical trials on acupuncture in the Japanese literature. Clin Acupunct Orient Med 2002; 3: 105-113.
4. Duplan B, Cabanel G, Piton JL, Grauer JL, Phelip X. Acupuncture et lombosaciatique à la phase aiguë – Etude en double aveugle de trente cas. Sem Hop Paris 1983; 59: 3109-3114.

5. Wang RR & Tronnier V. Effect of acupuncture on pain management in patients before and after lumbar disc protrusion surgery – a randomized control study. Am J Chin Med 2000; 28: 25-33.
6. Maruyama T. Clinical observation of acupuncture treatment for the ruptured lumbar disc patient – clinical observation of acupuncture treatment in orthopaedic surgery, 2nd report. J Jpn Soc Acupunct Moxibust 1984; 33: 375-382. [Japanese with English abstract]
7. Yamashita H, Tsukayama H, Sakai T, Nishijo K, Amagai H. Effects of acupuncture treatment on lumbar radiculopathy – a case series study –. J Lumbar Spine Disord 1997; 3: 27-32. [Japanese with English abstract]
8. Japanese Orthopaedic Association. Assessment of treatment for low back pain. J Jpn Orthop Ass 1986; 60: 391-394. [Japanese with English abstract]
9. Nakazawa M. Touka ni okeru Youtsui Tsuikan-ban Hernia ni taisuru Hari-chiryo Koka. Gendai Shinkyu Gaku 2006; 6: 39-44. [Japanese]
10. MacPherson H. Acupuncture research: time to shift from theoretical to practical questions. J Altern Complement Med 2006; 12: 837-839.
11. Yamashita H, Tsukayama H, Sakai T, Nishijo K. Clinical study on acupuncture and moxibustion therapy for pain in the low back and the lower extremities (Introduction) – a case report of lumbar disc herniation and discussion about methodology –. J Jpn Soc Acupunct Moxibust 1994; 44: 128. [Japanese]
12. Yamashita H, Tsukayama H, Mimura S, Nishijo K. Youbu Tsuikan-ban Hernia no Hari-chiryo to Rigaku Kensa no Kaishaku. Rinsho Shinkyu (Clin Acupunct Moxibust) 1995; 10: 32-37. [Japanese]
13. Yamashita H, Tsukayama H. Youtsui Tsuikan-ban Hernia ni Taisuru Hari-chiryo to Sono Rinsho Kenkyu no Genjo. Ido-no-Nippon (Jpn J Acupunct Manual Ther) 2005; 741: 30-35. [Japanese]

Kampo Medicine - Current Research

Effects of Goreisan in Pediatric Acute Gastroenteritis

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Introduction

Pediatric acute gastroenteritis is a general term that describes disorders in infants and small children presenting the sudden onset of acute vomiting and diarrhea as primary symptoms. The condition is most commonly due to viral infection, but occasional instances of bacterial infection and food poisoning are also known. Although the majority of these viral infections in infants and small children have been attributed to rotaviruses, noroviruses have also recently been found to be extremely common. Infection typically follows a single-peak or double-peak pattern from winter into spring each year.

Rotavirus-induced gastroenteritis ordinarily presents with vomiting, followed by persistent watery diarrhea, with a fever that lasts for 1 to 3 days. Vomiting and fever are common in the early stage of the disease, and these symptoms, along with the subsequent diarrhea, normally resolve without treatment within a week. However, dehydration can develop, and if left untreated can result in death. In addition, even after the diarrhea resolves, several weeks can be required for full recovery of the intestinal mucosa, and the child's condition may be complicated by the development of secondary lactose intolerance. As a rule, gastroenteritis due to a norovirus is characterized primarily by vomiting, and diarrhea is relatively mild.

This condition is treated primarily by stopping the vomiting and by treating dehydration. The usual treatment is domperidone (Nauzelin®) by oral administration or as a suppository, together with fluid supplementation. Since the early-stage disease is characterized primarily by vomiting, oral intake can be problematic, making it difficult to give either medication or fluids by mouth. Recent findings suggest that early treatment with *goreisan* (Wuling san, 五苓散) can provide dramatic relief in many cases. These findings are supported by considerable research and numerous case reports. This treatment is now becoming widely accepted in Japan.

Research done to date is introduced below, with a summary of the methodologies used.

Research To Date

Goreisan is referenced in the classic Chinese texts "Shang Han Lun (Discussion of Cold-induced Disorders)" and "Jin Gui Yao Lue (Essentials from the Golden Cabinet). Mention is made in several chapters. Specifically, Article 74 of the “Shang Han Lun” states that "... when the patient is thirsty but vomits when he or she drinks water, the condition is termed 'Water Reverse'. The primary treatment is *goreisan*." This applies to pediatric acute gastroenteritis. Such applications have been researched for over 50 years and are used primarily in the field of pediatric medicine.

Like other Kampo medication, *goreisan* is given primarily by oral administration. However, because it is often prescribed for patients who are vomiting, and because of the importance of rapid effectiveness, physicians also frequently prepare and administer *goreisan* in the form of a suppository or enema in children.

In 1987, Morishima published research on the use of *goreisan* Enemas in the treatment of pediatric vomiting where oral administration was complicated by vomiting or other difficulties[1]. This is the first reported case of the use of *goreisan* by a route other than oral

administration. Subsequently, in 1995, Koga and colleagues investigated the administration of *goreisan* extract in suppository form. Of 45 patients between 1 and 8 years of age who had acute gastroenteritis or viral gastroenteritis related diarrhea and vomiting and presented the primary complaint of vomiting (28 boys and 18 girls), the researchers found that *goreisan* suppositories were effective in 36 patients (78.3%) and somewhat effective in 6 patients (13.0%). During the same period and season in the following year, those researchers used Western medical treatment without *goreisan*. They monitored patient progress during both years, and reported that, in children experiencing the same extent of vomiting, intravenous fluid support was required 6 times more frequently without *goreisan* than when *goreisan* was included in the treatment regimen[2].

The use of *goreisan* as a suppository was developed out of necessity because of the difficulty of effectively administering oral medications to patients who are prone to vomiting. The original instructions for the treatment of "Water Reverse" conditions called for the oral administration of extremely small amounts of *goreisan* liquid very gradually, in order to control vomiting. However, current research indicates that internal administration can provide equivalent effectiveness. These two studies are the pioneering works in the field.

Ongoing Research

(1) Study by Fukutomi et al.[3]

Fukutomi and colleagues selected 211 children age 6 months to 11 years (mean 3.7 ± 2.3 years) who came to the hospital with the primary complaint of vomiting and in whom acute gastroenteritis was suspected. The researchers dissolved *goreisan* extract 2.5 g in 20 mL of warm physiological saline solution, and administered the resulting liquid by catheter as an enema. If the enema stopped the vomiting, the treatment was considered to be effective. If the vomiting continued but lessened in severity, treatment was considered somewhat effective, and if the vomiting continued to the point of dehydration requiring supplemental i.v. fluids, the treatment was considered to be ineffective. The overall efficacy rate for the *goreisan* enema was 82.9%. Efficacy by age range was as follows: 80.0% at 0 years of age, 80.0% for 1-year-olds, 85.7% for 2-year-olds, 82.1% for 4-year-olds, 86.5% for 5-year-olds, 88.2% for 6-year-olds, 80.0% for 7-year-olds, and 83.3% for 8-year-olds. The *goreisan* enema was effective in all treated children 9 years of age or above (the number of patients in this age group was very small).

The researchers also investigated the efficacy of *goreisan* in relation to the number of times the child had vomited before being brought to the hospital. They found that better results were achieved in cases where fewer vomitings had occurred. Symptoms before coming to the hospital were vomiting in 72 cases (34.1%), and vomiting and fever in 87 cases (41.2%). Where fever was noted, it was measured at 37.5°C to 38°C in 35.6% of patients, 38°C to 38.5°C in 56.3%, and more than 38.5°C in 8.0% of cases. Additional symptoms included abdominal pain in 32.2%, and upper respiratory inflammation such as cough and nasal drip in 11.8% of cases.

(2) Study by Yoshida[4]

Yoshida used *goreisan* suppositories, already widely accepted for pediatric applications by Kampo pediatric specialists in a double-blind randomized clinical trial (DB-RCT). For the comparator drug he used *hochuekkito* (Bu-Zhong-Yi-Qi-Tnag, 補中益気湯) suppositories prepared by the same method. Targeted subjects

were 34 children (21 boys and 13 girls age 1 to 9 years, mean age 3.9 years) who had vomited at least 3 times in the 24-hour-period before coming to the hospital, and who presented with nausea and/or vomiting. The children were treated with numbered suppositories using the double-blind method. Thirty minutes after administration, the children were given water to drink, and the effectiveness of treatment was evaluated on the basis of whether or not this induced nausea and/or vomiting.

There was no statistically significant difference between the *goreisan* suppository group of 16 children (10 boys and 6 girls) and the Hochu-ekki-to group of 18 children (11 boys and 7 girls) with regard to age, sex, number of vomitings, presence or absence of diarrhea, or underlying disease. Within the *goreisan* group, treatment was effective in 12 patients (75%), somewhat effective in 2 patients, and ineffective in 2 patients. In the Hochu-ekki-to group, treatment was effective in 5 patients (28%), somewhat effective in 2 patients, and ineffective in 11 patients.

(3) Study by Hashimoto[5)]

Hashimoto treated acute gastroenteritis patients with *goreisan* enema (297 children) or *saireito* enema (263 children). The mean number of days before coming to the hospital was 1.2±4.2 for the *goreisan* group and 1.0±1.0 for the *saireito* group. The study showed no significant difference in the efficacy rate between the two groups (*goreisan* 84.8%, *saireito* 85.6%). There was also no significant difference in the efficacy rate with regard to patient age, fever, or number of vomitings.

These findings indicate that *goreisan* can be highly effective against pediatric acute gastroenteritis. The reports show an efficacy rate of 75% to 84%, proof of the usefulness of *goreisan* in treating this condition.

Administration was either by suppository or by enema. Since the results showed no significant difference between these two methods, medical practitioners should feel free to choose the method that is easiest for them and for their patients.

The Yoshida study (DB-RCT) was performed using *hochuekkito* as the comparator drug. That prescription, which is classified as a Qi Tonic prescription, is not considered to be effective in treating diarrhea from conditions such as infectious enteritis. This study, performed with the consent of patients and guardians, showed that *hochuekkito* was ineffective while *goreisan* was highly effective, as expected. The study by Hashimoto used prescriptions of *goreisan* and *saireito. Goreisan* is included within the formulation of *saireito* as an ingredient, so these two prescriptions were essentially the same. Results for these two prescriptions were nearly identical, as would be expected.

Closing Remarks

As long as dehydration can be prevented, pediatric acute gastroenteritis, due to rotavirus or norovirus infection, is not a particularly serious condition. However, most patients improve quickly if given early treatment with *goreisan* extract in the form of a suppository or enema. Out of consideration for the child's symptoms and the worry and strain on the parents, it is obviously important to relieve this condition as soon as possible.

Additionally, in the developing nations where modern medical procedures such as intravenous

drip might be unavailable, these prescriptions and treatment methods could provide an extremely important tool for reducing mortality. It is our hope that this research will prove useful to those ends.

Reference

1) Morishima A: Effectiveness of *goreisan* enema in the treatment of pediatric vomiting. Kampo medical treatment 6:30-32, 1987
2) Koga M, et al.: Effectiveness of *goreisan* suppository in the treatment of pediatric vomiting. Journal of the Japan Research Group for Oriental Medicine 11:30-32, 1995
3) Fukutomi O, Matsuo N, Teramoto T, et al.: Study of *goreisan* enema in the treatment of pediatric vomiting that accompanies acute gastroenteritis. Japanese Journal of Pediatrics 53:967-970, 2000
4) Yoshida M: Effectiveness of *goreisan* suppository in the treatment of pediatric vomiting. Toyo Igaku 28(3) 36-38, 2000
5) Hashimoto H: Comparison of *goreisan* and *saireito* enemas in the treatment of vomiting that accompanies pediatric viral gastroenteritis. Kampo Igaku 25: 73-75, 2001

Clinical Report 1 (Japan)

Acupuncture for Cervical Dystonia

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Abstract

We introduce our new concept for acupuncture therapy in patients with cervical dystonia. To achieve satisfactory therapeutic effects, we divided the affected muscles into two groups using clinical evaluations and EMG findings on motion analysis, i.e., muscles affected by a primary disorder and those by a secondary disorder. Abnormal hypertonus or hypotonus of the muscles and unsustained head movement are designated as the primary disorder. Muscle and skin shortening were designated as the secondary disorder. We used the needle retaining method for primary disorders and multiple epidermis-penetrating needle stimulation on tender spots for secondary disorders. Thus, we applied these different and specific acupuncture treatments to each group once a week. After 10 sessions of acupuncture treatment, clinical examination showed improvement in 72.9% of the patients, EMG evaluations showed improvement in all patients, and with no side effects in any patients. The characteristics of patients who did not respond to our acupuncture treatment were as follows: 1) longer duration of disease, 2) neck posture demonstrating retrocollis, 3) severe unsustained head movement, 4) longer intervals of treatment of more than a week, and 5) treated by several different methods of acupuncture previous to our treatment.

These findings suggest that acupuncture treatment using the needle retention method combined with multiple epidermis-penetrating needle stimulation is one of the most effective and promising methods in patients with cervical dystonia.

Key words: cervical dystonia, acupuncture, electromyography, primary and secondary disorder, needle retention method, multiple epidermis-penetrating needle stimulation

I. Introduction

Dystonia is a diverse set of movement disorders characterized by involuntary muscle contractions, which may cause twisting and repetitive muscle movements, or abnormal postures. Different classifications of dystonia have been proposed based upon the following criteria: distribution of affected body parts, age at onset, cause, and genetic criteria. Cervical dystonia is one of the most common subtypes of dystonia.

Dystonia is the least understood movement disorder associated with basal ganglia dysfunction; however, a newly proposed hypothesis to explain this disorder involves multiple levels of the nervous system: spinal cord, basal ganglia, thalamus, somato-sensory system, sensorimotor integration, and motor cortical function[1)].

Treatment options for dystonia include drug treatment and surgical procedures. Drug treatment can be subdivided into the application of systemically active orally administered drugs and local botulinum toxin injections, while surgical treatment may involve selective peripheral denervation or functional brain surgery. We treated patients with cervical dystonia using acupuncture, and followed their progress by clinical and electromyography (EMG) evaluations[2)]. In this report, we introduce our new acupuncture method and provide clinical and EMG evaluations of the outcome.

II. Materials and Methods

To determine the most appropriate

acupuncture method for each patient with cervical dystonia, clinical and EMG evaluations were performed before acupuncture treatment. Based on these clinical and EMG evaluations, acupuncture regimens were developed respectively for primary or secondary disorders of cervical dystonia. Primary disorders indicate local muscular hypertonus, hypotonus, or unsustained head movement due to basal ganglia dysfunction or other causes derived from the central nervous system. Secondary disorders indicate muscle and/or skin shortening due to primary disorders.

Written informed consent for our acupuncture method was obtained from each patient.

1. Clinical evaluations

Clinical evaluation included the Tsui scale modified by Mezaki et al.[3], range of motion (ROM) of the neck and visual analogue scale.

① Modified Tsui scale (Table 1)

Table.1 Modified Tsui Score

A) Amplitude of sustained movements
(Rotation, Lateral head tilt and Antero-or Retro-collis)
0:absent 1:<15° 2:<30° 3:<45° 4:≧45°
B) Duration of sustained movements
1:intermittent 2:constant
C) Axial distortion
・Scoliosis
0:absent 1:<15° 2:<30° 3: ≧30°
・Shoulder- elevation
0:absent 1:<7° 2:<15° 3: ≧15°
D) Unsustained head movements
・Severity
1:moderate, 2:severe
・Duration
1:occasional, 2:continuous

Total Score=(A×B)+C+D

This scale has a maximal score of 34 and assesses the abnormality of neck posture based on the amplitude of sustained movements of the neck, duration of sustained movements of the neck, axial distortion, and unsustained head movement.

② ROM of the neck

Active and passive ROM of the neck were tested to clarify abnormal mobility, muscle tonus, muscle and skin shortening, and muscle weakness.

③ Visual analogue scale

The visual analogue scale awarded values on a scale of 0 (normal) to 10 (worst).

2. EMG evaluation

EMG evaluation using Viking Ⅳ (NICOLET) tested the EMG activity of the sternocleidomastoid muscle (SCM), the trapezius muscle and the splenius muscle (SPL) at rest and during actions involving 5 different movements: neck flexion, extension, right rotation, left rotation, and shoulder elevation in the sitting position. To determine whether shoulder and trunk muscles were affected, EMG activities of these muscles, such as the abdominal muscle and erector spinae muscle, were also tested. In addition, neck movement was tested using displacement transducers, built-in reel type (KYOWA) and dynamic strain amplifiers, DPM-601A (KYOWA), simultaneously with EMG records

The affected muscles with clinical evaluations showing abnormal EMG findings indicated primary disorders, i.e., hypertonus muscles, hypotonus muscles, or unsustained head movement. Affected muscles with normal EMG findings indicated secondary disorders, i.e., muscle shortening. Skin shortening is also an important secondary disorder.

3. Acupuncture methods

The needle retention method on the meridian points for primary disorders and multiple epidermis-penetrating needle stimulation on tender spots for secondary disorders were applied once a week.

For the needle retention method, pre-sterilized disposable acupuncture needles (0.2 mm in diameter, 50 mm in length) were inserted ipsilaterally into Hegu (LI4) when the SCM muscle was affected. Also, we selected ipsilateral Waiguan (TE5) when the trapezius was affected

and ipsilateral Houxi (SI3) when the SPL muscle was affected. The selection of these acupoints was based on the meridian concept of typical distal acupoints on the meridians running through the affected muscles. If the affected muscles included the trunk flexor or extensor muscles, pre-sterilized disposable acupuncture needles were inserted into the ipsilateral Chongyang (ST42) and ipsilateral Kunlun (BL60), respectively. Acupuncture needles were inserted 5 mm in depth and left in place for 5 minutes to decrease and 10 minutes to increase muscle tonus. A retained needle on Baihui (GV20) at the top of the head was used for treating unsustained head movement, with needles being 5 mm in depth and left for 10 minutes. For muscle and skin shortening, ten points in the tender area were selected and multiple epidermis-penetrating needle stimulation was applied to decrease the tension in the tender area.

III. Results

1. Effect of acupuncture

Among 48 patients (26 males and 22 females, mean age of 40.8 years, mean disease duration of 44.8 months; range: 3- 252 months), clinical examination, especially by the modified Tsui scale, showed improvement in 35 patients (72.9 %), and no change or deterioration in 13 patients (27.1%) after 10 sessions of acupuncture treatment. EMG evaluation showed improvement in all patients after the acupuncture treatment. There were no side effects in any of the patients.

The characteristics of patients who did not respond to our acupuncture treatment were as follows: 1) longer duration of disease, 2) neck posture demonstrating retrocollis, 3) severe unsustained head movement, 4) more than 1 week intervals between acupuncture sessions, and 5) treated by several different methods of acupuncture previous to our treatment.

2. Case studies

Patient 1 was a 24-year-old male. He had previously received medication and MAB (muscle afferent block) in other hospitals, but the neck posture remained unchanged and demonstrated left rotation and left lateral flexion. The modified Tsui score was 14. Clinical and EMG evaluations revealed that the main problems were increased muscle tonus in the left SPL and decreased muscle tonus in the left SCM. EMG activity in the left SCM during right neck rotation was weak (Figure 1, left). Acupuncture treatment was initially performed once a week using the retaining needle method at the left Houxi (SI3) to decrease the tonus of the left SPL and left Hegu (LI4) to increase the tonus of the left SCM. Multiple epidermis-penetrating needle stimulation was employed in the left nuchal region before the retention needle method was applied. After 25 sessions using these techniques, the abnormal neck posture with left rotation and left lateral flexion, and EMG findings during right neck rotation were markedly improved and the modified Tsui score recovered to 8 (Figure 1, right).

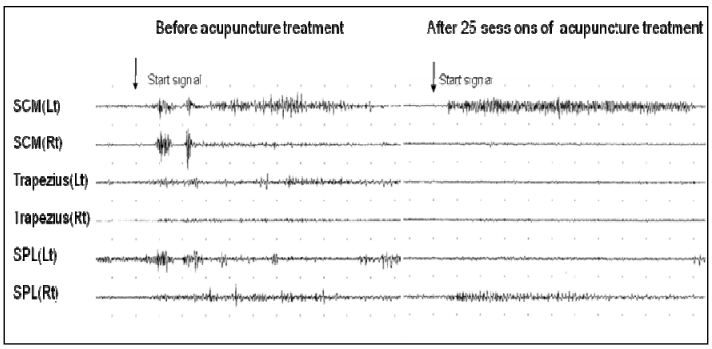

Figure 1

Patient 2 was a 21- year-old female. She had previously received medication and MAB in other hospitals, but left rotation of the neck and left elevation of the shoulder girdle were still prominent. The modified Tsui score was 25 and the visual analogue scale was 10. Clinical and EMG evaluations revealed that the main problems were increased muscle tonus in the

right SCM and the left SPL, and shortened skin at the left front region of the neck. EMG activities in the right SCM and the left SPL increased during right neck rotation (Figure 2, left).

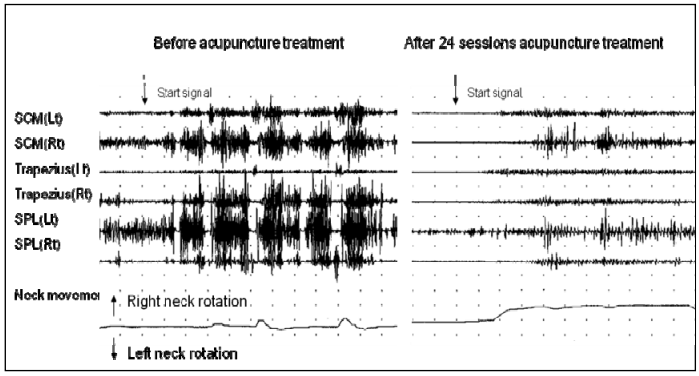

Figure 2

Acupuncture treatment was initially performed once a week using the needle retention method at the right Hegu (LI4) and left Houxi (SI3) to decrease the tonus of the right SCM and left SPL. Multiple epidermis-penetrating needle stimulation was employed at the front neck to stretch the skin before the needle retention method was applied. After 10 sessions using these techniques, the abnormal neck posture was slightly improved to 22 in the modified Tsui score, and 7 on the visual analogue scale. However, elevation and flexion of the left shoulder girdle still remained, indicating the involvement of the levator scapulae muscle and pectoralis major. Therefore, the needle retention method at the left Kunlun (BL60) to decrease the tonus of the left levator scapulae muscle and at the left Chongyang (ST42) to decrease the tonus of the left pectoralis major muscle was added to the regular acupuncture regimen. The EMG data, modified Tsui score, and visual analogue scale showed further improvement after 40 sessions of acupuncture treatment (Figure 2, left and Figure 3).

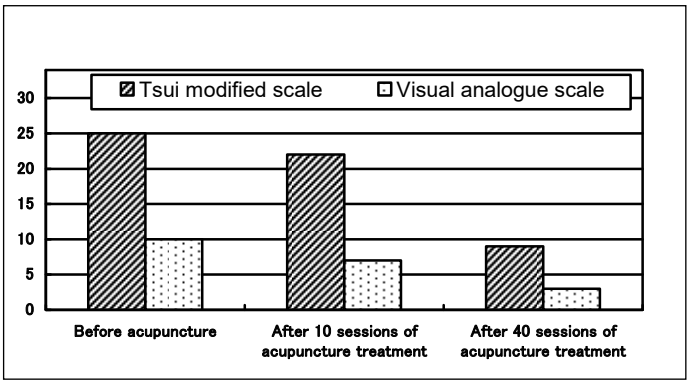

Figure 3

Patient 3 was a 47-year-old male with retrocollis and extension of the trunk. Clinical and EMG evaluations showed that the main problems were increased tonus in the bilateral trunk extensor muscles and the bilateral SCM, and decreased tonus in bilateral trunk flexor muscles during walking (Figure 4). Acupuncture treatment was initially performed once a week using the needle retention method at the bilateral Kunlun (BL60) to decrease the tonus of the bilateral trunk extensor muscles and bilateral Chongyang (ST42) to increase the tonus of the bilateral trunk flexor muscles. Neck and trunk posture during walking were improved with almost normal EMG data after 24 sessions of acupuncture treatment (Figure 4).

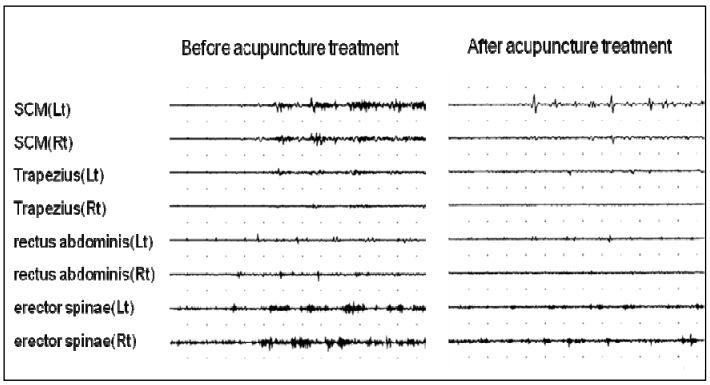

Figure 4

IV. Discussion

Treatment of cervical dystonia includes several methods such as medication, injection of botulinum toxin, surgery, and so on, but presently, there are no specifically effective methods. Although acupuncture is not widely accepted as a common method to treat this intractable

neurological disease, we applied acupuncture in patients with cervical dystonia, and developed a unique method of acupuncture treatment. Our method employs knowledge of both modern medical technology and ancient Chinese/Japanese traditional medicine, particularly that of meridians.

The following is a summary of our unique acupuncture method:

1) Using clinical evaluations and EMG findings on motion analysis, we divided affected muscles into two groups, muscles affected by primary disorder and those by secondary disorder. Thereafter, we applied different and specific acupuncture methods to each group.

2) For muscles with primary disorder, we used the needle retention method on distal acupoints along the meridian running through the affected muscle. For muscles with secondary disorder, multiple epidermis-penetrating needle stimulation on tender spots was applied. In our previous study[2], EMG findings during and after acupuncture using our method were much improved compared to other acupuncture methods, indicating the superiority of our method.

3) In addition, we applied the same acupuncture method to trunk muscles, and found that it was very important to improve trunk function for the successful treatment of cervical dystonia. When we assessed patients who had both cervical and trunk postural abnormalities, we realized that correction of the trunk muscles positively influenced the postural abnormality of the neck.

4) We decided the depth of retained needles to be 5 mm since the potential in the primary sensory area during acupuncture treatment with 5 mm depth showed a significant change in the somatosensory evoked potential (SEP).

5) We decided the standard duration of retained needle treatment to be 5 minutes to decrease muscle tonus and 10 minutes to increase it, although we changed the duration to some extent according to the condition of the affected muscles, determined by manual palpation in individual cases. Importantly, techniques such as botulinum toxin injection can only decrease muscle tonus, whereas we found that acupuncture can produce bidirectional effects, both increasing and decreasing muscle tonus.

6) For multiple epidermis-penetrating stimulation on tender spots, we learned from our experience that we should continue stimulation until the tenderness disappears in each treatment.

7) In patients with dystonia exhibiting both primary and secondary disorders, we found that we have to treat muscles with secondary disorders first.

Although the effectiveness by clinical evaluations after 10 sessions was 72.9 %, there were some patients who did not show any improvements using our method. Therefore, we need to develop other new techniques of acupuncture treatment for those patients, particularly with retrocollis and unsustained head movement.

V. Conclusions

We have developed a unique method of acupuncture treatment using knowledge of modern medical techniques as well as ancient Chinese/Japanese traditional medicine. We believe that our method will become one of the most effective treatments for patients with cervical dystonia.

Reference

1) Maja T: Dystonia update. Curr Opin Neurol 16:495-500, 2003

2) Suzuki T, et al: Evaluations clinique et electromyographique de l'effet de l'acupuncture sur les patients souffrants de torticolis spasmodique. MERIDIENS 115:17-26. 2000 (French)

3) Mezaki T, et al: The clinical usefulness of Botulinum Toxin type A for spasmodic torticollis and facial spasm. Brain and nerve 47: 749-754, 1995 (In Japanese and abstract in English)

Introduction of Kansai University of Health Sciences (KUHS)

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1) General information of Kansai University of Health Sciences

Kansai University of Health Sciences (KUHS), former Kansai College of Oriental Medicine (KCOM), is located in southern Osaka Prefecture near Kansai International Airport. Access from the airport as well as from the railway station is very convenient. KUHS is composed of three departments, Department of Acupuncture and Moxibustion, Department of Physical Therapy and Graduate School of Health Sciences. The Department of Acupuncture and Moxibustion includes two divisions, a program in oriental medicine and a program in acupuncture and athletic training.

KCOM was founded in 1985 as a three-year college for training acupuncturists, then reorganized as a four-year college in 2003. On April, 2007, a four-year program for physical therapists was added, and the name of the institution became Kansai University of Health Sciences. In addition, a postgraduate two-year master degree program was started at the same time.

2) Educational stuffs of KUHS

The motto of KUHS is bringing up young talent to serve the community as an acupuncturist or physical therapist. To send fully trained professionals to the community, KUHS provides capable teachers in the fields of general education, basic and clinical oriental medicine, basic and clinical western medicine, acupuncture and moxibustion, and physical therapy all supported by a detailed curriculum.

3) Research works conducting in KUHS

Researchers actively perform investigations in the field of basic and clinical medicine related to acupuncture and moxibustion, and physical therapy. The themes of each research team are listed below.

(1) Anatomical and biological investigation of the mechanisms of action of acupuncture and moxibustion

(2) Investigation of the influence of acupuncture and moxibustion on the immune system

(3) Neurobiology of acupuncture stimulation

(4) Novel acupuncture treatment in patients with cervical dystonia and related disorders

(5) Study of the effect of acupuncture in patients with hemodialysis

(6) Effect of acupuncture treatment on patients with osteoarthritis of the knee - a randomized controlled trial

(7) Changes in the autonomic system following acupuncture stimulation

(8) Psychological changes in patients receiving acupuncture and moxibustion

(9) Study of the effect of ear acupuncture

4) Outpatient Clinic attached to KUHS

The mission of our outpatient clinic is to render good service to the community and patients, and to lead our students to learn clinical skills of acupuncture and moxibustion, physical therapy, as well as skills for personal communication. Our outpatient clinic has 16 medical doctors working in the Divisions of Internal Medicine, Neurology, Psychiatry, Orthopedics, Surgery, Rehabilitation, Dermatology, Gynecology and Kampo Medicine (Japanese traditional herbal medicine). The clinic is equipped with MRI and other modern technological instruments to establish a precise diagnosis as well as to prepare crude drugs from plants and animal products to provide traditional and natural remedies.

In addition, the clinic has an institute for acupuncture and moxibustion treatment. Presently, 21 acupuncturists work in the institute treating patients using traditional, modern or combined techniques. Techniques or principles used are traditional Japanese / Chinese medicine, Ryodoraku method, Akabane method, trigger point techniques and so on.

In conclusion, KUHS provides good opportunities for the students aiming to become a knouledgeable, skillful and well trained acupuncturist and physical therapist as well as for patients who are eager to receive oriental medical therapies and integrated (modern and traditional combined) medical therapies.

Photo1: University Campus,

Photo 2: Outpatient Clinic

Clinical Report 2 (Japan)

Two Cases for which Boiogito (Fang-Yi-Huang-Qi-Tang, 防已黄耆湯) was effective for Rheumatoid Arthritis

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Boiogito is the first selective prescription for degenerative rheumatoid arthritis. In this case study we report on two cases of advanced rheumatoid arthritis that, as we have experienced, were responsive to "*boiogito* plus moderate amounts of other Kampo elements".

Case Report

Age 73 , Female

Chief Complaint: Polyarticular pain

History, Family history: No particular mention

History of Pharmaceutical Adverse Reaction: Felt sick by Salaziopyrin. Shiozol drug eruption, renal disorder due to Rimatil, hematuria due to Methotrexate.

Present Illness: Rheumatoid arthritis occurred in 1974. Pains in nearly all joints since 1994. Antiphlogistic analgetic and immune suppressant unable to manage pain. For two years had difficulty walking and visited this department. PSL now in use for these four years.

Findings by Wakan Medicine: Face and four limbs swollen. Pain in all the joints, especially knee joint pain with the accumulation of joint fluids. Five hours of morning stiffness. Fatigable and cold limbs. Lips and gum dark red. Pigmentation in orbicularis oculus region.

Steinbrocker's staging classification: Class 4

Pulse condition: Intermediate between floating and deep, slightly weak, and slightly irregular.

Tongue condition: Purple and slightly swollen. Covered with moderate furs with puncta.

Abdominal condition: Strength - slightly flaccid, stuck feeling in pit of stomach, excessive strain of abdominal muscles, and pain at side of navel on palpation.

Course: Treated with *boiogito* plus Non-prepared *Aconiti* Radix 4g. After one year, treatment effects were assessed with the results of improvement in hours of morning stiffness from 5 to 1.5 hours. Lansbury's index score from 168 to 15., and sedimentation value to 21mm/h from 40mm/h. Edemas were alleviated with a weight reduction by 4kg. Steinbrocker's functional classition was improved to Class 3 from Class 4. At the time of this report, the patient who has a 13 year history of hospital visits, continues to visit using a cane.

Case Report

Age 62, Female

Chief Complaint: Polyarticular pain

Past History: Tonsillectomy (1965), removal of thyroid gland (1967), pregnant toxicosis (1967), artificial joint replacement (right knee joint 1995, left knee joint 1997).

Family History: Father - SLE

History of Pharmaceutical Adverse Reaction: Drug eruption due to Rimatil.

Present Illness: Rheumatoid arthritis occurred in 1962. Pain in nearly all joints since 1994. Gold drug and PSL were started. Immunosuppressant being administered since 1997. The first visit to this department of the hospital was May 28, 1997.

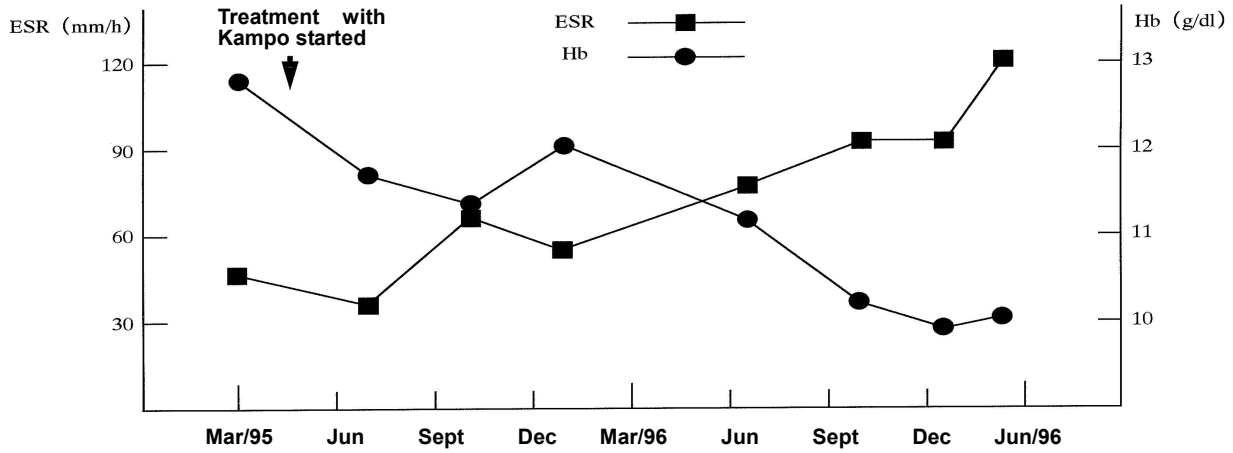
Findings by Wakan Medicine: Feels somatic fatigue, fatigable. Sensitive to cold. The body feels heavy and hands are stiff in the morning.

Steinbrocker's staging classification: Class 4

Pulse condition: Slightly deep, weak and irregular.

Tongue condition: Pale white with tooth scars.

Abdominal condition: Strength – moderate. Stuck feeling in pit of stomach and pain at side of navel on palpation.



Course: Fig 1 shows the course of ESR and Hb after the treatment with *boiogito* plus Non-prepared *Aconiti* Radix 2g. After one year, the morning stiffness disappeared and joint scores was reduced to 13 from 40 with an improvement in Lanbury's index to 19% from 86%. Loxoprofen and Diclofenac suppository were no longer required. Steinbrocker's functional classification was Class 3 without any difference between before and after the treatment.

Following is the record the patient wrote in her rheumatism note.
Since the start of Kampo medication, the body feels light. Able to go to a supermarket for shopping with the support of a baggage cart. Facial swelling slightly reduced. Have become able to wash the face as previously.

This case may be a successful example of Kampo medication. However, her husband called to tell of her death in 1999. (The death was not related to rheumatoid arthritis.)

I have experienced many cases of rheumatoid arthritis for which *boiogito* was effective. *Boiogito* are considered the first-line medication for rheumatoid arthritis with the main symptom of joints pain in the lower extremities.

If the course is prolonged, the practitioner can increase the amounts of *Sinomeni* Caulis et Rhizoma, *Astragali* Radix, and *Atractylodis Lanceae* Rhizoma and to add moderate amounts of *Aconiti* Radix Processa and non-prepared *Aconiti* Radix.

Case Series

Kampo Treatment for Rheumatoid Arthritis

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Introduction

Rheumatoid arthritis is a systemic inflammatory disease characterized by chronic destructive processes with non-suppurative arthritis as its leading symptom. Even today, there is no established therapy available for this condition. Here I would like to discuss the application of Kampo for the treatment of rheumatoid arthritis.

Materials and Methods

Over the 12 years from April 1994 until April 2006, 46 patients (7 men and 39 women) of the total 73 patients who consulted the Center for Oriental Medicine of the Suwa Chuo Hospital were the subject of this study. The morbidity duration was on the average 11.6 years and the Steinbrocker function as well as the average value of the disease stage classification were Class 2.2 and Stage 2.4 respectively. Prior to consultation, 36 patients had been treated with western medications.

For the evaluation of the effects of Kampo treatment I used the Lansbury index. Generally, duration of the morning stiffness, articular scores, grip power and the erythrocyte sedimentation rate are used for the calculation of the Lansbury index. Since I did not measure the grip power in this study, this parameter was excluded and therefore calculated as a modified Lansbury index. A marked effectiveness was defined as a drop in this modified Lansbury index to below 25% of the pretreatment value after one year of treatment with Kampo medications. Below 50% was designated as effective, below 75% as slightly effective and other results assessed as ineffective. The results before and after the Kampo treatment were compared using the paired t-test.

Results

Marked effectiveness was observed in 43.5%, effectiveness in 15.2%, slight effectiveness in 17.4% and no effect in 23.9%. Among the 36 patients receiving western medications, 24 patients could either discontinue that medication or reduce the dosage. The modified Lansbury index dropped from 41.7% to 19.1% ($p<0.0001$, Figure 1), the average Class staging fell from 2.2 to 1.8 ($p<0.0001$) and thus indicated a significant improvement. Other improvements of the CRP and γ-globulin values were also observed (Table 1).

Table 1 Variations in laboratory values before and after treatment

	Before treatment	After treatment
Leukocytes (/mm^3)	8002±3469	6055±1762*
Eosinophils (/mm^3)	5194±2784	3786±1467*
Lymphocytes (/mm^3)	1830±641	1629±557*
Hemoglobin (g/dl)	12.6±1.5	12.7±1.6
Platelets (/mm^3)	31.4±10.7	28.1±8.6
Total protein (mg/dl)	7.5±0.6	7.0±1.3*
γ-globulin (mg/dl)	1.37±0.53	1.17±0.32*
CRP (mg/dl)	3.2±3.0	1.7±2.6*
ESR (mm/hr)	50.6±33.5	34.2±26.5*
CH_{50} (mg/dl)	42.3±3.7	40.2±5.3

*$p<0.05$ mean±SD CH_{50} had been measured in 12 patients

Side effects of non-prepared *Aconiti* Radix were observed in 13 patients but alleviated in all patients with a decrease in dosage (Table 2)[1]. During the evaluation one year later it was found that 5 patients received roasted aconite, 10 patients received salt *Aconiti* Radix (aconite

soaked in salt water, sprinkled with lime stone and dried) and 23 patients received non-prepared *Aconiti* Radix, so that a total of 38 patients had been treated with aconite and the maintenance dose was on the average 3.2g/day.

Side effects of *Astragali* Radix were observed in 2 patients who received 20 g/day, which corresponds to 5-6 times the usual dosage. Yet, when treatment was switched to *Hedysari* Radix the treatment could be continued[2].

Table 2 Side effects of aconite

Age	Sex	Aconite	Toxic amount (g)	Measures	Outcome	Prescriptions	Initial symptoms
65	Female	raw aconite	5.5	brewing instructions	improvement	*tokikenchuto*	Numbness around lips
28	Female	raw aconite	5.0	aconite dosage reduction	improvement	*keishikaryojutsubuto+α*	Numbness around lips
54	Female	raw aconite	4.0	aconite dosage reduction	improvement	*boiogito*	Sensation of physical instability
62	Male	raw aconite	1.5	aconite dosage reduction	improvement	*keishikaryojutsubuto+α*	Sensation of physical instability
54	Male	raw aconite	3.5	aconite dosage reduction	improvement	*boiogito*	Nausea
63	Female	raw aconite	5.0	switching to salt aconite	improvement	*boiogito plus aconite*	Numbness around lips
50	Female	raw aconite	2.0	aconite dosage reduction	improvement	*keishakuchimoto*	Epigastric discomfort
53	Female	raw aconite	5.0	aconite dosage reduction	improvement	*bushito+α*	Tingling sensation of cheeks, insomnia
78	Female	roasted aconite	4.5	aconite dosage reduction	improvement	*bushito*	Numbness in lips, Blackouts
56	Female	roasted aconite	1.0	discontinuing aconite	improvement	*hochuekkito plus aconite*	Stuffed nose, headache
49	Female	roasted aconite	0.7	aconite dosage reduction	improvement	*bukuryoshigyakuto*	Rising blood pressure
50	Male	roasted aconite	1.0	discontinuing aconite	improvement	*boiogito*	Epigastric discomfort
65	Female	processed aconite powder	0.5	Discontinuing	improvement	*daibofuto*	Nausea

Table 3 shows the variations in the Lansbury index obtained with prescriptions that led to slight improvements or better results. *Boiogito+α* followed by *keishikaryojutsubuto+α*, *bushito*, *keishinieppiichito+α* were most frequently effective. When in the *boiogito* a higher than usual dosage of both *boiogito* was used. The preparations were found to be effective quite frequently. Moreover, when the use of *keishikaryojutsubuto+α* by itself did not produce sufficient results, combination with *boiogito* often allowed to increase its effectiveness[3]. In the present study a combination was used for 4 out of the 7 patients treated with *keishikaryojutsubuto+α*.

Table 3 Effective Prescriptions

boiogito	13 cases
keishikaryojutsubuto+α	8 cases
uzuto	3 cases
keishinieppiichito +α	3 cases
daibofuto	2 cases
bukuryoshigyakuto	2 cases
Others	4 cases

Discussion

In the classic of Kampo therapy, "Shang Han Lun (Discussion of Cold-induced Disorders)" and "Jin Gui Yao Lue (Essentials from the Golden Cabinet), various passages such as "painful suffering of bones and joints, painful suffering of the body, relate to athralgia[4], slightly tensed limbs, pain of bones and joints, pain affecting the entire body, pain in the joints of the limbs, people having difficulties in bending and extending their joints, pain causing by light touch, pain in the various joints and inability to bend or extend them, inability of rolling over etc." According to these descriptions rheumatoid arthritis seems to have existed 2,000 years ago and treated with Kampo medicine.

In the present study, the pretreatment Lansbury index of 43.5% of the patients improved and fell below 25%, thereby verifying a certain usefulness of Kampo medications. Yet, since the manufacture of Kampo placebos is associated with many difficulties, the evaluation of therapeutic effects included no control group.

Although the modified Lansbury index did not show any improvements, the eleven patients in whom the treatment was assessed as ineffective, still continued to visit our clinic after one year. Asking the patients for their reasons to continue the treatment, two stated, it allowed them to discontinue immunomodulators, one stated the ability to discontinue immunosuppressive drugs, three stated reduction in arthralgia, one reported the ability to walk with a walker, one a reduction in edema and feeling of greater comfort, one cited an improvement in the tendency to feel cold, and two said they were under the impression it is better to take the Kampo medicine. These 11 patients seemed to regard the Kampo therapy as having certain positive effects.

When the use of *keishikaryojutsubuto+α* by itself did not produce sufficient results, addition of *Sinomeni* Caulis et Rhizoma and *Astragali* Radix often increased its effectiveness[4] . Side effects of *Aconiti* Radix were observed in 13 patients (Table 3). This was probably due to the gradual increase in the dose of *Aconiti* Radix until sufficient therapeutic effects were obtained. The incidence of adverse reactions of Disease Modifying Antirheumatic Drugs (DMARDs) is said to be 60%[5]. Thus, the incidence of adverse reactions of therapeutic drugs for rheumatoid arthritis represents a problem. Often the mode of

action of Kampo medicines varies from that of western medications, but if *Aconiti* Radix is used carefully, there should be few side effects. The indication for Kampo medicines also depends on the disease stage. A combination therapy with western medications is possible. Rheumatoid arthritis is considered to be one of the diseases for which Kampo medications may be expected to be sufficiently effective.

Significance of the use of Kampo formulations for rheumatism

(1) Improvement of symptoms other than arthralgia may be expected.

Kampo medicine does not simply eliminate pain, but also bestows a feeling of wellness and improves feelings of coldness etc.

The symptoms of rheumatoid arthritis may improve simultaneously.

(2) Many Kampo formulations affect the immune system.

Some people assert that "*hochuekkito* and *juzentaihoto* act on the immune system, but *keishikaryojutsubuto*, *boiogito*, drugs for overcoming blood stagnation simply alleviate the pain". However, this concept is mistaken. While *boiogito* and formulation for dissolving blood stagnation do alleviate pain, they also improve γ-globulin and antinuclear antibody levels. Just alleviating the pain cannot explain this improvement in γ-globulin and antinuclear antibody levels. Thus, Kampo medications may be classified as immunomodulators.

(3) In contrast to the delayed activity of immunomodulators, Kampo formulations have fast-acting properties.

Evaluation of results after one year in this study revealed that if no effects appeared between the second to fourth week, either changing the prescription or else adding Aconiti Radix, Sinomeni Caulis et Rhizoma, Astragali Radix etc. might enhance the pharmacologic effects of the Kampo formulations.

Reference

1) Kazuhiko Nagasaka: Discussion of 33 cases presenting with aconite intoxication, Journal of Traditional Medicines, 16 (4), 168-174, 1999
2) Kazuhiko Nagasaka, others: Investigations of side effects of Ogi, Kampo and Modern Therapy, 8 (1) 35-38, 1999
3) Mosaburo Kainuma, others: Significance of prescriptions with added Sinomeni Caulis et Rhizoma, Astragali Radix for the treatment of chronic rheumatoid arthritis, Journal of The Japan Society for Oriental Medicine, 48 (6) 91, 1998(collection of abstracts)
4) The Japan Kampo Medicin Association, academic department: Shokanzatsubyoron, Toyo Gakujutsu Shuppansha, Japan, 2000
5) Kouichiro Ishikawa, others: Trial results of long-term "Bucillamine" application for the treatment of chronic rheumatoid arthritis, Inflammation, 8 (2) 169-180, 1988

Clinical Report (Europe)

Case Report: Chronic Recurrent Diarrhea

Ulrich Eberhard

The subject in this report was a 69-year old retired teacher with chronic recurrent diarrhea that continued since an acute gastrointestinal infection two years earlier.

Findings:

Recurrent diarrhea (at least 1x/week) continuing for 1-2 days, always starting with colicky pain, mostly following the intake of food. Followed by adynamic defecation of liquid stools (3-4 x daily), occasionally defecation is associated with flatulence.

Previous diagnostics and therapy:

Repeated examination by gastrointestinal specialists without findings, fecal examinations for pathogenic microorganisms repeatedly negative, colon endoscopy revealed no pathologic findings. If required, treatment with Perenterol forte (Saccharomyces bulardii) or Loperamid.

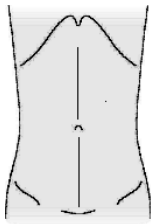
Other anamnestic information:

Weakness and exhaustion
Fatigue and marked need for sleep
Desire for warm beverages
In case of cold beverages or foodstuff, immediate onset of diarrhea
Frequently abdominal pain that improves with the application of heat.

First examination / Shô identification:

Sick appearance, weakness, underweight (46), pallor, withered face
Cold extremities, cold sensitivity
Bloodpressure 120/85 mmHg
Tongue: thin, wet, little fur
Pulse: weak, deep

Abdominal finding: "central core" extending above and below the navel



Course:

Acupuncture and moxibustion: Japanese meridan school (Keiraku Chiryo 1-2 sessions/week).
Kampo prescription: *North Water God Decoction* (Zhen-Wu-Tang,真武湯 *shimbuto*) 9.86 (with Rad. Aconiti praep 0.5).
First prescription for 7 days, well tolerated, no marked changes, since diarrhea recurred on the third day (as usual).
Subsequent prescription of the same formula for 14 days (with Rad. Aconiti praep. 1.0).
No diarrhea during the second and third week of the treatment, frequency of bowel movements: once daily, normally shaped, no colicky pain.
Subsequent prescription of the same formula for 21 days (with Rad. Aconiti praep. 1.0).
During the further course, occasional unformed stools (1x per day), yet no more diarrhea. Further improvement of the general condition (less fatigue, gaining strength, increase in body weight). Acupuncture and moxibustion therapy was discontinued.
Subsequent prescription of the same formula for 28 days (with Rad. Aconiti praep. 1.0). Treatment led to further stabilization and shift towards longer intervals between individual doses of the extract or application only if required. Over an observation period of approximately 12 months the patient remained free from symptoms, only occasionally unformed stools that normalized immediately after application of *shimbuto*.

Introduction of Japanese Acupuncture

Considering the Therapist's Hand (4)

Shuichi Katai

3. Establishment of stimulation methods appropriately modifying responses.

It is important to establish treatment and stimulation techniques allowing the appropriate modification of the responses ascertained through palpation. In other words, a system has to be established determining what kind of stimulation has to be delivered in order to modify specific responses. Since palpation naturally does not include treatment, inclusion of stimulation methodologies in the theory of palpation may seem to be somewhat awkward. For the sake of progress in palpatory skills, it is essential to develop the skills of modifying somatic responses. The reason for this lies in the fact that modification of reactions literally grasped with one's hands through stimulation (therapy) allows for a smoother acquisition of the changes through palpation skills. In fact, palpation skills are techniques to modify somatic responses (in other words, therapeutic techniques) and therefore inseparable from treatment. Thus, efforts should be made to acquire both techniques together rather than try to acquire them separately. It goes without saying, that during the very early stages of the training separate explanations and practice of each portion are easier to comprehend.

When I referred to suitable stimulation methods, a major portion of the decisions regarding the intensity of the stimulation during acupuncture treatment are based on the experience of the clinician. For example, and this is always the same problem, the questions of whether to needle inflamed regions, or else what degree of inflammation would still allow needling, still have no clear answers. Moreover, questions dealing with the conditions of skin, connective tissue, muscles, indurations and the like, as well as the kind of stimulation appropriate for particular situations have not been clearly summarized. Naturally, the theories pertaining to tonification and drainage of deficient and excess states have been established, but tonification of deficient states using moxibustion, while using acupuncture for sedation in states of excess are just too crude. It is possible to use moxibustion for both tonification and sedation of deficient and excess states and acupuncture can be used the same way for both tonification and sedation of deficient and excess states respectively. In this case it is not clear whether the pathologies here associated with the meanings of deficient and excess states are either identical or different, while the differences in the meaning of the methods employed for tonification and sedation are ill-defined.

In Japan, tonification and sedation are often expressed as the strength of the stimulus dose. In other words, a strong stimulus represents reduction, while a weak stimulus represents tonification. However, in China tonification and sedation are not infrequently expressed in form of the changes the stimulation had brought about. For example, there are the expressions that the burning mountain fire method is warm and therefore tonifying, while the heaven-penetrating cooling method is cooling and therefore sedating. For both the burning mountain fire method and the heaven-penetrating cooling method neither the size of the needles, insertion depth nor stimulus dose vary. The difference is solely whether the needle is twisted to right or to the left. Thus, even while using the same terms "tonification and sedation", the techniques related to tonification and sedation are different in China and Japan. In the future, the differences in acupuncture and moxibustion between China and Japan should be the subject of comparative

analyses and research.

Thus, one of the problems clinicians using acupuncture and moxibustion face during their daily clinical practice is that theories pertaining to the association of particular techniques to the various findings on the patient's body surface are not clearly defined. The needling techniques cannot be simply explained in terms of tonification and sedation for the needling and moxibustion skills, but need to be summarized as techniques associated with specific body surface reactions. At the same time it is also necessary to devise and establish a system for the classification of the findings obtained through palpation.

4. The role of theorization within the theories of acupuncture and moxibustion.

It should be clearly defined what role palpation plays in acupuncture and moxibustion theories play within the above described summarization. A unified theory of the classification of reactions identified through palpation as well as the methods of their identification and the techniques for the modification of these reactions has yet to be established.

Only after the reactions and the methods of their identification, as well as the acupuncture and moxibustion techniques with which these reactions are modified have been systematized, these reactions will be regarded as therapeutically significant reactions. If these reactions are not modified by the acupuncture and moxibustion treatment and are judged not to be indications for acupuncture and moxibustion treatment, they may serve as evidence for differential diagnosis. In other words, these reactions do have a significance as rule-out items, but not for the treatment.

5. Establishment of educational methods and practices for the acquisition of palpatory skills.

Since palpation is a skill, it is necessary to acquire this skill through repeated instructions and the practice of identifying somatic reactions. However, the education methods pertaining to palpation skills have not yet been established. In particular the teaching of acupuncture and moxibustion itself has inherent problems. Table 3 summarizes these problems (Table 3).

Table 3 Problems pertaining to the teaching of acupuncture and moxibustion

1. Insufficient educational contents pertaining to acupuncture and moxibustion
2. Dissociation between the academic and practical aspects of acupuncture and moxibustion
3. Acupuncture and moxibustion are taught mainly in the form of lectures
4. Indistinct image of the clinician to be trained
5. Insufficient teaching time for clinical practice
6. Method for the handing down of acupuncture and moxibustion techniques have not been established.

An important question among these problems is that "teachers do not have a distinct image of the clinician to be trained". Since it is not clear what kind of acupuncturist should be raised, students do not understand the relevant intentions.

The next problem is, that "methods for the handing down of skills have not been established". As opposed to the traditional model of "learning through observation", repeated technical instructions should also be accompanied by verbal expressions in order to ensure the transmission of a minimum of technical skills.

Naturally, skills can hardly be verbalized. Certainly, this is an area where seeing is believing and only actual touch will lead to a real understanding. Yet, systemization of a minimal degree of verbalization forms an important part of the work of those who try to teach (transmit) these skills. At least on the stage of basic practical training it is necessary to systemize the verbalization of the techniques. It should be remembered that only thanks to the systematic writings in medical books (verbalization), at least in the classics beginning with "Su Wen" and "Ling Shu", the knowledge and skills of oriental medicine could be handed down to the present day.

All things considered, it should be noted that the percentage of classroom lectures in the curricula of modern educational programs is comparatively too high and thus disadvantageous for a field like acupuncture and moxibustion that centers on practical skills. This is an adverse effect of modern education, where knowledge is considered to be superior to practical skills and thus can be said to represent a social disadvantage for the field of acupuncture and moxibustion. Yet, there are still no signs of changes in the social tendencies overstressing intellectual training. On the contrary, these tendencies seem to gain momentum. It is important here to determine how to establish appropriate methods of handing down technical skills instead of being vexed by the curse of overstressed intellectual training.

Medical History in Japan

Japanese Acupuncture and Moxibustion under the Rule of GHQ after World War II (4)

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

The advent of Law No.217 (the Law for Business of Massage, Acupuncture, Moxa-Cautery, Judo-Orthopaedy etc.), which provided highly desired legislated status for these occupations, was a cause for great rejoicing in the field, and caused acupuncturists to feel more confidence and pride in their work. This law also provided a starting point for a variety of reforms in the field of acupuncture and moxibustion. These reforms were placed in the hands of the acupuncture industry, since the GHQ disapproved of the Ministry of Health and Welfare carrying out the reforms itself. The reforms were thus carried forward with only indirect support from the Ministry of Health and Welfare.

Reeducation of acupuncturists

The first step in reform within the industry was the convening in Tokyo of a "Reeducation Instructor Training Short Course", sponsored by the LMAMP (League of Moxa-cautery, Acupuncture and Massage Practitioners) with the support of the Ministry of Health and Welfare (MHW). This short course, which lasted for 15 days (from September 12 to September 26, 1948), was held to train the instructors who would subsequently lead "reeducation short courses" to be offered in cities and prefectures throughout Japan. Participants included acupuncturists from across the country.

Because the GHQ had previously expressed disapproval at participation by the Ministry of Health and Welfare, the curriculum for the short course was created by members of the acupuncture industry. Materials were drawn from a wide range of sources, not limited to the classical Asian medicine theory of acupuncture and moxibustion and the theory of meridians and acupoints, but also referencing topics related to Western medicine, such as anatomy, physiology, and sports medicine, and discussing regulations related to the Medical Affairs Law. This curriculum laid the foundation for modern education in acupuncture and moxibustion.

The lecturers in each of these fields were acupuncturists and related personnel who had worked for the enactment of legislated status or had been involved in responding to the "GHQ tornado", and who would actively support the acupuncture industry in the future. Although the Ministry of Health and Welfare was officially limited to a supporting role, individual members of the Ministry participated as speakers in the training short course. We can thus infer that the MHW was cooperating in this reform of the industry.

The reeducation program, which was intended to improve the stature and social standing of acupuncturists, indicates both the greatly improved spirits within the industry as it took on these major responsibilities for self-reform, and also the high expectations held by the Ministry of Health and Welfare. The industry and the MHW cooperated on these reforms, and attendees at the first short course subsequently contributed to the reeducation of acupuncturists throughout Japan by serving as presenters in reeducation short courses around the country,.

During that same time period, on September 17, the Institute of East Asian Medicine was established as a corporation by a Diet member Mr. Kobayashi, Mr. Komori of the LMAMP chairman, Mr. Okabe and Mr. Hanada as acupuncturists, with Dr. Takeshi Itakura as director. In the wake

of the "GHQ tornado" and the enactment of the Law for Business of Massage, Acupuncture, Moxa-Cautery, Judo-Orthopaedy etc., this institute was established to provide scientific evidence for the effectiveness of acupuncture and to oversee educational reform. Its philosophy and ideals were subsequently transferred to regional research organs focusing on Asian medicine across Japan.

Conclusion

Today the "GHQ tornado" is commonly believed to have been intended to ban the practice of acupuncture and moxibustion in Japan. However, if we look closely at materials from the time, we see that the GHQ "Order for the Prohibition of Moxibustion and Acupuncture" was actually a proposal for reform, rather than a blanket prohibition of acupuncture and moxibustion.

In the process of reviewing the overall situation in Japan, the GHQ observed the longstanding contribution of acupuncture in maintaining the health of the Japanese people, noted the effectiveness of this treatment, and recognized the undeniable importance of this form of medical treatment for the country. However, some issues remained to be resolved before acupuncture could be incorporated into the new medical system. The GHQ proposals for resolving those issues by stringent reforms were interpreted by the Japanese side as "prohibition".

The GHQ was willing to accept the Japanese government's enactment of legislated status for acupuncture and moxibustion. However, the Occupation officials did actively attempt to prohibit the visually impaired from performing acupuncture/moxibustion therapy. This was because there were no other countries in the world where the visually impaired were permitted to perform medical procedures as they were in Japan, and to the GHQ it appeared dangerous for visually impaired persons to perform acupuncture or moxibustion. However, the visually impaired had a surprising amount of political power, and the Order for the Prohibition of Moxibustion and Acupuncture met with strong resistance. If the GHQ had banned the visually impaired from practicing acupuncture, many visually impaired persons would have lost their means of livelihood and ended up in the streets, inviting tumult and confusion within society. This was an outcome that the GHQ wished to avoid at all costs, since they wanted the occupation government to succeed in order to bolster US credibility and prestige. It thus seems likely that overall Occupation policy was at the root of the GHQ decision to allow the visually impaired to continue working professionally in acupuncture and moxibustion.

The problems that were perceived initially by the GHQ were due in part to differences in cultural expectations and customs between Japan and the United States. It is not an easy thing for any nation or people to understand the culture and customs of another country, so it was unsurprising that the GHQ could not understand the traditional medical system of acupuncture in Japan. If the Japanese side had been unable to comprehend the GHQ's true motives of demanding evidence for the safety and scientific foundation of acupuncture, and of requiring educational reform, and had responded less appropriately to those demands and requirements, then this system of medical therapy might have truly been banned, and acupuncture in Japan would have taken a very different path from what we see today.

The "GHQ tornado" on acupuncture epitomized the relationship at that time between Japan and the United States as occupied and occupying nations. We can expect the incident to be long remembered as an interesting example of the situation in Japanese society after World War II.

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Excerpted from National Park Service