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The picture by Leonardo da Vinch represents a balanced body and health.

Completing our logos is a ring which represents the unity of space fulfilling the total meanings of lifence.

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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.

小太郎漢方製薬株式会社

漢方を
近く
より多くの人に

KOTARO PHARMACEUTICAL introduced in 1957 the world's first Kampo extract preparations on the market. Later, in 1967, six of our preparations could be covered in Japan for the first time by the health insurance and after 1976 more than 100 of our preparations were used in hospitals and clinics. Now it is half a century since we put our Kampo extract preparations on the market and believe, we made a major contribution to this industry.

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The company was named "KOTARO" by its founder Taro Ueda with reference to his birth place. Close to the ancient city of Nara. Kotaro is the name of an enormous sheer cliff, 700 m wide and about 200 m high. Mr. Ueda felt an affection rising to the heavens for this cliff and thus made it the company's name.

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Editorial

Acupuncture and Moxibustion: Present and Future

In this sense, it can be said that these people possess a perspective that is not found in practitioners of orthodox acupuncture that is advocated as a national policy, as it is in China and South Korea. Following the modern institutionalization of acupuncture in China and South Korea in the 1950s to 1960s, United States, Canada, European countries, Nicaragua, Mongolia and Australia institutionalized Acupuncture or Oriental Medicine after 1990s. From this process, diverse methods of acupuncture will also appear.

"Natural acupuncture" is both similar and dissimilar in some respects with these various other styles of acupuncture. In the West, it draws a sharp contrast with acupuncture practiced by physicians of Western medicine. The unique perspective of "natural acupuncture" has been developed by people who recognized the negative aspects of a capitalist economy and were inspired to open up a new horizon.

Over a period of 2000 years, acupuncture evolved under the various influences of the times, and today, yet a new style of acupuncture is taking shape in the West.

What, then, is the situation with Japanese acupuncture? There is no doubt that Japanese acupuncture is backed by a long history and tradition. However, when considering the institutional status and social status of Japanese acupuncture today, it is difficult to say that its present status is built on a proper evaluation of its tradition. Neither can it be said that a framework has been established, that can receive the benefits of the latest science and IT technologies and social systems.

I have stated earlier that acupuncture has evolved under the various influences of the times, but what influences have the "times" had on acupuncture? In The West, acupuncture is a type of alternative medicine that has "newly" appeared, so from the standpoint of Western medicine, the issue lies in how it should be "integrated." However, from the Japanese standpoint, acupuncture is a medical technique or medicine that has existed on this island country for more than 1,500 years. During the Edo Period, it was actively practiced as a national medicine in the context of Edo culture and civilization. In order for it to serve a certain role in today's society, be regarded as an institution, and acknowledged in society, it is necessary to clarify and understand what types of modern contexts have had an influence on Japanese acupuncture.

When thinking about the status of Japanese acupuncture in today's Japanese society, I tend to think that Japanese acupuncture is more than a bit similar to "natural acupuncture" in Western countries.

Hereafter, the further development of acupuncture in the world will likely produce various new variations of acupuncture in each country and bring the uniqueness of Japanese acupuncture into question. What is the uniqueness or the characteristics of Japanese acupuncture? The time has come to firmly communicate this to the world.

At the same time, we must realize that an acceptance of the global diversity of acupuncture must underlie. This means viewing Japanese acupuncture objectively, clarifying the similarities and differences among acupuncture around the world, and accepting the diversity that is revealed in that process. From there, a wealth of new possibilities of acupuncture shall emerge.

Shuichi Katai
Associate Editor of the Journal of KAIM
National University Corporation
Tsukuba University of Technology

Integrating Kampo and Evidence-Based Medicine (3) – Type 2 Case

The Effects of Goshuyuto on Migraines

Hiromichi Yasui
Japan Institute of TCM Research

Introduction

In this series, I define four types of use of Kampo medicine in daily clinical practices within Japan's unified medical system, and discuss the diseases that fall under each of these types, by respectively giving relevant case examples. In the previous issue of this journal, I introduced four episodes, and explained that they fall under the four types of use of Kampo medicine in daily clinical practices. Let me recount them below.

Type 1: Kampo treatment is better than standard modern medical treatment

Type 2: The effects of standard modern medical treatment and Kampo treatment are both strengthened when the two are used in combination

Type 3: The side effects of standard modern medical treatment can be mitigated in combination with Kampo treatment

Type 4: Circumstances prevent the application of standard modern medical treatment, but treatment is needed

In this article we shall take a look at Type 2, in which the effects of both Kampo medicine and standard treatments of contemporary medicine are strengthened when the two are used in combination. This is a type that is most commonly experienced in daily clinical practices. However, there are various types to this type. In cases where standard treatment does not have an adequate effect, standard treatment gradually loses its effect, or a presently administered standard treatment cannot be used frequently, the combined use of Kampo medicine could have a dramatic effect.

Below, I shall introduce the effects of goshuyuto on migraines. Goshuyuto is effective against certain types of migraine, but let me explain how it is used in daily clinical practices, through a number of examples.

1. A Certain Episode

In the latter half of the 20th century, Dr. Domei Yakazu, a prominent Kampo doctor, established a study group called Onchikai. Large numbers of researchers who hold Dr. Yakazu in high respect still gather today and hold monthly study meetings.

In the meeting that convened in October 2014, Dr. Yoshihide Yakazu presented the following case example[1].

Patient: 42-year-old woman

Chief complaint: Migraine (from the forehead to the frontal region)

History of present illness: Since a few decades ago, the woman had been receiving oral medical treatment after being diagnosed with a migraine. She had taken rizatriptan orally, but because her headache had worsened in the past few months, she took the medicine once every two days. The triptan preparation that previously had had an effect no longer alleviated her headache as it had used to, and she couldn't go to work regularly because of her serious attacks of headache.

Medical interview: Headache and vomiting appear simultaneously. She was strongly susceptible to the cold, such that air conditioners in trains and at work made her felt ill and induced a headache. Her headache also worsened with intense stress.

Kampo medical observations:

Pulse: Sunken and weak

Tongue: Pink, wet, furry, teeth marks (+)

Prescription: 3 packs/day of goshuyuto extract

Progress: A month later, she was no longer forced to be prostrated in bed, nor be absent from work. The amount of triptan she took could be reduced, and her condition could be controlled with 3 to 4 oral

tablets a month. Thereafter, she has hardly been laid up in bed with a headache—perhaps only a few times a year.

The patient started to be suffered by a migraine in her twenty. She was benefitted from triptan after it appeared on the market, but her condition worsened again to the point where she had to take it every two days. She was at a complete loss. Dr. Yoshihide Yakazu took the particular note of the fact that her "headache and vomiting appeared simultaneously," and that she "was strongly susceptible to the cold, such that air conditioners in trains and at work made her felt ill and induced a headache." He thus administered goshuyuto, and as a result, her migraine diminished, and her use of rizatriptan significantly decreased.

To treat migraines, we often use goshuyuto in combination with NSAIDs, triptan, or other headache prophylactic. Goshuyuto is effective in preventing certain types of migraine. For information on what types of migraine it is effective against, please see the article in the *Journal of KAIM*, Vol. 2, No. 2[2].

Goshuyuto is an effective prescription against migraines. However, its efficacy will be inconsistent for each case. While a month of taking it may completely eliminate all occurrences of the headache in some cases, it may simply decrease the frequency of occurrences and weaken the intensity of the pain without completely curing the condition, in other cases. The above example is typical of the latter. Although goshuyuto did not completely cure the patient of her migraine, it is indispensable to her. It probably also benefitted her economically, as her frequency of taking triptan was reduced. This is a successful case example in which standard treatment was combined with Kampo medicine, and can be classified as a typical Type 2 case.

Dr. Yoshihide Yakazu who presented this case example is Dr. Domei Yakazu's grandson.

2. Oral Instruction Regarding Goshuyuto

Dr. Yoshihide Yakazu prescribed goshuyuto for the above case for a number of reasons, but the most important was the following oral instruction given by Dr. Keisetsu Otsuka, who was a contemporary of Dr. Domei Yakazu [3].

"Use Goshuyuto for severe paroxysmal headaches. Most occur as a migraine. In cases of severe attacks, vomiting also occurs. Attacks commonly occur when one is tired, has eaten excessively, or before menstruation among women. They may occur once or twice a month, or even five, six times a month. When an attack occurs, the muscles of the neck contract and cause extreme stiffness from the shoulders to the neck. […]. The degree of stiffness of the neck serves as an indicator for using goshuyuto. When a patient is examined during an attack, an inflation of the epigastric area is observed, and the patient frequently claims a feeling of having a clogged stomach. This abdominal condition is also an important indicator for using goshuyuto. […]. Also during an attack, the feet become extremely cold, and the pulse tends to become sunken and slow. This is sometimes accompanied by a type of agitated condition in which the patient cannot remain relaxed but tends to agonize over repeatedly getting up and going to sleep. Vomiting bile with strong nausea occurs during strong attacks, but not necessarily..

Patients who have such headaches would no longer experience attacks if they are prescribed with goshuyuto when they are not experiencing an attack. They should continue to take the prescription for at least two to three months, although it depends on the patient. When they take goshuyuto during an attack, their headache will disappear almost immediately.

[…]. Based on the above indicators, it can be said that goshuyuto has a marked effect on migraines. Additionally, goshuyuto can be used for headaches other than migraines. […]. Additionally, patients who display types of goshuyuto sometimes develop a flushed face and complain of their head feeling hot. This was called "true cold and false heat" by ancient

people, and is not real heat. In my experience with goshuyuto, there were two patients who complained that cooling their head made them feel ill no matter how painful their headache was.

Goshuyuto is effective against cold headaches and not thermal ones. Therefore, it is best not to cool the head even if feels burning hot."

The above oral instruction contains many hints for using goshuyuto against migraines. Some may say that it is simply a narrative and does not contain anything trustworthy according to EBM. However, from the perspective that "no evidence means that validity has not yet been proven, which differs from being 'not valid'," it could be a subject of research as clinically useful information.

It must be noted, however, that symptoms specific to migraines and the indications of goshuyuto are mixed in the instruction, and that if they are confused, the prescription will not be able to be used properly. For instance, about the passage, "In cases of severe attacks, vomiting also occurs. Attacks commonly occur when one is tired, has eaten excessively, or before menstruation among women. They may occur once or twice a month, or even five, six times a month," these are general symptoms of migraines, and not indications of goshuyuto.

On the other hand, the passages, "When a patient is examined during an attack, an inflation of the epigastric area is observed, and the patient frequently claims a feeling of having a clogged stomach" and "Also during an attack, the feet become extremely cold, and the pulse tends to become sunken and slow," refer to indications specific to goshuyuto.

Let us take a look at the results of clinical tests that were performed to prove this.

3. Clinical Studies of Goshuyuto on Headaches

In a sense, it is common understanding in Japan that goshuyuto is effective against migraines. However, it is not clear to what percentage it is effective against what conditions of headaches in what types of people. Thus, a number of researchers have conducted clinical studies to find the answer to these questions. The scope of these studies includes not only migraines, but also tension headaches. Therefore, they do not reveal to what percentage goshuyuto is effective against migraines in it, but nevertheless provide a clinically significant reference. A couple of representative studies are introduced below.

1) Study on the uniform administration of Goshuyuto to chronic headache patients by Odaguchi et al.[4)]

The subjects of the study were 49 people (men/women = 6/43, age 43+/-14) who use medicine for their attacks of chronic primary headache once a month in principle. According to the improvement of the intensity and frequency of their headaches, chills, menstrual cramp, and stiff shoulders, they were divided into a Responder group (R group; 36 people) and Non-responder group (N group; 13 people) based on a certain set of criteria, and were uniformly administered 7.5g of Tsumura goshuyuto extract 3 times a day for a month. A contingency table examination was then performed.

As a result, the subjective symptom "being immune to motion sickness" (R group 34 people, N group 8 people: $P = 0.01$) and the objective finding "para-umbilical tenderness and resistance" (R group 15 people, N group 1 person: $P = 0.04$) were significantly frequent in the R group. Other tendencies of the R group included some items, namely, chills, hypochondriac discomfort and distension, without flushed face, and without sigmoid colon tenderness. Additionally, items with sensitivity and specificity exceeded 0.5 were chills, menstrual cramps, epigastric discomfort and resistance, and abdominal tenderness, without sweating, without menstrual irregularity, without abdominal deficiency, and without weakness of the lower abdominal region.

This study examined the differences in symptoms between a group of patients who were sensitive to goshuyuto (Responder group) and a group of patients who were not susceptible to goshuyuto (Non-responder group), and is a groundbreaking study that marks the first step toward revealing the facts of goshuyuto pattern. The results are clearly evident in subjective symptoms and abdominal examination findings, and have provided a hint to the future application of goshuyuto.

2) Study by Hayashi et al.: Clinical study of Goshuyuto against chronic headaches[5)]

Goshuyuto was administered to 32 chronic headache patients, and was effective at a rate of 34.4%. However, there were no factors that had a significant relevance to the effectiveness of goshuyuto ($p<0.05$). Goshuyuto was neither particularly effective against either migraines, tension headaches, or combined headaches.

To reveal the types of goshuyuto, this study also examined more than 100 subjective symptoms in a multivariate analysis. The methodology was highly subjective, and excluded the perspective of Kampo medicine as much as possible. As a result, there were hardly any symptoms that were related to goshuyuto. This result was obtained, because the study eliminated any partiality to Kampo medicine as much as possible, in contrast to the Kampo-oriented study by Odaguchi et al.

Normally, an efficacy rate of around 30% in the field of pain can be construed as being the same as a placebo. In this respect, this study suggested that goshuyuto is in no way a special medicine. However, many physicians who were involved in the study say that patients who benefitted from goshuyuto became dramatically better. This is a characteristic of goshuyuto that cannot be ignored from the standpoint of narrative medicine.

4. Goshuyuto in Integrated Medicine

When treating migraines in general practice, it is important to alleviate the pain that has developed, but more important is to prevention. Some studies have been conducted on the effects of goshuyuto in preventing migraines. I shall introduce two such studies below. One is a study by Dr. Koji Maeda et al., in which the frequency of administering triptan could be reduced by the combined use of goshuyuto. The other is a study of combined therapy using lomerizine hydrochloride and goshuyuto, by Dr. Tetsuhiro Katayama.

Dr. Maeda's study[6)]

Dr. Koji Maeda administered goshuyuto to patients who took Triptan to treat their migraine, experienced an attack more than four times a month, and continued to require 5 Triptan tablets or more per month although they saw no change in the frequency of their attacks of headache (12 patients: 2 male, 10 female). He then examined the number of occurrences and frequency of their headache, the number of times they took Triptan, associated symptoms, the effects of reducing medical expenses, effectiveness, and side effects. As a result of taking Goshuyuto in combination, their attacks lessened to about two times a month roughly three months after taking goshuyuto.

At the same time, 9 out of 12 patients became able to reduce their dose of goshuyuto from 7.5g to 5.0g. Goshuyuto was also effective against stiff shoulders and stiff nape in 5 out of 8 patients, and effective against chills in 7 out of 10 patients. Nausea and vomiting during an attack were mitigated in 7 out of 10 patients. The combined use of goshuyuto reduced medical expenses compared to using triptan alone (Triptan: approx. ¥1,000/tablet; goshuyuto: approx. ¥100/day; lomerizine hydrochloride: approx. ¥140/day), and was judged to be effective in 75% of cases.

Dr. Maeda states that the combined use of triptan and goshuyuto helped control the headache attack, lowered the occurrence of attacks, and produced satisfactory results in preventing headaches, as well as improved other associated symptoms and reduced

the number of Triptan tablets that need to be taken. He gives high marks to goshuyuto, as having freed patients from the anxiety of anticipating migraine attacks that were apt to occur at any time, and making it possible to fully control migraines.

Dr. Katayama's study[7)]

Dr. Tetsuhiro Katayama examined the effect of the headache prophylactic lomerizine hydrochloride and goshuyuto in preventing migraines in a crossover comparative study.

Fourteen patients (all women, average age 28.4+/-3.8) diagnosed as a migraine, as defined by the International Classification of Headache Disorders, were divided into two groups. One group (7 patients) was first administered 10mg/day of lomerizine hydrochloride for 28 days, followed by 7.5g/day of goshuyuto extract for the next 28 days. The other group (7 patients) was first administered goshuyuto extract for 28 days, followed by lomerizine hydrochloride for the next 28 days. The effect of preventing migraines in the two groups was then evaluated by examining the number of times a migraine attack occurred and its intensity evaluated via visual analogue scales prior to and during the 28 days of taking the preventive drugs. The patients were allowed to take Triptan if they experienced an attack during the test period. All 14 patients completed the 56-day clinical test, with the result that the group that was first administered goshuyuto experienced a significant decrease in the frequency of their migraine attack and headache intensity. In the group that was first administered lomerizine hydrochloride, 2 patients experienced sleepiness, but none of the patients in the group that was first administered goshuyuto experienced any such adverse event. Goshuyuto also controlled the frequency of nausea as a secondary effect.

This study examined the combined effect of goshuyuto and lomerizine hydrochloride in preventing migraines, and showed goshuyuto's significant power.

Such studies as the above have clarified the effect of combining goshuyuto with Triptan or lomerizine hydrochloride in treating migraines. The studies by Drs. Maeda and Katayama, in particular, showed that Dr. Yoshihide Yakazu's case example that was introduced at the beginning of this article is not a special case, but a common one.

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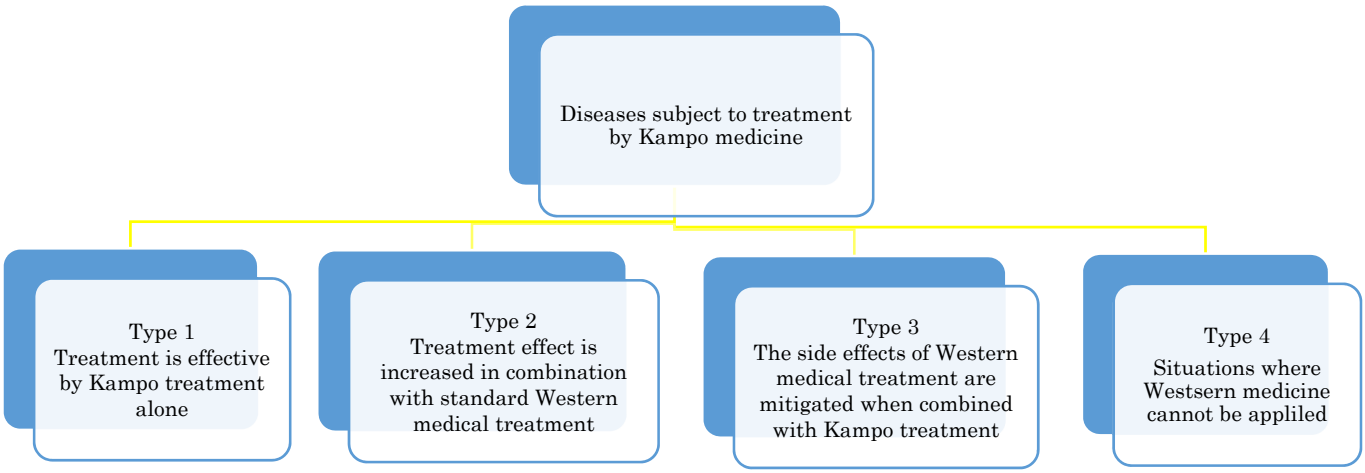
The four types and their characteristics



Other Type 2 pathologies and prescriptions are as follows.

Example 1: Combined use of carbamazepine and goreisan for trigeminal neuralgia
Example 2: Combined use of MTX and Kampo prescriptions for rheumatoid arthritis
Example 3: Combined use of an antibacterial agent and daiokanzoto for colonic diverticulitis
Example 4: Combined use of kakkontokasenkyushini and standard treatment for purulent rhinorrhea
Example 5: Combined use of steroid and Kampo for bronchial asthma and COPD
Example 6: Administration of daikenchuto for bowel movement after an intra-abdominal surgery

Japanese Acupuncture - Current Research

Japanese Traditional Medicine Text (17) – Psychiatry

Tetsuya Kondo

1. Present State of Clinical Studies Outside of Japan

With respect to studies in the fields of psychiatry and psychosomatic medicine outside of Japan, a detailed review of psychosomatic disorders associated with fibromyalgia[1] has been published in 2001, and those of depression[2], chronic pain[1], anxiety disorder[2], schizophrenia[2], drug addiction[2], and gastrointestinal disorders[3] have been published in 2008.

Depression is among the top ten diseases for which patients tend to rely on complementary and alternative medicine due to dissatisfaction with Western medicine. Many large-scale, randomized controlled studies thus exist regarding depression[4]. Among its symptoms, acupuncture and moxibustion has been reported to be more effective against anxiety and somatic symptoms than the tricyclic antidepressant amitriptyline, and caused fewer side effects[5]. In a comparison with a tetracyclic antidepressant, acupuncture and moxibustion was found to have roughly the same effect. However, both antidepressants used in the comparison are old drugs, and the only study that provides a comparison with a new drug, namely serotonin reuptake inhibitor that is presently the mainstream, simply reports that a kind of serotonin reuptake inhibitor, paroxetine had a greater effect when used in addition to acupuncture and moxibustion than when used alone[6]. New studies need to be made, as new drugs such as mirtazapine have appeared that provide the same effectiveness as amitriptyline but greater tolerability[7], and also since different drugs are effective against different symptoms[8].

With regard to chronic pain, many studies suggest that acupuncture and moxibustion is effective particularly against lower back pain and head and neck pains[1]. This is related to the fact that meridians are concentrated in the head and neck area, with 7 of the 12 main meridians and 7 of the 8 extrameridians passing through the area. It may also be related to the fact that such extrameridians as the yang link , belt , governor , and yan heel vessels run through the lower back area. The American Psychiatric Association classifies chronic pain of which psychological factors play an important role in the development, severity, aggravation or sustainability as a type of psychiatric disease, but hardly any specific study on this exists.

Fibromyalgia is a subject of many high-quality randomized controlled studies, which report that real acupuncture is more effective than sham acupuncture in improving scores, mainly by raising the pain threshold. However, these studies do not entail long-term follow-up, so the effects of additional treatment, appropriate simulation frequencies, the effects of combining drug therapy, and other such aspects remain unknown.

Anxiety disorders are classified into heart and kidney deficiency, liver excess, non-interaction between the heart and the kidney, etc., and are a subject of various studies. There are a number of reports on randomized controlled studies that have utilized ear acupuncture to treat generalized anxiety disorders and anxieties accompanying surgery and colonoscopy. According to them, ear acupuncture has contributed to reducing the necessary amount of anti-anxiety drug before endoscopy and mitigating discomfort and pain during the exam. However, no studies exist that have been conducted in Japan. On the whole, evidence level is low in most papers, so future studies need to be made. It should also be noted that no reports exist regarding other forms of anxiety disorders such as obsessive-compulsive disorders and panic disorder[9].

Schizophrenia has not been a subject of any randomized controlled studies. The only controlled test that exists reports that the metabolite which increases when the disorder is exacerbated is further increased with electroacupuncture. As this goes against the effectiveness of acupuncture and moxibustion, further studies need to be made.

Drug addiction is studied mostly outside of Japan, as a reflection of social situations. A number of randomized controlled studies have been conducted, but they include studies that have both proven or failed to prove the effectiveness of acupuncture and moxibustion, probably due to differences in severity of the disorder and the psychotherapy that was applied in combination.

With regard to the digestive system, patients with a tendency toward depression are known to develop a disease based on hypersensitivity to pain in hollow organs from the esophagus to the intestine. They are respectively called irritable esophagus, biliary dyskinesia, and irritable bowel syndrome. The mutual complication of biliary dyskinesia and irritable bowel syndrome is high, as seen in Shimada et al.'s diagnosis criteria for biliary dyskinesia, which includes the presence of irritable bowel syndrome among the reference findings[10], and suggests that a common basis exists. Acupuncture treatment has proven effective against the above types of conditions, particularly irritable bowel syndrome, but since sham acupuncture was also found to be effective, it likely acted on the pain threshold in the central nervous system that is regulated by opioid.

2. Present State of Clinical Studies in Japan

Studies in the fields of psychiatry and psychosomatic medicine in Japan include those that take into consideration the Japanese climate. Ascendant hyperactivity of liver yang caused by yin deficiency, which is a problem in China's dry inland climate, and warm dryness that is an effect of dryness in the hot season, are rarely seen in Japan. However, humidity, which becomes a problem on the continent only during the long summer, is a year-round problem in Japan, and treatment needs to take cold humidity into consideration in the winter[11]. In fact, there have been cases where treatment that simultaneously addresses the cold and humidity has been applied to depression, when stress far exceeded the patient's physical strength. Asia is experiencing a dramatic increase in population, with the majority of the people living along the coastal regions, where humidity is high due to the impact of the monsoon climate. There is high possibility that Japanese-style treatment could apply to people in those regions.

In Japan, dialectics is also based on perspectives of Qi, blood, and fluid[12], which is independent of the dialectics of the five viscera. In a large-scale study performed on 914 new outpatients to a psychosomatic department of a university hospital, it was found that Qi deficiency and Qi depression are involved to the same degree in depression among women, while Qi deficiency is involved to a far larger degree than Qi stagnation among men[13]. Qi deficiency and Qi stagnation were involved in depressive state, anxiety state and generalized anxiety disorder in addition to Qi flowback in females and blood deficiency in males[13]. There are also findings that emphasize fluid retention and blood stagnation as factors associated with depression, rather than (liver) Qi depression (stagnation) and other Qi abnormalities that are common to traditional Chinese medicine[14]. There have also been findings indicating association between blood deficiency and somatoform disorder in females, between irritable bowel syndrome and Qi flowback, and between eating disorders and fluid retention [13].

The Sawada method, which is adopted by many practitioners of acupuncture in Japan, focuses on the triple energizer meridians, and particularly the left TE4. Kondo et al. also revealed a model that suggests involvement of excess heat from the triple energizers, namely scybala, nausea, and oligohydruria, in a study on outpatients of mental and psychosomatic disorders, which is consistent with Sawada's theory[15].

It is known that patients with classic psychosomatic disorders, diabetes, or hypertension have little self-awareness of their bodies, and tend to develop the disorder due to poor communication between mind and body. Kansai University of Health Sciences and other such institutions are

conducting studies of evaluation methods for autonomic nervous functions using finger plethysmography that can record measurements in a non-invasive, simplified manner, based on the idea that harmony of mind and body could be achieved by presenting objective indicators in response to one's physical conditions. Oriental medicine places focus on curing diseases in their pre-symptomatic state. The deficiency or excess of one's predisposition is a type of pre-symptomatic disease. As measures that specifically detect subtle changes in a living body, the indicator that is calculated from the Lyapunov exponent, which is a non-periodic component of finger plethysmography and expresses the vagaries of the trajectories of the pulse wave, and the indicator that is calculated from entropy as an indicator of complexity, are reported to be high in the excess pattern and low in the deficiency pattern[16]. It has also been observed that these indicators recover in the healthy direction after exposure to the aromatics of moxibustion therapy[17]. The healthy direction refers to a state in which subtle adjustments are made per pulse and bring an abundant change. Additionally, it has been reported that these indicators drop below normal levels at the preliminary stage before developing depression, which is also a pre-symptomatic disease[18]. Furthermore, the closer F Constant, an index of how many pulses equal a cycle, is to 4.69, the better homeostasis is maintained in a living body. When this is obtained through finger plethysmography, homeostasis is reported to be highest in the medium pattern that determines the degree of deficiency in response to questions about fatigue, chills, and pernoctation burden[19]. If a state of tension is considered a psychological excess, and sleepiness and fatigue are considered a psychological deficiency, homeostasis is reported to drop below the medium pattern[16] in both cases.

Acupuncture and moxibustion have the effect of mitigating stress. Their effects are reported particularly against saliva chromogranin A, which is specific to psychological stress[20], and amylase, which is said to increase in response to unpleasant stimuli[21]. With regard to the neuroendocrine system, an increase in 17-KS-S/17-OHCS ratio has been reported the day after acupuncture therapy, indicating an increase in latent stress tolerance[22].

Psychosomatic medicine in Japan widely introduces transactional analysis, and a unique egogram has been developed as a method of quantifying the intensity of five ego states of an individual, which is an important factor in transactional analysis. There is a theory that associates these five ego states with the five viscera[23]. In psychosomatic disorders, in which the same symptoms appear sustainably in a certain organ, the ego of the "adapted child" is so strong that over-adaptation becomes the cause of the disorder in many cases. In fact, when examining the medium pattern between egogram and ryodoraku, it was found that electric current in the spleen and liver decreased among patients whose "adapted child" was predominant over their "free child," and contrarily increased in the liver among patients whose "free child" was predominant over their "adapted child"[24]. A decrease in electric current in the spleen and liver is a ryodoraku pattern that is deeply related to depressive state such as fatigability, insomnia, taste disorder, depressive mood, and hypobulia, and may reflect depression caused by excess adaptation due to typus melancholicus. Such tendency for excess adaptation is at the foundation of disease conditions such as definite chronic pancreatitis[25] and gastroduodenal ulcer. Thus, there is strong possibility that mind and body therapy that takes into consideration ryodoraku and psychological aspects could contribute to the treatment of psychosomatic disorders.

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Clinical Report 1 (Acupuncture)

A Case of Intractable Pain of Around the Right Shoulder Effectively Treated by Acupuncture and Moxibustion at the Lumber Jiaji Point (Ex-B2)

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Introduction

Chronic pain may be caused by many factors and have a major impact on the patient's quality of life. There are a variety of treatment forms from such as pharmacotherapy, psychotherapy, nerve blocks, laser therapy, non-invasive and brain stimulation[1]. However there is few standard method of treatment. A substantial number of patients with refractory chronic pain have symptoms that are not alleviated by those treatments. They suffer from pain for many years. Often some of them visit acupuncture and moxibustion clinics. We report a case of pain in the right shoulder that was unknown origin and continued for more than 2 years with successful treatment by acupuncture and moxibustion.

Case Presentation

An 18-year-old male high school student had been suffered from continuous pain of the proximal region of the right shoulder. He had sustained a compression fracture of a lumbar vertebra (L5) during soccer practice 8 years ago. About 2 years ago, numbness and pain developed radiating upon flexion of the neck from the right scapular region towards the right upper arm. When the condition exacerbated he consulted an orthopedist. Loxoprofen Sodium and Pregabalin were administered, but were not effective. Following the recommendation of the orthopedist he underwent several treatment sessions at a different acupuncture and moxibustion clinic, but this had no effect either. In June, he was hospitalized for detailed examinations. The results of nerve root stimulation tests during extension and lateral flexion were negative. There were neither obvious motor and sensory disturbances nor deep tendon reflex anomalies. Neither magnetic resonance imaging (MRI) of the cervical spine and the brachial nerve plexus nor a myelo-CT during flexion showed any organic disease. An electromyogram performed because of suspicion of a right-sided C5 nerve root disturbance also did not show any abnormality. To prevent exacerbation he wore a Polyneck. When he went to bed, he could not maintain the same posture over 30 minutes, even when using a pillow. For this reason, he was referred in August for consultation to our acupuncture and moxibustion outpatient.

During the first examination pain associated with a tingling numbness from the right side of the neck towards the right scapula and into the right upper arm was observed. The pain was particularly strong along the medial edge of the right scapula and exacerbated by anteflexion of the neck and continued even after returning to the original position.

Present state had no problem (height: 177.7cm, weight: 78.6 kg, BMI: 24.9, blood pressure: 116/70 mmHg, pulse rate: 65 bpm). Subjective symptoms were lack of motivation, depressive mood, and easy sweating. In physical findings, Jackson compression test, Spurling's test, and Allen test were all negative, and there was no restriction of neck and shoulder ROM and no sensory anomalies.

In oriental medical findings, tongue was observed pale red color with moistwhitecoat by tongue diagnosis. Abdominal wall strength was intermediate and both sides of rectus abdominal muscles were strain by abdominal diagnosis. The Pulses were decreased at the left middle and the left proximal pulse which concluded as liver meridian deficiency by six-position pulse diagnosis.

Treatment

Based on the six-positon pulse diagnosis the essential treatment was administered by using acupuncture needle according to the Kitasato style meridians therapy and the symptoms were treated locally and symptomatically by using acupuncture needle and moxibustion. The needles were retained in both supine and abdominal position for about 15

minutes. Disposable stainless steel needles of 0.2×40 mm (No. 3) and 0.23×50 mm (No. 4) were used with insertion tube. Insertion depth was in general approximately 2-3 mm on essential treatment, but depending on site occasionally also 5-10 mm. The treatment was started in intervals of basically one week, but switched during the course to 2-3 times per week. Also, the intensity of the pain was assessed before and after treatment using a Visual Analogue Scale (VAS).

Most of pulse findings in this case over the entire course indicated either kidney or liver deficiency. The main acupoints used for the essential treatment were LU5, LI10, KI10, KI7 and KI3 for the kidney deficiency. For the liver deficiency PC4, KI10, LR8, LR4 and LR3 were used. Also, GV20, CV12, ST25, CV6, CV4, BL10, GB20, BL11, BL13, BL17, BL23, BL40 and BL57 were chosen as the supplemental points of essential treatment.

Results

From the 1st to the 20th treatment visit no major changes were observed and the pain subsided only temporarily after the treatment. The patient's VAS score of 100 obtained before the first treatment decreased at best to a level of around 80. The treatment effect did not last and the VAS score would return to 100 by the next visit. However, the patient stopped complaining about lack of motivation, depressive mood and easy sweating. Also the patient reported that "except for the pain I am now in good physical condition".

Figure 1 shows the clinical course from the 21st treatment. At the 21st treatment the VAS score of the pain before the treatment was 100. At that time he also complained about low back pain that had not been present at the time of the first visit. Since the patient's cold feet was found, we applied moxa needle at BL26 for symptomatic treatment. After the treatment the VAS score had dropped to 70.

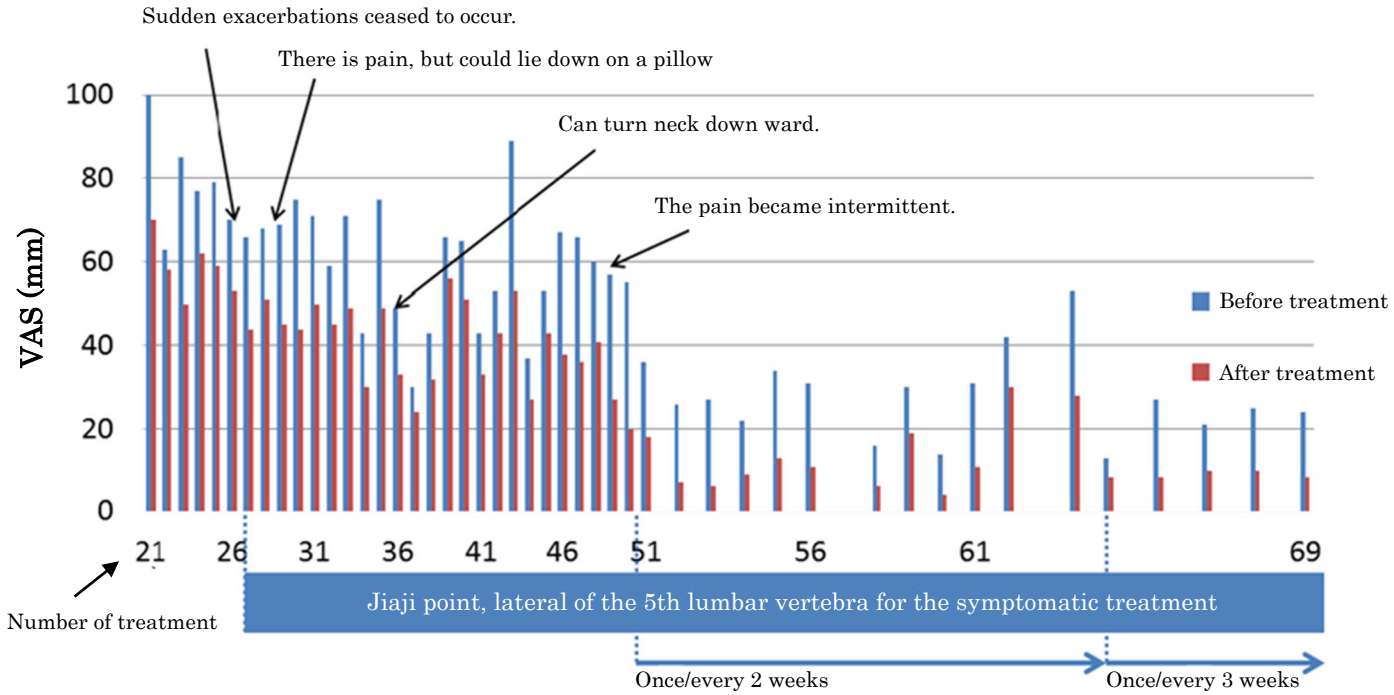


Figure 1 Clinical course

During the 22nd visit, the VAS score was 63 before treatment, indicating that the effect of the previous treatment continued. We administered the same treatment until the 26th visit. By the 27th visit the VAS score before treatment was 66. The low back pain had become localized at the lumber Jiaji point (Ex-B2) to the right of L5. We changed the acupoint to that location instead of using BL26 for symptomatic treatment (Figure 2). When we continued to administer the moxa needle because the patient's cold feet persisted the VAS score dropped to 44. The patient reported during the 29th visit "I do have pain, but can lie down on a pillow". By the 36th visit he said he was able to anteflex the neck without exacerbating the pain. By the 49th visit the pain became intermittent and following the 50th visit treatment intervals were extended to once every 2 weeks. By the 65th visit the VAS score had markedly improved to 27 before and 8 after the treatment. At the time of this writing the pain is almost gone.

Discussion

Nociceptive pain disappears when the injured tissue heals. However, even though lesions have been repaired and no anomalies can be observed, subjective pain may develop into chronic pain generally caused by neurogenic or psychogenic factors.

In this case, the patient was worried at the time of the first visit about chronic pain of unknown origin that had lasted for more than 2 years. The pain was located at the proximal right shoulder and intensity was highest along the medial edge of the right scapula. Even though cervical anteflexion exacerbated the symptoms, detailed examinations did not reveal any causes for neurogenic pain. Since the patient was a high school student just before taking entrance examinations of university, his complaints about "lack of motivation and depressive mood" suggested involvement of mental symptoms and stress. However until the 20th visit, we considered few possibilities of psychogenic factors.

His past history showed a long interval of 8 years from onset of a compression fracture of his lumbar vertebra. This injury is hard to explain anatomically the causes of his right shoulder pain, where he complained. Yet, we found severe pressure pain on the right side next to the 5th lumbar vertebra at the standard location of the lumber Jiaji point. Symptomatic treatment on the acupoint almost completely alleviated the right shoulder pain. This observation induced our conclusion that the right side of the 5th lumbar vertebra has a correlation to the medial edge of the right scapula.

Usually, a compression fracture of the lumbar vertebrae is a disease, causing injury to the ventral column of the lumbar vertebrae, but through vertebral body deformation it may also induce chronic pain originating from the paravertebral erector spinae muscles. According to reports indicating muscles as the responsible region of chronic pain indicates the continuous contraction of muscles results in indurations of the muscles and poor local circulation as well as continuous stimulation of polymodal receptors inside the muscles develops myalgia. Also, muscle tension induced excessive stress on the tendon attachment sites may possibly result in the development of inflammation at these sites and therefore contribute to the myogenic pain[2].

There are a few reports describing prolonged pain when tissues surrounding the bone are injured in case of fractures, leading to prolonged pain or edema in the vicinity of the injured region. However, we could not find any cases in which these symptoms continued over prolonged periods of time after healing of the fracture. Also, regarding the site of the pain there have been reports describing low back pain after compression fractures of thoracic or lumbar vertebrae, but any reports about the onset of pain in a region as remote from the fracture site as in this case could not be found.

The longissimus thoracis muscle attaches to both the region of the most intense pain along the medial border of the right scapula and the right side of the

5th vertebra. This longissimus thoracis muscle arises from the sacrum, iliac crest, spinous processes of the lumbar vertebrae, the transverse processes of the lower thoracic vertebrae, attaches medially to the costal processes of the lumbar vertebrae to support the lumbar region and laterally to the 2nd through 12th ribs and thoracic transverse processes to support the chest. Innervating nerves are the individual posterior and external branches from the 1st cervical to the 5th lumbar vertebrae[3].

In this case the lumbar vertebral fracture may have injured the longissimus thoracis muscle and caused chronic elevated muscle tension that generated pain at a distant location. We considered the lumbar vertebral compression fracture to be the cause for the pain in the proximal region of the right shoulder.

The meridian therapy consists of both essential treatment that treat the primary aspect of a disease and symptomatical treatment that treat the secondary aspect of a disease. The essential treatment of meridian therapy itself is based on classical theories of reinforcement and reduction, which are describe in chapter 69 in the classic text *Nanjing*. In the classical theories, diseases are interpreted as imbalances of the *zang* (solid) and *fu* (hollow) organs. Those imbalances appear deficiency or excess along the course of the meridian. Following the rule in chapter 69 therapeutic acupoints are determined. Pulse diagnosis and other techniques were used to identify deficiency or excess in meridians to find the imbalance of *zang* and *fu*. Treatment consists tonifying deficiency meridians and reducing excess meridians and thus returning the body to its normal state.

Sodo Okabe, the first head of our acupuncture and moxibustion department, developed the Kitasato style meridian therapy by improving on fundamental meridian therapy with feedback from his clinical experience. It is a style of treatment that concentrates on reinforcement of deficiencies which we currently employ at our research institute.

In this case we used Jiaji point for the symptomatic treatment. Jiaji point is a group of altogether 34 extraordinary points located 5 *bu* (about 0.5inch) lateral from the 1st thoracic to the 5th lumbar spinous processes. In this case we used only the point located below and to the right of the 5th lumbar vertebra as shown in Figure 2.

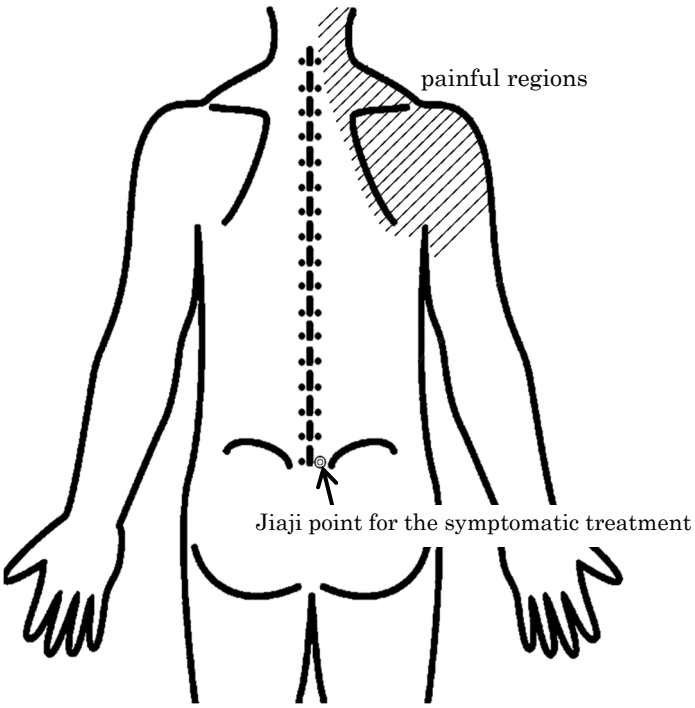
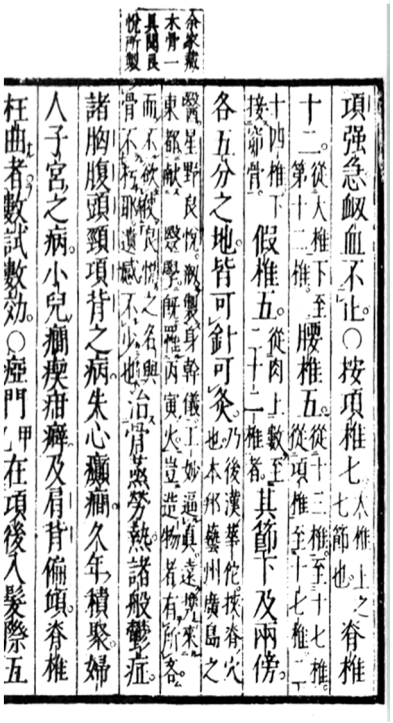


Figure 2　Jiaji point for the symptomatic treatment and painful regions in this case

We found Jiaji point seems to be classified into 2 types. One type is named as Hua Tuo's paravertebral acupoint, used for treating a patient with distortion of the body, as described in the classic text *Sanguozhi* (三国志)[4]. The other type is named paravertebral point used for treating patients with severe diarrhea such as that caused by cholera, and described in the classic text *Zhouhoubeijifang* (肘後備急方), *Qianjinyifang* (千金翼方), *Waitaimiyaofang* (外台秘要方) and *Ishimpo* (医心方). All five classical texts only described treatment by moxibustion. However, in the classic text *Shinkyusetsuyaku* (鍼灸説約), the book of acupuncture and moxibustion written by Sotetsu Ishizaka, and published during the latter Edo period in 1812 (Figure 3), a section

with an anatomical description of the individual vertebral bodies is followed by the passage: "these points are found next to the spine all the way down at the distance of 5 *bu* (about 0.5inch) each, they should all be needled, they should all be treated with moxa. In other words, these are the point described by Kada [Hua Tuo] of the latter Han dynasty", showing that by the late Edo period that they had also been adapted for use with needles. According to the *Shinkyusetsuyaku* Jiaji point could be used to treat "steaming bone taxation fever, various forms of depression, all kinds of diseases of the chest, abdomen, head and neck, syncope and epilepsy, chronic abdominal masses, disease of the uterus in women, irritability and convulsion in children, twisting of back and shoulders as well as bending of the backbone". Their use had also become more frequent; the text states, "They [Jiaji point] have often been tried and often found to be effective". Figure 3 shows a piece of the *Shinkyusetsuyaku* manuscript wherein Jiaji point is described.

In 1957 Sorei Yanagiya, who had restored the Japanese traditional acupuncture and moxibustion, reprinted the surviving text of the *Shinkyusetsuyaku* along with his commentary under the name of *Shinkyumeiwa* (鍼灸茗話). In *Shinkyumeiwa* he wrote "the paravertebral point is generally known as Hua Tuo's paravertebral acupoint or as paravertebral point, and also as the first line of the bladder meridian" (Figure 4). In the same year Yanagiya also wrote the book *Hihouipponshindensho* (秘法一本鍼伝書), in which he describes acupuncture for five viscera and six bowels and the needling techniques for internal organ diseases by using Jiaji point[5]. The *Shinkyusetsuyaku* was reprinted as well in 1970 by Sodo Okabe. In recent years, deep needling at Jiaji point to achieve nerve root stimulation has reportedly been shown to be effective for the treatment of radicular pain[6] or postherpetic neuralgia[7] Since treatment using Jaiji point has spread in Japan, both the way they are used and their applications have changed. Sorei Yanagiya and Sodo Okabe had a major influence on acupuncture and moxibustion in Japan during the Showa period both reprinted the works of Sotetsu Ishizaka. It is conceivable that Ishizaka's efforts still influence the way they used and their applications of Jiaji point.


項強急衄血不止。○按項椎七。大椎上之脊椎七節也。
十二。從大椎下至腰椎五。從十三椎至十七椎。
第十二椎。腰椎二十
十四椎下數至接命骨。假椎五。從肉上數至二十一椎者。其節下及兩傍。
各五分之地皆可針可灸。乃後漢華佗按脊穴也。本邦藝州廣島之
諸胸腹頭頸項背之病。失心癲癇。久年積聚。婦
人子宮之病。小兒癇痓疳癖及肩背偏頃。脊椎
枉曲者數試數効。○痙門。甲
在項後入髮際五

廿一、俠脊之穴

大椎より脊椎の十二椎と。腰椎五節を合て。十七椎の両傍相去ること各五分の
処（脊骨を除て量る）皆鍼灸すべし。乃ち是華佗か俠脊の穴なり其主治は。骨蒸労熱
諸般鬱症、諸胸腹頭頸項背之病、失心癲癇、久年積聚、婦人子宮之病、小児癇

俠脊之穴は所謂華陀穴と通称せらるものである、人或は脊椎の穴又は膀胱経第一行と云うこともある。

Figure 3 *Shinkyusetsuyaku* (鍼灸説約)

Figure 4 *Shinkyumeiwa* (鍼灸茗話)

Conclusion

Acupuncture and moxibustion treatment of Jiaji point was effective for treating pain in the right shoulder of unknown origin that had persisted for more than 2 years. It seemed possible that a previously sustained compression fracture had induced the pain in the right shoulder.

A part of this manuscript has been published at the 66th annual conference of The Japan Society for Oriental Medicine[8].

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* Only in Japanese

Clinical Report 2 (Kampo Medicine)

Case Studies from Ehime Prefectural Central Hospital (2)
– From the Rural Bedside to the Global Podium –

Genki Shimizu, Hiroshi Kakuto, Den-ichiro Yamaoka
The Internal Departement of East Asian Traditional Medicine of Ehime Prefectural Central Hospital

Type 2 Cases
Combined use with standard Western medical treatment

[Case 6 (Dr. Kakuto's case)]

Administration of Unseiin-go-tsudosan-based prescription (温清飲合通導散加減) [ys1][mi2] for refractory prurigo nodularis in a 77-year-old woman

[Chief complaint]

General rash, itching

[Past medical history]

Type 1 diabetes (use of insulin), lumbar compression fracture

[Regular medication]

Amlodipine, telmisartan, epalrestat, aspirin, sennoside, famotidine, EPA, mecobalamin, olopatadine, levocetirizine, strongest class of steroid ointment

[History of present illness]

The patient became aware of an itching of skin around December of X-1. She consulted the dermatology department in our hospital in March X and was diagnosed with overall prurigo nodularis. She was prescribed an antihistamine drug and steroid ointment, but they failed to have a sufficient effect, so she requested Kampo treatment and was introduced to our department in September.

[Observations]

Dry mouth (-), excessive thirst (-), constipation (+) (use of a laxative)

Appetite (+), hot flashes (-), cold hands and feet (+)

Bitterness in mouth (-), susceptibility to colds (-)

Skin: Numerous nodules accompanied by rubefaction on the trunk of the body

No discharge liquid. Nodules are hard and raised. (Photos 1, 2)

Tongue: Rose pink, light tongue fur, no fissures, no varicosis

Pulse: Moderate, thin, powerful

Abdomen: Weak abdominal strength, weakness of the lower abdominal region, gas accumulation

[Progress]

First visit: Orengedokuto (黄連解毒湯) extract 7.5g + Tsudosan (通導散) extract 5g

Second visit (11 days later): The redness abated somewhat. Feces is soft but is of no problem.

Nodules on the back have slightly flattened. (Remark from the dermatology dept.)

Unseiin (温清飲) extract 7.5g + Tsudosan (通導散) extract 5g

Third visit (39 days later): The redness has improved, but the nodules are still hard.

Nodules on the back have slightly flattened. The prescription appears to have an effect. (Remarks from the dermatology dept.)

Unseiin-plus-juyaku (温清飲加十薬), Tsudosan (通導散) extract 5g

Unseijin (温清飲) consists of oren (Coptis japonica 黄連) 1.5g, obaku (amur corktree 黄柏) 1.5g, ogon (Baikal skullcap 黄芩) 3g, sanshishi (gardenia fruit 山梔子) 2g, toki (Japanese angelica root 当帰) 4g, shakuyaku (peony 芍薬) 4g, senkyu (cnidium rhizome 川芎) 4g, jukujiou (rehmannia root 熟地黄) 4g, juyaku (chameleon plant 十薬) 10g.

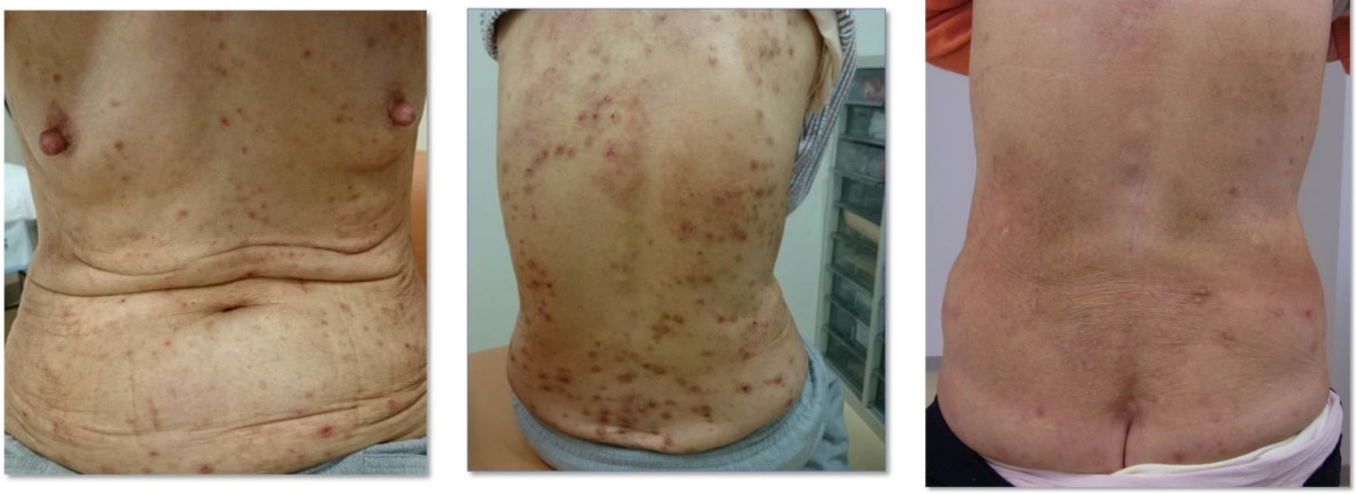
Fourth visit (67 days later): An improvement is observed. The nodules have flattened out. (Figure 3)

Successful (Remark from the dermatology dept.)

Continuation of treatment in same manner.

Good progress continued thereafter, and the prescription was stopped three months after the patient's first visit.

(Figure 3)



(Observation)

We diagnosed this case as wind as a result of blood deficiency. We also hypothesize that the epidermal acanthosis and hypodermal hyperplasy of collagenous fiber due to chronic inflammation results in blood stagnation. Consequently, the combination of Unseiin (温清飲) and drugs for overcoming blood stagnation was effective.

We have to research more cases with prurigo nodularis suitable for these crude drugs.

[Case 5 (Dr. Shimizu's case)]

68-year-old man

[Chief complaint]

Difficulty in breathing

[History of present illness]

The patient has been seeking regular medical attention for bronchial asthma. Since Sept. 20, he has experienced repeated asthma attacks, and used an inhalant. Around 7 p.m. on October 1, he suffered another asthma attack that did not improve even after using the inhalant, so he made an emergency visit to the hospital.

[Present symptoms]

Blood pressure 136/68mmHg, temperature 36.7℃, SpO2 = 90% (ambient air)

Pulmonary sound: Marked wheezing

[Progress]

Steroid infusion and ß-agonist inhalation improved oxygenation, but white frothy sputum and diluted saliva began spilling from the patient's mouth, and he could not stop coughing. After he was given 6g of Shoseiryuto (小青竜湯) extract dissolved in warm water, his frothy sputum, saliva and coughing stopped in about 5 minutes.

[Observation]

In this case example, white frothy sputum was interpreted as edema from the epigastric region, and the patient was thus successfully prescribed) Shoseiryuto (小青竜湯). Shoseiryuto (小青竜湯) contains crude drugs that have a warming effect, and lacks any alternative in Western medicine. (The figure below shows that six out of eight crude drugs that constitute Shoseiryuto (小青竜湯) have a warming effect.)

Ingredients of Shoseiryuto

Maou (ephedra 麻黄)
Keishi (cinnamon 桂枝)
Saishin (wild ginger 細辛)
} Eliminates water and cures wheezing. Stops coughs.

Shakuyaku (peony 芍薬) Relaxes tension in smooth muscles.

Kanzo (licorice)甘草 Harmonic action

Kankyo (zingiber siccatum 乾姜)
Hange (pinellia tuber 半夏)
} Warms the body and eliminates water. Antitussive expectorant action

Gomishi (schisandra fruit 五味子) Prevent water from leaking.

[Case 8 (Dr. Kakuto's case)]

Administration of Inchinkoto-go-goreisan (茵蔯蒿湯合五苓散) for refractory ascites caused by decompensated cirrhosis in a 58-year-old woman

[Chief complaint]

Neck pain, sense of abdomen distension

[Past medical history]

Diabetes, hepatitis B

[History of present illness]

The patient was diagnosed with diabetes and chronic hepatitis B at a different hospital and has received treatment from around X-5, but terminated the treatment at her own discretion and neglected her condition. In late November X, she had a fall at home and hit her temporal region, so she made a visit to our hospital. The patient was suspected of a cervical sprain and was set to receive symptomatic treatment, but because she also clearly displayed jaundice and ascites, as well as a complication of hyperglycemi with an HbA1C (NGSP) of 8.6%, she was immediately admitted.

[Western medical observations]

Lucid, no disorientation. Blood pressure 155/75mmHg.

Overall jaundice, marked ascites. Normal heart sound, breathing sound.

Capillary dilatation observed on the face and trunk of body, and red palms.

No edema of the extremities. Weight 50.4kg, abdominal girth 86.2cm.

After hospitalization, the patient's blood glucose was controlled by insulin and entecavir was introduced. She was also given antibiotic treatment, as she was found to have a complication of purulent spondylitis caused by methicillin sensitive Staphylococcus aureus (MSSA). For her complication of cirrhosis, liquids and salts were restricted immediately upon hospitalization, and she was given 60mg/day of furosemide and 75mg/day of spironolactone in an attempt to gain a diuretic effect, but hypoalbuminemia and hyponatremia progressed, and no improvement was gained. Ascites puncture drainage was attempted as necessary, and an intravenous drip of two 50ml of albumin 25% and furosemide 20mg1A was administered over three days, but since no improvement was observed, Kampo was considered.

[Kampo observations]

The patient is of medium height and build, but her abdominal region is swollen like a frog belly. She has overall jaundice, and the capillary veins in her face stand out. Her tongue has no teeth marks, and is dark red and lightly coated. No varicosis is seen on her tongue. Her pulse is sunken and powerful. She has constipation.

Judging by her jaundice and ascites, Inchingoreisan (茵蔯五苓散) [infusion] was administered from January 21, X+1. The patient thereafter requested an extract preparation, so she was prescribed Goreisan (五苓散) extract (Tsumura, 7.5g/day) from January 28, but no particular change was observed.

Because the patient had a complication of constipation, a prescription containing a laxative was considered, and her prescription was changed to Inchinkoto-go-goreisan(茵蔯蒿湯合五苓散)[infusion] from February 4. Thereafter, she was given albumin IV and ascites puncture drainage was performed once each. Whereas ascites previously recurred soon after administering albumin or draining ascitic fluid, the patient's abdominal girth gradually decreased after commencing Inchinkoto-go-goreisan (茵蔯蒿湯合五苓散).

Her weight also decreased, such that she weighed 43.4kg and had an abdominal girth of 69cm by April 18. From there, she reached a plateau and her condition stabilized. (Figure 1)

Thereafter, her prescription was changed to Inchinkoto (茵蔯蒿湯) extract (Tsumura, 7.5g/day) + Goreisan (五苓散) extract (Tsumura, 7.5g/day) when she was discharged from the hospital on May 15. She still takes the prescription today, but has experienced no recurrence of ascites.

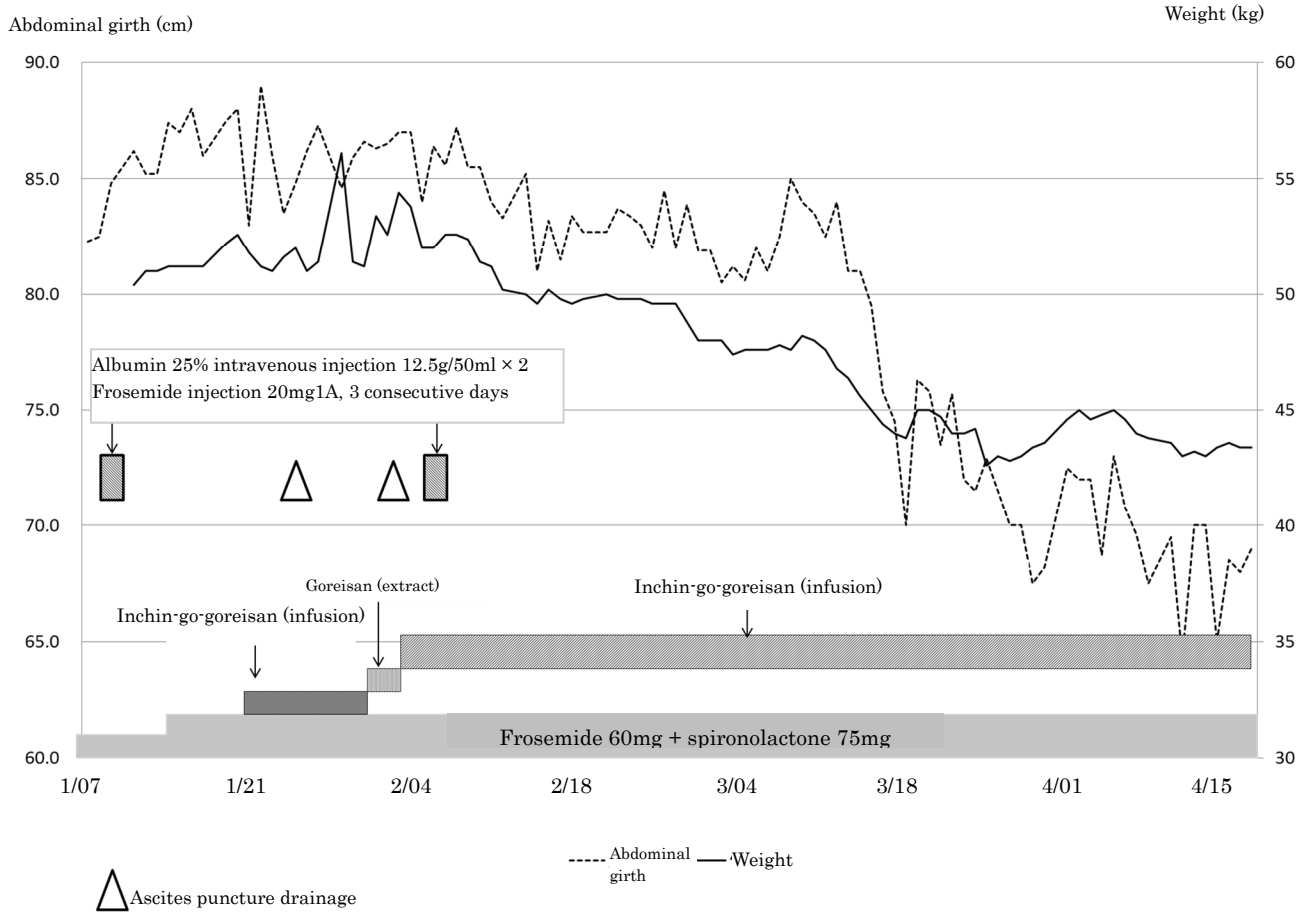


Figure 1　Change in abdominal birth and weight

(Discussion)

We usually use Inchinkoto to treat the liver diseases, or Goreisan for asciteses in Japanese Kampo style. In this case, we found that an inchinkoto-go-goreisan decoction was more effective than an Inchingoreisan decoction or a goreisan extract. This suggests that the effects of Gardenia and Rheum they are made from can be significant.

Conference Report

Impressions of the 3rd ISJKM

Keiko Ogawa
Departement of Japanese-Traditional (Kampo) Medicine
Kanazawa University Hospital

Introduction

The 3rd International Symposium for Japanese Kampo Medicine (ISJKM) was held in Vienna, Austria on June 19, 2015.

The symposium was first organized by Dr. Heidrun Reissenweber-Hewel from Germany and held in Munich on November 25, 2011, by taking a cue from the 5th International Congress of Complementary Medicine Research (ICCMR), which was held in Tromsö, Norway in the previous year in 2010 in the style of a satellite symposium on Kampo medicine. It was the first attempt of its kind, but the symposium was well attended by some 80 participants and ended successfully.

The second ISJKM was held in London on April 10, 2013, ahead of the ICCMR for that year. Many participants flew in from Japan and took part in fruitful discussions.

The recent 3rd ISJKM, held in Vienna under the chairmanship of Dr. Bernd Kostner, became an even more productive forum in light of the experience of the past two symposiums. The conference room at Hotel de France, located near the University of Vienna, was crowded with some 80 participants who were already seated by 9 a.m. and waiting for the symposium to open. With the attendance of roughly 20 participants from Japan and 60 participants from Europe (Germany, Austria, Spain, and the United Kingdom), the United States, Brazil and Israel, the symposium venue was filled with an air of excitement from the start.

In addition to the Japan Society for Oriental Medicine, the symposium was also sponsored by the German Medical Association of Acupuncture (DÄGfA) and the Austrian Society for Acupuncture (ÖGA), and for the first time this year, it also received support from the Association of Pharmacists in Vienna. This is but one indication that Kampo medicine has become a subject of global-scale discussion.

Opening Ceremony and Symposium Proceedings

The symposium opened in a relaxed and friendly atmosphere, as Dr. Bernd Kostner, chairman of the symposium who resides in Vienna, gave a welcome address, followed by greeting remarks by Dr. Reissenweber-Hewel, Chairman of ISJKM, the chairman of ÖGA, and Dr. Stör, Chairman of DÄGfA.

Dr.Kostner

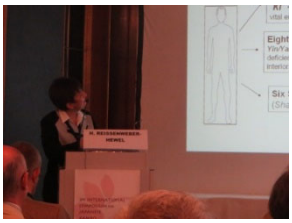
Dr. Reissenweber-Hewel

The program was as follows.

Oral Presentation
Session A: Introduction and Historical Aspects

The special characteristics of Japanese Kampo Medicine

Heidrun Reisenweber-Hewel, Clinic for Japanese Medicine, and Competence Centre for Complementary Medicine, Techn. University, Munich, Germany



On the "Japanization" of materia medica studies (honzō-gaku) in 17th-century Japan

Wolfgang Michel-Zaitsu, Kyushu University, Fukuoka, Japan

How do medical illustrations of the Tokugawa period reflect Japanese society and science of the time?

Gretchen De Soriano, University of Westminster, London, UK

Session B: Preclinical Actions and Clinical Efficacy

Daikenchuto, a Kampo medicine, ameliorates post-operative ileus by anti-inflammatory action through nicotinic acetylcholine receptors

Tetsuro Oikawa, Kitasato University, Tokyo, Japan

Effects of Leonurus japonicus Houtt. and eight of its bio-active constituents on the activity of PPARα, β/δ, and γ in a newly developed in vitro luciferase reporter gene assay

Kenny Kuchta, Sanyo Gakuen University, Okayama, Japan

Clinical efficacy of Kampo therapy in pediatric lymphangiomas - a pilot study -

Naoki Hashizume, Kurume University, Kurume, Japan

Integration of a Kampo medicine, Nijutsuto, and Western medical treatment in the treatment of long-term refractory frozen shoulder: A case series

Young-Chang Arai, Aichi Medical University, Nagakute, Japan

Kampo medicine for alleviation of symptoms of pediatric cancer patients: A case series

Keiko Ogawa, Kanazawa University, Kanazawa, Japan

Session C: Standardization and Methodology of Kampo Medicine

Kampo practice standardization project

Hiroshi Odaguchi, Kitasato University, Tokyo, Japan

Visualization and standardization of Japanese Kampo Medicine by a large clinical database

Tetsuhiro Yoshino, Keio University, Tokyo, Japan

Systematic review on the use of Kampo diagnosis in randomized controlled trials of Kampo medicines

Yoshiharu Motoo, Kanazawa Medical University, Uchinada, Japan

Session D: International Aspects of Kampo Medicine

Field trial of Traditional Medicine Chapter in ICD-11

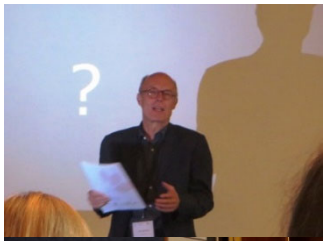
Kenji Watanabe, Japan Society for Oriental Medicine, Tokyo, Japan and Nenad Kostanjsek, WHO, Geneva, Switzerland

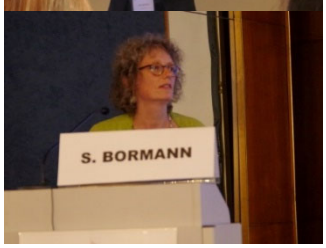
Registration of herbal medicinal products in the EU

Astrid Obmann, Austrian Medicines and Medical Devices Agency, Vienna, Austria

How can European physicians become acquainted with Kampo?

Ulrich Eberhard, Kampo Clinic, Madrid, Spain and Sigrid Bormann, Kampo Clinic, Luneburg, Germany





Case report writing: A new competency for the internationalization of Kampo

Gregory Plotnikoff, Penny George Institute for Health and Healing, Minneapolis, USA

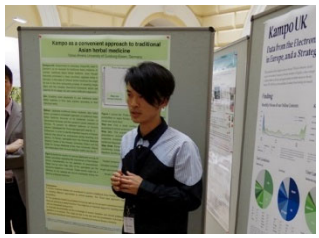
Poster Session

1. **Kampo as a convenient approach to traditional Asian herbal medicine**

Tobias Ahrens, University of Duisburg-Essen, Germany

2. **Data from the electronic Publication on Kamp5 in Europe, and a strategy for Kampo UK in 2015**

Takuya Furukawa, Gretchen De Soriano, Atsuko Fritz, UK Kampo Association, London, United Kingdom

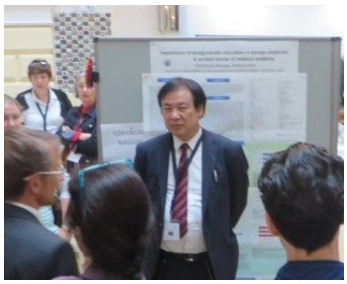


3. **Importance of postgraduate education in Kampo Medicine: A current survey of medical residents**

Yoshinobu Nakada, Makoto Arai Department of Kampo Medicine, Tokai University Schoo1 of Medicine, Kanagawa, Japan

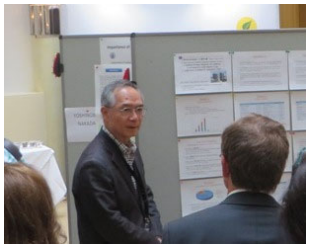
4. **A new non-contact method for measuring tongue moisture to assist in tongue diagnosis, and development of a Tongue Image Analyzing System (TIAS)**

Takao Namiki[1)],
Toshiya Nakaguchi[2)],
Kanako Takeda[3)],
Yuya lshikawa[1)],
Takeshi Oji[1)],
Satoshi Yamamoto[3)],
Norimichi Tsumura[4)],
Keigo ueda, Koichi Nagamine, Yoichi Miyake[2)]
1) Department of Japanese-0riental (Kampo) Medicine, Graduate School of Medicine, Chiba University, 2) Center for Frontier Medical Engineering, Chiba University, 3) Graduate School of Engineering, Chiba University; 4) Graduate School of Advanced integration Science, Chiba University, Japan



5. Shokenchuto, a popular Kampo Medicine for children: a retrospective study based on the experience of pediatric outpatient clinics

Akira Saito and Takeshi Sakiyama, Department of Pediatrics and General internal Medicine, St. Marianna University School of Medicine, Kanagawa, Japan



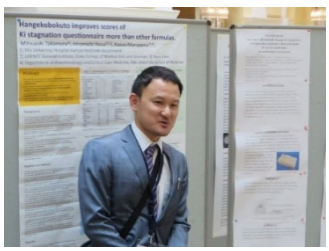
6. Observing whole body responses to develop knowledge of a Kampo prescription

Shaun Sutton
Clinic for Traditional East Asian Medicine, London, United Kingdom

7. Hangekobokuto improves scores of ki-stagnation questionnaire more than other formulas

Mitsuyuki Takamural[1)],
Hiromichi Yasui[2)],
Kazuo Maruyama[3)]

1) Mie University Hospital Kampo Medicine Department, 2) Yasui Clinic, 3) Department of Anesthesiology and Critical Care Medicine, Mie University School of Medicine, Tsu, Japan



8. Modifications to a new abdominal diagnosis simulator to reproduce patterns characterized by local Variations in resistance to pressure

Shuji Yakubo[1)2)], Yukiko Uedat[2)], Kazuhiro Muroga[1)], Naomichi Tanekura[1)], Tomoyuki Okudaira[1)], Toshifurni Sasanuma[1)], Masdayoshi Souma[1)], Takao Namiki[3)], Takashi Nakayama[4)] and Kazufumi Yamanaka[4)]
1) Division of integrated Herbal Medicine, Department of Medicine, Nihon University School of Medicine; 2) Kampo institute in Japan, 3) Department of Japanese-Oriental (Kampo) Medicine, Graduate School of Medicine, Chiba University, 4) Nomura Techno Co., Ltd.

9. Efficacy of shigyakusan in modern society from a global perspective-stress evaluation by chronological analysis as comprehensive interview method

Den-ichiro Yamaoka
Department of East Asian Traditional Medicine, Ehime Prefectural Central Hospital, Matsuyama, Japan

10. Japanese herbal medicines (Kampo) in a German university

Silke Cameron
Hospital Environment Department for Gastroenterology and Endocrinology, University Medicine Göttingen, Germany

Audience of the Poster session

In the Heurige

Social Gathering

After the symposium program was completed, the participants headed to a *heuriger* in the suburbs of Vienna by bus. A heuriger is a wine tavern that is commonly found in eastern Austria. The mixed group from various countries took to eight tables of six to eight people each, and enjoyed the genial atmosphere while discussing academic issues, introducing themselves to each other, and sharing stories about their personal interests and a host of other topics. Time passed quickly, and it was close to 11 p.m. by the time everyone headed back home or to their hotels feeling fully content with the evening.

Conclusion

The 3rd ISJKM was completed in what could be said to be perfect success, owing to the passion and dedication of all who participated. The next symposium will be held in 2017 as a sort of foregoing event to the ICCMR that is scheduled to take place in Berlin. The participants of the 3rd ISJKM already have their hearts set on attending it. It will no doubt be a superb event.

Members of the General Meeting held on the following day:
Dr. Kostner, center-left in front row, Dr. Reissenweber-Hewel, center-right in front row

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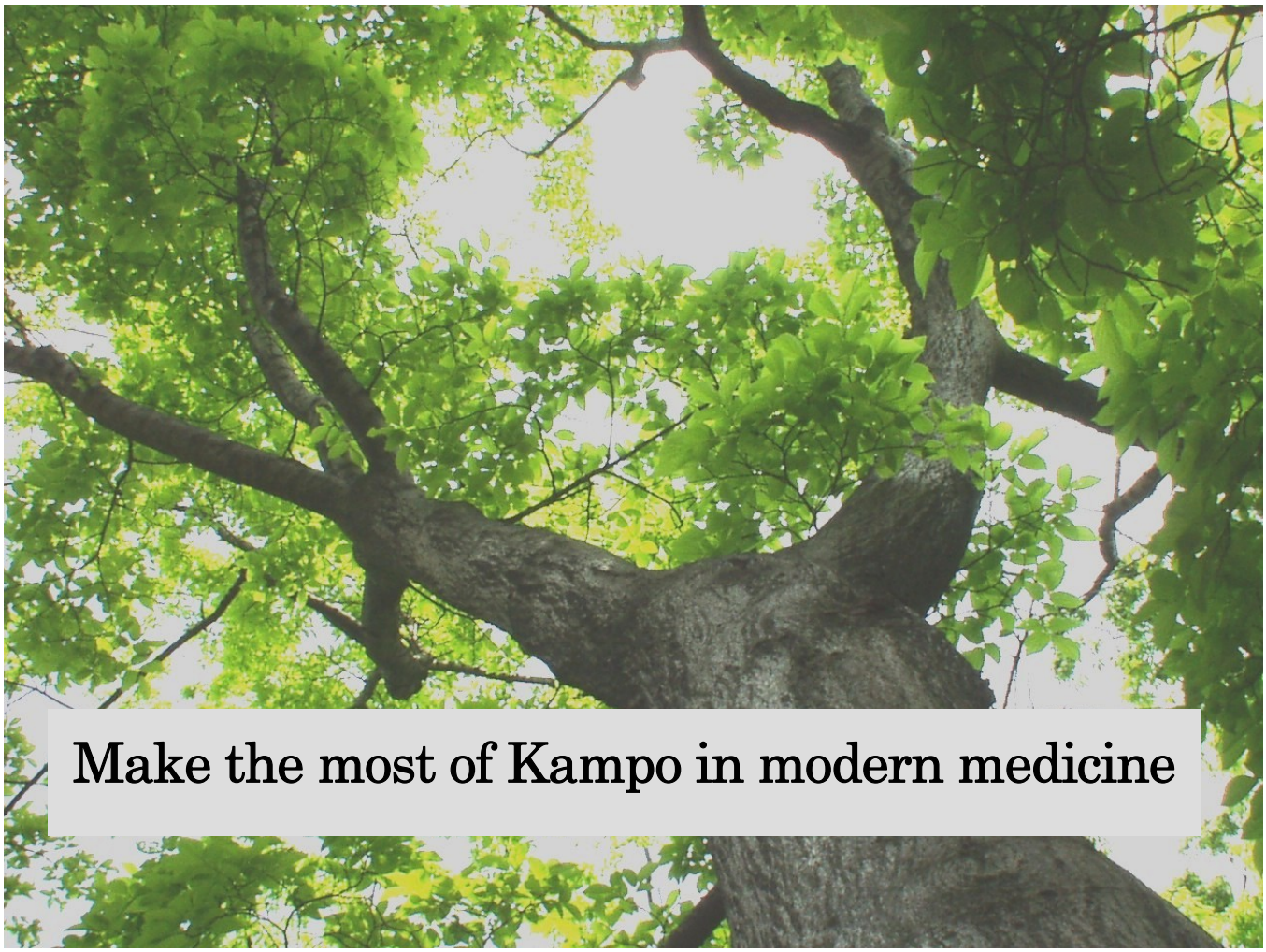

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