Clinical Report 1 (Acupuncture)

Traditional Chinese Acupuncture and Moxibustion in Japan (1) – Pain and Numbness of the Low Back and Lower Extremities

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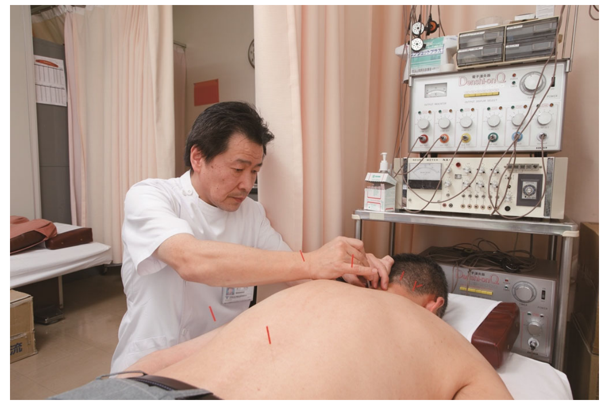
Preface

Japanese acupuncture and moxibustion has its own characteristic history and while Chinese thoughts were introduced to Japan during the various periods, Japan has developed its own original techniques and concepts. The needle tube widely used worldwide today is an invention made by a Japanese, the delicate treatment form called meridian therapy too was developed by a Japanese. Yet, today there are still many acupuncturists in Japan practicing Traditional Chinese acupuncture and moxibustion. In this series acupuncturist Masanori Taskashi of the Oiso Tokai University affiliated hospital will introduce these TCM methodologies and current clinical practice in four reports to be published from No. 1 through No. 4 of Volume 11.

Tokai University Oiso Hospital



Dr. Takashi in treatment.

Introduction

Our office in the Department of Oriental Medicine in the Oiso Hospital affiliated with the Tokai University School of Medicine has been established in 1984 by late Dr. Kumio Yamashita. The author (Takashi) has been employed at this office since April 2001 and performs here daily acupuncture and moxibustion treatment. In March 2008 Dr. Arai joined the treatment and research.

We are treating many diseases with acupuncture and moxibustion. A part of this series introduces some case reports. We report cases with certain diseases. In this first part we report a case with pain and numbness of the low back and lower extremities as it is commonly encountered in clinical practice.

[Case] 34 years old, male, employee
[Chief complaint] Pain and numbness of the low back, numbness of lower extremities
[Present illness]

The low back pain started during his senior high school days when he was a field and track athlete and for which he consulted a local physician. He was told his symptoms were due to fatigue. Five years ago he visited this acupuncture and moxibustion clinic because of his low back pain. The treatment assuming the presence of kidney yang deficiency slightly alleviated the low back, but it continued to

recur thereafter in intervals of 1-2 months. Whenever this happened he underwent acupuncture and moxibustion treatment.

Late in June of this year he experienced a sudden onset of low back pain immediately after jumping into the water during swimming and consulted our office for that reason. Immediately after the acupuncture and moxibustion treatment the pain had been reduced to half of its intensity, but the symptoms improved slower than usual. By the middle of July some discomfort developed while driving a car and during the night of that day severe pain (as if being squeezed) developed in the low back and region around the sacrum. Since numbness of the lower extremities had also newly developed, he visited our office again walking with a cane. Due to the pain his posture was bend laterally. Because I found signs of radiculopathy when I performed a physical examination, I referred the patient to the orthopedic outpatient department. The physician diagnosed based on x-ray and MRI images of the pelvis a prolapsed disk at L5-S1 and prescribed an antiphlogistic analgetic.

[Past history]

Four years earlier admission due to antibiotic induced anaphylactic shock

[Present status]

A squeezing type of pain of the low back and sacral regions as well as a heavy, dull pain of the right buttock. Numbness of the right leg appeared on the posterior aspect of the thigh and the lateral side of the lower leg. The pain caused a tendency toward insomnia. Micturition frequency was high with 10 times/day.

Pulse: deep, wiry

Tongue: tongue body dark red, white coat

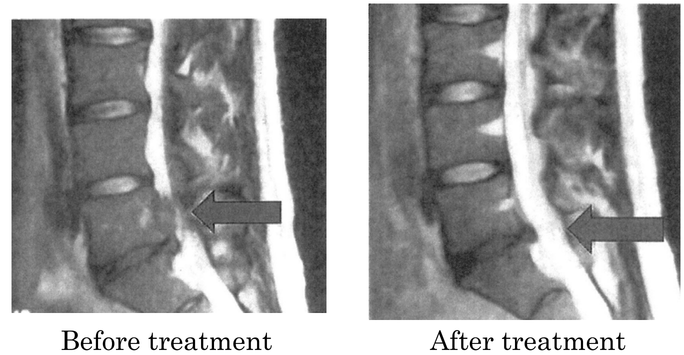
Western medical findings: MRI findings (Figure 1)

SLR: R 20 degrees, L 60 degrees (pain in the right low back region), no dysfunction of bladder and bowels

Deep tendon reflexes: both Achilles tendon reflex and patellar reflex were normal

Manual Muscle Testing (MMT)	R	L
Tibialis anterior muscle	5－	5
Extensor hallucis longus muscle	5－	5
Flexor hallucis longus muscle	5	5

Pain was 85 mm on a Visual Analog Scale (VAS) and numbness on a similar (VAS) 60 mm.



Before treatment After treatment

Figure 1

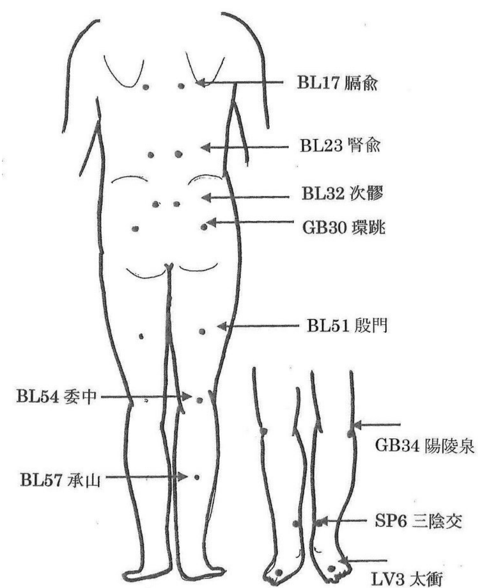


Figure 2

[TCM diagnosis]

Blood stagnation and channel blocking

Kidney deficiency

[Therapeutic principle]
Activating Blood and eliminating stagnation
Tonifying the Kidney
[Acupoint selection]
BL23 - tonification using twirling
BL17 / BL32 /right BL51 / BL54 / BL57 / GB34 / SP6 / LV3: all neutral supplementation and drainage
right GB30 - lifting-thrusting reduction
BL17 / BL32 / BL54 – cupping. (Figure 2)
Used needles: sterile Seirin acupuncture needles, length: 1 cun 6 fen, No.3 and 2 cun No.3
[Explanation]
Based on the concept that the 'low back is the mansion of the kidney'[1] the back transport point of the kidney BL23 was used to tonify the kidney. To free the flow of Qi of the bladder channel a combination of BL32[2], BL54[3] and BL57[4] was used. At BL17[5] as the meeting point of the blood and BL32[3] as a point on the greater yang bladder channel in the sacral region as well as BL54[4] for Blood stagnation as its main indication cupping was performed to activate Blood and eliminate stagnation. And the combination of BL17, SP6 and LV3 was needled to strengthen the activation of Blood and resolving stasis function[6]. At GB30 as the meeting point of the bladder and gallbladder channels we used a 2 cun No.3 needle, inducing a needling sensation extending down to the lower leg to free the flow of Qi between the two channels.

[Course]
First session: Immediately after the treatment the pain score on the VAS changed to 60 mm. Numbness did not change. Yet, pain increased again during the night, bringing the VAS score back to 80 mm.
Second session (next day): Upon arrival in our clinic the score for both pain and numbness was 40 mm. At the time he came into the office he used a cane, but forgot it when he returned home after the treatment.
Third session (1 week later): After the treatment the score for both pain and numbness was 30 mm. There were almost no impediments to ordinary life. During work he put on a corset.
Fourth session (1 month later): The score for both pain and numbness was 0 mm. Two weeks earlier he had stopped taking the antiphlogistic analgetic.
Fifth session (2 month later): No symptoms. Only development of a feeling of heaviness in the low back region when tired. The acupoint selection focused on supplementing the kidneys (BL23, BL26, KI3, CV4, ST36, SP6). The herniated L5-S1 disk found on the MRI images taken 2 weeks before the patient visited our office had disappeared. By this time we considered the condition almost cured and terminated the treatment.

[Discussion]
Acupuncture and moxibustion treatment led in this patient to pain relief in the same way Yamashita et al. have described in “The journal of Japanese Society of Lumbar Spine Disorders” and could improve activities of daily living[7]. Conservative treatment of lumbar disk herniation is known to lead to spontaneous remission. According to a report by Dr. Hijiguro et al. the shrinkage or disappearance of lumbar disk herniation (except in cases with a history of surgery or spinal canal stenosis) requires an average time between 4.0 and 6.6 months[8]. Considering that in this case a shrinkage was observed in less than 2 months the possibility is conceivable, that acupuncture and moxibustion treatment has some influence on the shrinkage of herniations.
This patients was diagnosed during his first visit with kidney deficiency. Later, since symptoms improved and exacerbated several times, the condition led to impaired blood circulation and the development of Blood stagnation. This matches the description in "Jing Yue's Complete Works" saying 'Kidney deficiency is often associated with low back pain. However, this state of deficiency can also be superimposed by excess pattern pathological conditions'[9].

Trauma, contusions, Blood-cold, Blood-heat, Qi stagnation, Qi deficiency may cause Blood stagnation which then may impair the functionality of the organ and viscera channels. For that reason the condition impedes a smooth movement of Blood throughout the body and leads to stagnation.

This case presented with the clinical characteristics of Blood stagnation. The pain was of stabbing or else squeezing nature and its site fixed. Moreover, refusal of pressure (a condition in which application of pressure at the site of the pain exacerbates the pain) and nocturnal exacerbation were also observed. In this case the laterally bend posture was one of the indications suggesting the refusal of pressure. Also, the disengagement and prolapse of the nucleus pulposus too was considered to be the Blood stagnation. Based on these characteristics we presumed the patient condition to be the result of kidney deficiency and Blood stagnation obstructing the channels, administered a suitable treatment and therefore obtained good results.

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