

THE JOURNAL OF
KAMPO, ACUPUNCTURE AND INTEGRATIVE MEDICINE
Research on Theory, Practice and Integration

KAIM

**The Journal of
Kampo, Acupuncture and Integrative Medicine**

INTERNATIONAL INSTITUTE OF HEALTH AND HUMAN SERVICES,
BERKELEY

Volume 13, Number 3 · Fall 2018

Editorial

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Type 3 Case of Yasui Classification

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Clinical Report (Acupuncture)

Acute Low Back Pain Following a Holiday
Tsuyoshi Hashimoto

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Human Services, Berkeley
2550 Shattuck Avenue, Berkeley
California 94704-2724, U.S.A.

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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.

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Editorial

The Possibility of Exist of "Halo Effect" on Clinical Pearls

Dr. Keisetu Otsuka (1900-1980) had begun researching Kampo medicine since the 1920s and Japanese traditional medicine has greatly developed due to his accomplishment. He put great emphasis on "kuketsu", the clinical pearls, which have been made and inherited by many past Kampo doctors for more than 300 years long.

Dr. Otsuka himself is also well known for making and diffusing many own clinical pearls. Let's see one of them.

The proportion of target patients of *boiogito* are higher in females than in males, more often in "a lady of leisure" with the so-called "a flabby body". They are increasingly obese because they do not move their bodies, although they want to lose more weight.

They are fine to skip a meal, take a lot of tea and are hyperhidrosis. Their menstruation is irregular and menstrual blood volume is low. These kinds of females may complain of pain in the knee joint if they became over 50 years old. Also, in the evening, edema occurs on their foot and the socks become tight-fitting. Abdominal examination reveals the abdomen to be a whole fat belly without resistance or tenderness and it may be soft.

Other doctors who have referred to this clinical pearl prescribed *boiogito* for elderly women suffering from osteoarthritis of knee. This usage has been widely spread and several clinical studies have also supported the contents of this clinical pearl. Many doctors might think that it was enough to believe because the clinical pearl was made by the Kampo authority Dr. Otsuka and it could be important.

However, there is a possibility of "halo effect". The contents of this clinical pearl did not apply to all patients and clinical studies with different conclusions also existed. Regarding this fact, Dr. Otsuka himself was aware of it, and for the sake of later researchers he left the following words; The explanation of *boiogito* in medical book "Fukushokiranyoku" written about 200 years ago says "The characteristic of *boiogito*'s indication is noble females who are very rich, eat delicious things with a sedentary lifestyle. Their menstruation often stops and they are always tired." I got a hint from this description and made that clinical pearl. However, when others read this original text, another interpretation may come out. I hope future researchers will do so.

In clinical reasoning, clinical pearls which form the background of System1 are very important but we must not forget the possibility of bias. And we have to always pay attention to "halo effect". This is one of the important lessons from Dr. Otsuka.

Hiromichi Yasui

Japan Institute of TCM Research

Report from WFAS Tokyo/Tsukuba 2016

"Acupuncture and Moxibustion in Palliative Medicine"

Masaki Tsuda

Tohokai Oriental Medicine Acupuncture & Moxibustion
Clinical Study Group

Introduction

Within palliative cancer therapy the acupuncture and moxibustion treatment style of the Tohokai Oriental Medicine Acupuncture & Moxibustion Clinical Study Group (below: "Tohokai style acupuncture and moxibustion") has taken the initiative in 1985, when Dr. Nobuko Yokokawa introduced it in the department of anesthesiology of the National Cancer Center (currently the Central Hospital of the National Cancer Research Center) for the treatment of various symptoms of cancer patients. Relying on acupuncture and moxibustion treatment good results were obtained for clinical symptoms like weariness, numbness, pain etc. and since 1989 two acupuncturists from the Tohokai Group were dispatched to offer Tohokai style acupuncture and moxibustion treatment and this arrangement still continues today.

Acupuncture and moxibustion treatment applied in palliative cancer treatment does not focus exclusively on the treatment of symptoms, but comprehension of the correlation between the whole body and the site of the symptoms, based on oriental thought and using oriental medical specific examination techniques is very important.

Many cancer patients in need of palliative medical care suffer from exhaustion caused by the nature of the disease, surgeries or else the side effects of chemotherapeutics often progress into a state of deficiency. That is why the stimulus dose of the acupuncture and moxibustion treatment has to be carefully adjusted to prevent overstimulation. Essentially cancer patients and patients with other diseases are identical in the sense, that both present with symptoms, and the pathology of these symptoms can be understood by using the four

examination methods from the oriental medical perspective of "Qi and Blood".

About the Tohokai Group

The Tohokai style acupuncture and moxibustion treatment has been developed in Japan based on interpretations of the classics and belongs to the group of styles called channel therapy. This channel therapy has been proposed by Sorei Yanagiya, Sodo Okabe, Keiri Inoue, Shinichiro Takeyama and others in the 1930s. Channel therapy is characterized by its concept of disease based on deficiency and excess patterns of organs and viscera, allowing treatment of diseases by way of adjustment of deficient and excessive conditions. This treatment form has been systematized based on the identification of patterns using the four examination methods. Treatment can be divided into treating the root in order to adjust fundamental deficiency and excess patterns of organs and viscera on the one hand and local and symptomatic treatment on the other hand. Point selection for root treatment relies mainly on interpretations of the 69th difficult issue and selected points are then either tonified or reduced. The results, again, are then evaluated using mainly pulse diagnosis among the four examination methods. Local and symptomatic treatment is performed for the purpose of alleviating symptoms and to that end take both local and general conditions into account. In this case the treatment is performed with the purpose of changing the local, subjective symptoms of the patient.

Here I would like to present an organized classification of the needling methods used for Tohokai Group style acupuncture and moxibustion treatment. Needling can be classified mainly into the following five types.

1. Contact needle therapy (CNT) (Contact needling)
2. Insertion needle therapy (Stabbing needle therapy)
3. Special needle therapy (Special needling techniques)

4. Rounded contact needle therapy (Spoon needle contact needling)

5. Qi-retained needle therapy (Qi retention needling)

For contact needle therapy (contact needling) the needle tip is brought only into contact with the skin but not inserted, allowing to control Qi using techniques like tonification or reduction. It is used for diseases involving Qi (psychosomatic illnesses).

In case of insertion needling therapy the needle tip is inserted into the body to control Blood using techniques like tonification or reduction. It is used for diseases involving Blood (physical illnesses).

Special needle therapy (Special needling techniques) include techniques like big needle method, long needle method, moxibustion with warming needles, micropuncture technique, intradermal needling etc. These techniques are used, when achieving effects with contact needling or needle insertion is difficult. Rounded contact needle therapy (Spoon needle contact needling) refers to stroking or pressing against the body with the tip of a comparatively thick metal rod with a rounded head called spoon needle (chi zhen). It is used for infants or patients who are particularly nervous, so that the use of ordinary filiform needles may be difficult.

Qi-retained needle therapy (Qi retention needling) refers basically to the same technique as the so-called needle retention.

Contact needling in palliative medical care

In general medical practice these techniques are used selectively for tonification and reduction of the channels, but in palliative care contact needle therapy (contact needling) constitutes the fundamental technique.

Treatment is performed according to the following procedure. First, the four examination methods inspection, listening and smelling, asking and palpation are performed and the general pattern is identified. Within this flow of examination abdominal and pulse diagnosis are particularly

important for determining the pattern. Once the pattern has been determined, points for the treatment of the root are selected based on interpretations of the difficult issue No. 68 and 69 and then used to tonify or reduce the channels. After that a pulse diagnosis is performed and mainly based on changes in pulse patterns, but facial complexion, changes in expression, skin complexion, the tone of the voice, changes in symptoms and other information gathered using the four examination methods are also taken into consideration for a general evaluation of the treatment. If the effects are considered to be sufficient, the treatment is completed. If the effects are insufficient, further corrections will be made as far as possible, but the stimulus dose must be matched to the physical fitness and condition of the patient.

This is how the treatment is administered. Here I would like to explain contact needle therapy (the method of contact needling) used so frequently for patients in palliative care.

Contact needle therapy (contact needling) refers to a treatment form where the needles are inserted not even 1 mm deep, but only brought into contact with the target area. The movement of Qi in the channels as well as the fluctuations of Yin and Yang are modified via the body surface Qi. Concrete descriptions of methods and techniques follow below. The needles used are so-called long-handle needles, which are ordinary filiform needles that have, however, a longer handle, with a thickness varying between 0.18 and 0.16 mm and a length of 30-40 mm for which we recommend gold or silver as material. The Tohokai Oriental Medicine Acupuncture & Moxibustion Clinical Study Group does not use needle tubes, not restricted to the contact needling technique, but uses needle twirling without tube also for insertion of needles.

Indications for the techniques of contact needle therapy (contact needling)

The contact needle therapy (contact needling techniques) are divided into 9 types (Figure) and for each of these purpose and indication are clearly specified.

Transmeridian Qi tonifying therapy (Channel Qi replenishing needling)

Transmeridian Qi tonifying therapy (Channel Qi replenishing needling) is a method to replenish the Qi within the channels. As a tonification technique of the root treatment the channel Qi is replenished. The tip of the needle is laid at an angle of 30 degrees into the direction of the channel course and fixed there with the pressing hand. The needling hand applies some gentle up and down pressure on the needle tip and when the coming and going of the Qi is detected, the needle tip is held still. With the nail of the thumb of the needling hand the needle handle is flicked rhythmically. Once the arrival of Qi is felt, the flicking is stopped and the needle moved away from the skin surface. Simultaneously with removing the needle the needle hole is closed with the index finger or thumb of the pressing hand and a gentle massage is applied to the point location.

There is a first and a second way of selecting points for this method to be used as root treatment, but the first method is used more frequently. In this case LR8 is used for liver deficiency, KI7 for kidney deficiency, SP3 for spleen deficiency. LU9 for lung deficiency and PC7 for pericard deficiency.

Yin-yang balancing needling therapy (Yin-yang balancing needling)

The yin-yang balancing needling therapy (yin-yang balancing needling techniques) utilizes the transport and accumulation points to harmonize organs and viscera, so that it is frequently used to treat diseases of organs and viscera. They are used in particular for organic diseases and where needling methods are required that affect deeper lying disease of longer

duration. The selection of transport and accumulation points depends on the disease pattern. Perform palpatory massage along the channel course, a light massage as pretreatment and then determine the point with the pressing hand. The pressing hand then brings the needle body into close contact with the skin and holds it still, maintaining an angle of 90 degrees to the skin. After holding needle body and tip with the thumb and index finger of the pressing hand in close contact to the skin, the needling hand then stabilizes the needle tip. At this point it is important to pay sufficient attention to keep the needle tip in light contact with the skin and do not allow it to float free. Once the needle tip has been stabilized, apply a comfortable up and down pressure synchronized with your breathing to the needle tip and continue this manipulation until the Qi arrives. Normally the coming and going of the Qi usually should require about 5-6 respiratory cycles. When Qi has been obtained, the needle is removed. At this point be careful not to allow leakage of Qi and apply simultaneously with removing the needle some light massage to the acupoint as posttreatment.

Healthy Qi tonifying therapy (Healthy Qi replenishing needling)

Healthy Qi tonifying therapy (Healthy Qi replenishing needling) refers to a needling method to replenish healthy Qi and is used as local and symptomatic treatment for areas of marked deficiency, emaciation or weakness of the flesh. The used acupoints do not rely on patterns, but can be selected as required according to the findings of inspection of palpation.

Application of healthy Qi tonifying therapy (healthy Qi replenishing needling) means applying palpatory massage along the channel course and thus harmonizing Qi. When the point to be treated has been determined, the pressing hand fixes the needle at an angle of 90 degrees to the surface of the skin. After holding needle body and tip with the thumb and index finger of the pressing hand in close contact

to the skin, the needling hand then stabilizes the needle tip. The pressing hand is held in close contact with the skin, while at the same time the needling hand lightly applies some pressure on the needle tip. The needle is held still with the pressure applied and one awaits the arrival of Qi, which usually requires about 3-4 respiratory cycles. When Qi has been obtained, the needle is removed. At this point be careful not to allow leakage of Qi and apply simultaneously with removing the needle some light massage to the point as posttreatment.

Yang Qi tonifying therapy (Yang Qi supplementing needling)

Yang Qi tonifying therapy (Yang Qi supplementing needling) is a needling method to replenish the yang Qi within yang (protective Qi) and is used as local and symptomatic treatment for surface areas showing deficiency, conditions of numbness or opening of the interstices. Most of the used points are not actual acupoints but rather sites of changes on the skin surface. This needling method serves the purpose of supplementing the yang Qi of the body surface and close the interstices.

In the areas treated with this yang Qi tonifying therapy (yang Qi supplementing needling technique) palpatory massage is applied along the channel course to harmonize Qi. When the point to be treated has been determined, the pressing hand fixes the needle at an angle of 90 degrees to the surface of the skin. After holding needle body and tip with the thumb and index finger of the pressing hand in close contact to the skin, the needling hand then stabilizes the needle tip. The needling hand holds the needle body and swiftly performs alternating half-turns to the left and right. Here it is important to avoid using force with the pressing hand and not apply too much pressure. One to 2 turns are the norm, but if the yang deficiency very marked, perform 4 or 5 half-turns. As soon as the Qi flow swells, remove the needle. At this point be careful not to allow leakage of Qi and apply

simultaneously with removing the needle some light massage to the point as posttreatment.

Yin Qi tonifying therapy (Yin Qi supplementing needling)

Yin Qi tonifying therapy (Yin Qi supplementing needling) is a needling method to replenish the yin Qi within yin (nutritive Qi) and is used as local and symptomatic treatment for conditions of closed interstices, moist skin, feeling of coldness, weakness of the flesh, muscle tension or flaccidity. The used acupoints do not rely on patterns, but are selected as required according to the findings of inspection of palpation.

In the areas treated with this yin Qi tonifying therapy (yin Qi supplementing needling technique) palpatory massage is applied along the channel course to harmonize Qi. When the point to be treated has been determined, the pressing hand fixes the needle at an angle of 45 degrees to the surface of the skin. After holding needle body and tip with the thumb and index finger of the pressing hand in close contact to the skin, the needling hand then stabilizes the needle tip. The needling hand holds the needle body and gently applies some pressure and holds the needle for 2-3 respiratory cycles until Qi passes through the yin portion within the yang. As soon as the Qi flow swells, remove the needle. At this point be careful not to allow leakage of Qi and apply simultaneously with removing the needle some light massage to the point as posttreatment.

Qi dispersing needling

Qi dispersing needling is a needling method for the dispersion of Qi depressions and is a somewhat reducing, continuously performed needling technique for local and symptomatic treatment. Targets are skin areas that appear upon inspection darker than the surrounding skin, or upon palpation feel rougher. These are findings frequently observed on the back and in the lumbar region. Since a major characteristic of body surface Qi is its particularly

marked tendency towards stagnation, the use of Qi dispersing needling is frequently used in clinical practice.

During inspection the pressing hand is used for palpation and determines the scope in which the Qi dispersing needling is to be applied, when Qi depression has been found. The pressing hand is not held fixed on the body and the needle body is not brought into close contact. The contact is more like light touch to protect the needle, the hands keep moving while needling and at the same time constantly check, whether the Qi is dispersed or not. Hold the junction of needle handle and body gently with the finger pulps of thumb and index finger of the needling hand. Beware not to exert any force via the joints of the fingers and arms and learn how to apply light pressing and withdrawing movements through snapping motions of the needling hand. The needle is brought into contact with the areas of Qi stagnation and at once quickly withdrawn. The needle should have an angle towards the skin of about 60 degrees. Be careful not to drag the needle tip during the manipulation. Once the first needling is completed, slide to the next treatment point and repeat the procedure. Perform this technique consecutively for a third, fourth and fifth time without any intervals in between. After the needling palpate the skin and stop the treatment when the roughness of the skin has decreased, or the moisture of the areas of Qi stagnation seems to have increased. Care is required, since with this technique the stimulus dose may easily increase. The needle is brought into contact with the skin with a frequency of about 3-4 times per second.

Smoothing Qi needling

Smoothing Qi needling is a needling technique used, when in conditions other than Qi stagnation (Qi dispersing needling), yang Qi deficiency (yang Qi supplementing needling), or closure of the interstices a disharmony of smoothness and moistness of the skin surface is present. It does not rely on

conventional acupoints, but rather applies continuous needling to smooth the body surface and is performed as a finishing or harmonizing method. With a slightly supplementing effect it is combined with the slightly reducing effect of Qi dispersing needling.

The body surface is palpated with the pressing hand and the scope of the area to be treated determined. The pressing hand is not held fixed on the body and the needle body is not brought into close contact. The contact is more like light touch to protect the needle and the hands keep moving while needling, at the same time constantly observing whether the body surface is moistening. Hold the junction of needle handle and body gently with the finger pulps of thumb and index finger of the needling hand. Beware not to exert any force via the joints of the fingers and arms and learn how to apply light pressing and withdrawing movements through snapping motions of the needling hand. The needle tip is swiftly withdrawn almost simultaneously with bringing it into contact with the skin. The needle should have an angle towards the skin of about 30 degrees. Be careful not to drag the needle tip during the manipulation. Once the first needling is completed, slide to the next treatment point and repeat the procedure. Perform this technique consecutively for a third, fourth and fifth time. The needle is brought into contact with the skin with a frequency of about 3-4 times per second. After the needling palpate the skin and stop the treatment when the skin has become smoother and moister.

Qi drawing needling

Qi drawing needling is a technique that through remotely guiding healthy Qi disperses the evil Qi in the affected area. It is a supplementing needling technique and used for local and symptomatic treatment on all parts of the body, employing acupoints. The point selection depends on the nature of the disease and usually traditionally well-known acupoints are selected.

Qi drawing needling is performed, holding the concept of "drawing Qi" in mind. The channels are palpated along the channel course and a light massage is applied to the point locations. Bring the thumb of the pressing hand into close contact with the needle body and thereby fix it. At this time the needle should have an angle towards the skin of 45 degrees. After grasping needle body and needle tip firmly with thumb and index finger of the pressing hand, the needling hand stabilizes the needle. Bring the needle tip lightly into contact with the point location and hold it there for about 4-5 respiratory cycles. Immediately after the Qi arrives, remove the needle from the point location. Simultaneously with removing the needle the point location is closed by lightly pressing it.

Clear excess therapy (Pathogen draining needling)
 Clear excess therapy (Pathogen draining needling) is a needling technique to drain pathogen (in particular yang pathogens) and applied as local and symptomatic treatment. As systemic and general treatment the command points on arms and legs are used to drain the pathogenic Qi accumulated in the channels. As local and symptomatic treatment it is employed to treat heat associated with wind evil, bruises or else in the presence of pain due to swelling and distension at sites of pathogen accumulation. Applied as systemic and general treatment the connecting and cleft points of the channel presenting with excess are used. The proper use of these cleft and connecting points depends on whether the condition is due to external pathogens or not. In case of external pathogens the cleft points, or based on the exterior and interior correlation and in case of excess of flourishing Qi the connecting points are used.

First, locate the points to be needled. Hold the junction between needle handle and body gently with the finger pulps of thumb and index finger of the needling hand. Form the shape of the pressing hand, bring the needle tip lightly into contact with

the point location and hold it at an angle towards the skin of about 60 degrees. The direction is chosen based on the principle of the directional reducing-reinforcing method. The needling hand gently applies some pressure on the needle tip and performs 2-3 times an up-and-down movement. After this up-and-down movement is finished, the needle is quickly removed from the point location and the pressing hand leaves the needle hole without closing it.

When employed as local and symptomatic treatment palpate the region feeling warm (the site of pathogen excess) with the pressing hand to determine the scope of the local needling. Hold the needle gently at the junction between the long needle handle and body gently with the finger pulps of thumb and index finger of the needling hand. Swiftly bring the needle tip into contact with the area of warmth and immediately remove it. At this time the needle should be at an angle of about 90 degrees towards the skin. After completion of the first pathogen draining needling move slightly sideways to the next needling site and repeat the procedure. Perform this technique consecutively for a third, fourth and fifth time without any intervals in between. The movement should be performed at a speed of 5-6 times per second. The pressing hand is not held fixed on the body surface and moves together with the needle, constantly checking whether the feeling of warmth is fading or not as well as assessing the state of sweating. When the pressing hand senses sweating in the area of warmth and fading of the heat sensation, it is time to discontinue the treatment.

The above described contact needle therapy (contact needling techniques) are used to treat cancer patients in palliative care.

Conclusions

Cancer patients in palliative medical care present with pulse patterns showing exhaustion and suffer from the characteristics of their disease as well as

the side-effects of various treatments, so that the pulse is often very thin and weak. Contact needle therapy (contact needling techniques) are optimal for these patients. During the treatment it is important to carefully observe the pulse, skin condition and changes in indurations.

Contact needle therapy (contact needling techniques) have the advantage that they are safe, painless and not associated with the risk of infection. Also, for patients afraid of needles contact needle therapy (contact needling) is easier to accept than the typical treatment using needle insertion.

I believe wide application of contact needle therapy (contact needling techniques) can be an effective treatment for many patients in palliative medical care.

Type 3 Case of Yasui Classification

Effects of Kampo Medicines on Loss of Appetite and Irritation Caused by Attention Deficit Hyperactivity Disorder Medication

Kaori Kimata

Kawashima Family Clinic

Abstract

Methylphenidate hydrochloride sustained-release tablets and atomoxetine hydrochloride are preferred drug treatments for attention deficit hyperactivity disorder (ADHD), but both drugs often cause loss of appetite or irritability. In this study, we examined the effects of *shikunshito* and *rikkunshito* administered to alleviate these adverse effects. Although there were cases in which oral administration was not possible due to the taste or formulation, following administration, loss of appetite improved in 1–2 months. Because patients with ADHD are often “inattentive,” missed doses did occur; however, it was considered that patients continued taking Kampo because they felt it was effective. Many children with ADHD experience stress related to their condition and may have low self-esteem. Considering such condition of children with ADHD as “qi-kyo (qi deficiency),” *shikunshito* and *rikkunshito* improved gastrointestinal motility and sustained patient motivation.

Keywords: attention deficit hyperactivity disorder, loss of appetite, *shikunshito*, *rikkunshito*

Introduction

Drug treatment for attention deficit hyperactivity disorder (ADHD) includes methylphenidate hydrochloride sustained-release tablets (MPH), covered by health insurance for children since 2007, and atomoxetine hydrochloride (ATX), covered since 2009. As both drugs sometimes cause loss of appetite as a side effect¹⁾²⁾, these medications are often discontinued prior to achieving their optimal effects. Reports indicate that *rikkunshito* is an effective treatment for loss of appetite in patients undergoing

chemotherapy³⁾⁴⁾. In this study, we examined the effects of Kampo medicines administered to treat loss of appetite and irritability due to the administration of MPH and ATX.

Patients and Methods

Patients included 20 pediatric males who visited our developmental outpatient clinic during the 4 years between January 2014 and May 2017 and were prescribed MPH or ATX. They exhibited loss of appetite and irritability, for which Kampo drugs were additionally prescribed. The patients were all males and between 6 and 14 years of age at the time of Kampo medicines administration. Six patients had comorbid autistic spectrum disorder.

ADHD medication doses were ATX 50 mg/day (n = 1), MPH 18 mg/day (n = 8), MPH 18 mg/day (n = 1), ATX 10 mg/day (n = 1), and MPH 27 mg/day (n = 10) (Table 1). Loss of appetite, as a consequence of MPH administration, tended to increase in severity with the dose. It often appeared from the day the medication was administered. We attempted to prevent a significant decrease in daily intake by reducing the amount of school lunch that the children consumed for the first 1–2 weeks after starting the medication, while increasing the number of snacks and amount of food served at dinner. If loss of appetite persisted for ≥ 1 month or worsened due to environmental changes, Kampo medicines were added.

Rikkunshito extract granules (Tsumura & Co., Tokyo, Japan) at 5.0 g/day or *shikunshito* extract tablets (Osugi & Co., Osaka, Japan) at 12 tablets/day were administered before breakfast and dinner to combat loss of appetite. We explained the taste and formulations of the drugs to the patients and their parents or guardians. In cases where the patient could only tolerate the granulated formulation, *rikkunshito* extract granules were prescribed. If the patient preferred tablets, we prescribed *shikunshito* extract tablets.

In terms of response evaluation, we considered the drugs to be effective if consumption of food increased by more than half at school lunch. The medications were considered ineffective if loss of appetite persisted, or if the dose of MPH or ATX had to be reduced. The medication effects were considered unknown if oral administration could not be continued or evaluation was difficult due to poor medication compliance.

Results

The results of this investigation are depicted in Table 1. Of the 20 patients, 2 took *rikkunshito* extract granules, and 18 patients took *shikunshito* extract tablets. Many of the patients were sensitive to the drug formulation, smell, or taste and therefore refused the granular formulation or could not continue to take the granular formulation because of time constraints. In those cases, *shikunshito* extract tablets, with similar crude products and indications as *rikkunshito*, were prescribed so that the patients could continue to take the medication.

We found that patients often forgot to take the drugs before dinner. Twelve patients took their medication only once in the morning, and 8 patients took their medications twice per day, every morning and evening. Appetite stimulation effects were “good” in 16 cases, had “no effect” in 3 cases, and were “unknown” in 1 case. Ten patients out of the 16 that exhibited a “good” response to the drug discontinued the medication within 2 months. In 14 cases, administration of Kampo medicines was started between July and November, indicating that more patients appeared to experience loss of appetite during summer or at the start of sports day practice.

There was no case in which drug therapy for ADHD was discontinued due to sustained loss of appetite. In 1 case, the dose was reduced due to loss of appetite and nausea, and in another case, the dose was reduced because the patient’s ADHD symptoms improved.

Three cases exhibited irritability and frequent episodes of crying in addition to loss of appetite; therefore, we added 2.5 g/day of *kanbakutaisouto* (Tsumura & Co., Tokyo, Japan) before dinner. In 3 cases with continuous irritability and agitation, *shikunshito* was discontinued and switched to *daisaikoto* extract tablets (Osugi & Co., Osaka, Japan) at 6 tablets/day before breakfast. After switching Kampo medicines, the patients with irritability showed improvement in symptoms. The following Kampo medicines were additionally prescribed: *hangekobokuto* for severe anxiety (n = 1); *shokenchuto* for repeated abdominal pain (n = 2); *goreisan* for nausea (n = 1); and *hangeshashinto* for sustained diarrhea (n = 1). Due to the small sample size, individual examinations of each side effect were not performed.

Case presentation

Case 10: A 10-year-old 5th grade male student.

At first consultation: The patient was in 3rd grade. He visited the clinic accompanied by his mother.

Chief complaint: The patient was advised by his classroom teacher to consult a developmental outpatient clinic for his poor conduct in the classroom.

Patient’s complaints: difficulty in listening to others, often spilling drinks; often getting lost during early childhood, restlessness at home, and frequent movement.

Parental concerns: If medicine improved the patient’s condition, the mother requested that pharmacological treatment be initiated. The patient’s mother also wanted to better understand the patient’s psychological status.

Perinatal period: Unremarkable.

Developmental history: During early infancy, the patient was sensitive to sound and was a shallow sleeper. He did not exhibit stranger anxiety.

At 1 year of age, the patient started running as soon as he started walking. Patient had delayed speech and began speaking words at the age of 22 months.

At 2 years of age, he had difficulty understanding, even when auditory information was repeatedly presented. He liked to climb to high places and was restless, with frequent movement. At 3 years of age, he frequently misbehaved, despite warnings, and was restless. He showed great interest in letters and numbers. At 4 years of age, he showed no avoidance of dangerous activities and required repeated redirection. He talked about many things, but did not understand the feelings or positions of others. He was obsessed with winning and losing and had trouble maintaining friendships. Additionally, he often forgot his belongings.

[ADHD checklist (behavioral questionnaire) for children aged ≥ 6 years]

Inattention (7 points): does not pay attention to details while studying; has difficulty focusing on activities; cannot listen to instructions to the end; avoids tasks; often gets distracted; has difficulty learning tasks and activities in order; does not seem to hear when being spoken to.

Hyperactive/impulsive (5 points): restless and keeps moving; cannot keep still; talkative; answers questions without listening to the end; leaves seat when required to be seated.

Treatment course:

We encouraged the family, especially the mother, and the classroom teacher to understand the developmental characteristics of ADHD and discussed the following recommendations: (1) adjustment of the environment, such as reducing wall hangings that may be distracting; (2) how to talk to the patient, such as giving instructions separately for each item, and sending a signal to pay attention; and (3) how to support the patient when he gets in trouble. We had an individual interview with the patient once a month, where we observed the patient could not help touching whatever he saw, frequently turned around in his chair, switched from one topic to another during conversations, and constantly moved around during games, indicating an inability to complete a conversation or a game to

some extent. MPH (CONCERTA®) was started for hyperactivity and impulse control. The patient started taking MPH at 18 mg/day during the summer vacation prior to the 3rd grade, and loss of appetite appeared on the first day of drug administration. Starting in September, we reduced the amount of food served during school lunch by half and increased the amounts of snacks and dinner.

When sports day practice started in early September, he also experienced loss of appetite in the evening and his daily intake decreased to about half of pre-medication levels. Because the patient was unable to take the granulated formulation, we prescribed *shikunshito* extract tablets—at 12 tablets /day before breakfast and dinner. Although the patient was actually taking *shikunshito* only before breakfast, his appetite improved about 1 week after starting the medication. At this time, the patient was eating half of his school lunch and all of his dinner each day. After the sports day ended in October, he started to eat the full amount of school lunch. After 1 month, his appetite improved, and *shikunshito* was discontinued.

After starting MPH at 18 mg/day, he could remain calm in class for longer periods and required less frequent redirection by the classroom teacher. However, while learning at home, he often cried for hours.

In the 4th grade, he started to receive special guidance, in addition to his general classwork. At our clinic, we started to provide social skill training with the help of a psychotherapist and separately interviewed the patient and his mother. When practice for the sports day started in September, the patient found it difficult to focus and participate during class. He continued to be absentminded and spent time playing alone with his hands, disconnected from class activities. Then MPH dose was increased to 27 mg/day. While the patient was under observation, his appetite decreased, and he was barely able to eat school lunch. Beginning in

November, we prescribed *shikunshito* extract tablets at 6 tablets/day before breakfast.

After taking Kampo medicines, his appetite returned to the same level as when he was taking 18 mg/day of MPH, and he was once again able to eat half of his school lunch. After increasing MPH dose to 27 mg, he was able to listen to instructions in group settings and throughout the day. He remained calm and participated in class while at school, and he was more easily able to complete his homework. At present, the patient has been taking MPH at 27 mg/day for 6 months along with *shikunshito*.

Discussion

MPH suppresses hyperactivity and impulsivity, hallmark symptoms of ADHD, by activating the dopaminergic nervous system. MPH also suppresses eating behaviors, which can lead to a loss of appetite¹⁾²⁾. Loss of appetite is generally self-limiting and improves within 2–3 weeks, but if it does not improve, this adverse effect can alleviate by withdrawing the drug during weekends or reducing the drug dosage. There have been reports on the effects of *rikkunshito* on loss of appetite during chemotherapy³⁾⁴⁾, and we hypothesized that Kampo medicines would have similar effects on loss of appetite caused by MPH or ATX.

The crude products of *rikkunshito* are ginseng, *Atractylodis* Rhizoma, *Poria*, licorice, *Pinelliae* Tuber, citrus unshiu peel, ginger, and *Zizyphi* Fructus, and it is combined with *shikunshito* and *nichinto*. In addition to the digestion and food absorption effects of *shikunshito*, *rikkunshito* has the effects of *Pinelliae* Tuber and therefore suppresses nausea and vomiting due to fluid retention in the stomach and the effects of *Citri Unshiu* Pericarpium, which reduces gastric fluid retention and sputum. Similar to *shikunshito*, *rikkunshito* also tonifies qi. It is used to treat fatigue, nausea, loss of appetite, chronic gastritis, and symptoms of gastroptosis. *rikkunshito* enhances appetite and gastrointestinal motility by its antagonistic effects on serotonin 2 receptors. A

report describes the effects of *rikkunshito* for stress-related loss of appetite, focusing on serotonergic neurons involved in eating behavior⁴⁾.

Shikunshito consists of *Ginseng* Radix, *Atractylodis* Rhizoma, *Poria*, *Glyzirrhizae* Radix, *Zingiber* Rhizoma, and *Zizyphi* Fructus. A combination of *Ginseng* Radix, *Atractylodis* Rhizoma, *Poria*, and *Glyzirrhizae* Radix are the crude products of *ninjinto*, to which *Poria* is added instead of *Zizyphi* Fructus. Its diuretic effects are enhanced, and it is more effective for phlegm-dampness pattern than for *ninjinto*. This formulation tonifies qi and is used to treat impaired digestion and absorption (weakness of the stomach and spleen)⁵⁾. The difference between *rikkunshinto* and *shikunshito* is that *shikunshito* contains neither *Pinelliae* Tuber, which suppresses nausea and vomiting due to gastric fluid retention, nor *Citri unshiu* Pericarpium, which removes phlegm; thus, *shikunshito* has no effect on nausea.

Rikkunshito extract granules at 5.0 g/day or *shikunshito* extract tablets at 12 tablets/day before breakfast and dinner were prescribed for loss of appetite secondary to ADHD treatment drugs. In cases in which oral administration was continued, the effects of *rikkunshito* and *shikunshito* appeared in 1–2 months. A patient who could barely eat school lunch was soon able to eat more than half with improvement in appetite. Once patients adapted to the environmental changes and the temperature became cooler, those patients who wanted to discontinue Kampo medicine and those who frequently forgot to take their medication discontinued use within 2 months. The 3 patients who continued Kampo medication for 4–10 months continued to eat smaller school lunches, as did patients who were picky eaters. In these individuals, Kampo was continued over time. One patient continued taking *shikunshito* for 9 months. In this case, his appetite completely recovered to the extent that he consumed more than 1 serving of school lunch, but because Kampo medication helped him

stay calm, administration was continued. Soon after that, his MPH dose was reduced.

Regarding the time when Kampo medicines were initiated, 14 cases (70%) started during summer or fall when practices for field day were being held. In these cases, loss of appetite may have been caused by higher environmental temperatures and increased humidity as well as deterioration of ADHD symptoms due to changes in school–life rhythm.

There were many cases in which continuing medication was difficult due to the developmental characteristic of “inattention.” In 12 cases (60%), despite being instructed to take medication twice per day, before breakfast and dinner, patients were actually taking only 1 dose per day in the morning. However, they were able to continue taking Kampo medicines every day because they experienced an effect from the medication. If continuously taken twice per day in the morning and evening, the appetite-stimulating effects can be increased. Therefore, medication counseling is necessary in the future. Children with ADHD are often cautioned and restricted in their behaviors due to developmental characteristics, and they are under continual life stressors. If we consider the condition of these children, whose self-esteem declines by repeated failures due to inattention, as “qi deficiency”, *rikkunshito* and *shikunshito* can enhance motivation in addition to improving gastrointestinal motility.

Among the 6 cases that showed worsened irritability and agitation during the administration of ADHD medication, *kanbakutaisoto* extract granules were added in 3 cases, and the medication was switched to *daisaikoto* extract tablets in the other 3 cases. In both groups, irritability improved, indicating that the medication was effective; however, the sample size was small, and future studies with more cases are necessary.

Summary

When *rikkunshito* or *shikunshito* was administered for loss of appetite secondary to treatment with ADHD medicine, 16 out of 20 cases showed improvement. In addition, among the 16 cases that showed improvement, 10 cases were able to finish taking Kampo medicines within 2 months. There was no case in which ADHD medicine had to be discontinued due to persistent loss of appetite.

The abstract of this paper was presented at the 45th Japan Pediatric Oriental Medicine Society Annual Meeting (Nagoya, 2017).

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Clinical Report (Acupuncture)

Acute Low Back Pain Following a Holiday

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Introduction

I have learned the acupuncture and moxibustion skills from late Mr. Meiyu Okada and Mr. Akizo Okada. These masters used pulse diagnosis and pattern based treatment, treating the entire body using channel therapy. Also, at the pedagogic institution where I am employed, I strive to clarify the foundations of channel therapy through lectures and research and I am trying to apply these during my ordinary clinical practice. Low back pain is a symptom of one region of the body, but its treatment essentially requires the comprehension of findings from the entire body in order to determine how to proceed with the treatment. Using this case report I present here the use of channels in diagnostics and treatment.

Day of treatment: Year XX, May X

Patient: male, 44 years

Chief complaint: low back pain, left gluteal pain

Present illness

On the 6th of X (during the May holidays) the patient started experiencing low back discomfort and on the fourth of X severe pain developed when he went to work. He could not think, however, of any triggering event. In the morning on the third of X he could not get out of bed and called the company reporting he will take a day off. Even during bed rest he suffered from pain radiating from the lumbar region down into the left gluteal region and then visited our clinic because these symptoms interfered with his daily life.

Two years earlier he had visited our clinic because of chronic low back pain. Later complained about

fatigue and stiffness of neck and shoulders due to desk work and used to come for treatment once every two months complaining of low back pain.

Past history

Acute low back pain [an MRI taken about 15 years ago showed a herniated disk at L4-5]

Life history: no drinking and smoking, little exercise

Current condition: height 180 cm, weight 90 kg, blood pressure 156/90 mmHg, pulse rate 92/min

Examination findings:

The SLR could not be performed because the patient was too afraid. Chilling of the lower legs and feet +, without differences between left and right, numbness of the lower legs (-) and no obvious differences in the circumference of the lower legs. NRS (Numerical Rating Scale): 9

Inspection

Little facial expression with a dark complexion (examination of the skin of the medial forearm revealed dark skin and the patient had in general a naturally dark skin) and a tendency toward dry skin. The patient was large body build and a great abdominal circumference. He walked cautiously bend forward while holding his hand to his back. The soles of his feet showed erythematous patches but the plantar arch area was white.

Audio-olfactory examination

He was almost reticent and when he answered, his voice was quiet, without force and slightly high-pitched.

Inquiry

Recently he tended to be unusually thirsty and drank much water, micturition frequency slightly increased (10 times/day), bowel movements (once per day) of slightly soft consistency without abdominal pain. Reportedly a high stress level at the workplace. Channel palpation

The body in general was tense and hard. Due to high tension spontaneous sweating was observed on the face, back, lower legs, palms, and soles of the feet. Chilling of the abdomen and lower legs, while chest and head felt feverish, indicating a marked

differences in hot and cold feelings between the upper and lower parts of the body.

Hands

Taiyin lung channel of hand indentation at LU7: tenderness at LU5, indentation at LU8

Yangming large intestine channel of hand: tenderness at LI11, LI10 and LI4

Juejin pericard channel of hand: tenderness at PC6, PC8

Shaoyang sanjiao channel of hand: tenderness at TE5, TE6

Shaoyin heart channel of hand: tenderness at HT5, HT6, HT7 and HT8

Taiyang small intestine channel of hand: pinching pain at SI3, left > right

Feet

Taiyin spleen channel of foot: indentation at SP9, tenderness at SP8

Yangming stomach channel of foot : tenderness at ST36 and ST44, left > right

Jueyin liver channel of foot: tenderness at LR8, LR3, left > right

Shaoyang gallbladder channel of foot: tenderness at GB34, GB38, GB39 and GB41, left > right

Shaoyin kidney channel of foot: indentations at KI10, KI9, KI7 and KI3, left > right

Taiyang bladder channel of foot: tenderness at BL55, BL58

Abdominal diagnosis:

* Discomfort in the hypochondrial region

* Lower abdominal weakness, lateral abdominal tension

Pulse diagnosis:

Floating, large and deficient, left chi pulse intermediate, floating, deficient, right cun pulse slightly floating and deficient, left cun and right cun pulses slightly excessive

Pathology:

A yin deficiency of the kidney channel led to a kidney channel qi deficiency, the deficiency heat of the bladder channel affected the gallbladder channel leading to upper excess and lower deficiency and

with abundant heat in the chest, while the pulse characteristics indicated insufficient dispersion of heart heat.

Pattern:

Kidney deficiency heat pattern, deficiency heat affecting the gallbladder channel, heart heat.

Treatment

Needling:

For "floating pulse" mostly shallow needling, for "deficient pulse" reinforcement, in case of a "floating, large and deficient" pattern reinforce the deficiency first and later drain the excess.

The primary treatment channel is the kidney channel, but on this occasion it was a disease pattern of the gallbladder and bladder channels. I also used the small intestine channel to drain the heart heat, and used the lung and large intestine channels as well as the spleen channel to support the reinforcement of the kidney channel.

Supine position:

GB5, GV20 (needle retention), VC12, ST25, CV15 ~ hypochondrial region (singular insertion and scattered short pricking), LU8, LI11, SI3, TE3, ST37, KI9, KI7 (singular insertion, reinforcement), SP8, GB38 (singular insertion, draining)

Prone position:

Scattered short pricking in the interscapular region, BL14, BL15, BL43, BL17, BL18, BL22, BL23, BL52, BL26, left BL53, left BL54, BL55, BL58, BL60 (needle retention + far infrared irradiation for 25 minutes), left GB39, BL10, GB20 (singular insertion)

Sitting position:

Scattered short pricking along the ridge of the shoulder.

Results

At the beginning of the treatment the patient reported pain even upon lying down and turning in bed, but after the treatment the pain rating decreased from NRS 9→6. In a sitting posture there

was tenderness at GB39 on the gallbladder channel in the lower leg area. Attaching Pyonex 0.3 mm needles decreased the NRS to 5, but due to the low back pain the slow movements did not change. Facial expressions improved as compared to the pretreatment condition and dressing and walking remained somewhat awkward.

Course

Second session (+2 days)

On the day following the treatment the low back NRS score dropped to 4. Today he visited our clinic after work and the NRS score has currently been alleviated to 3. However, there is still no change in the slow movements and the patient keeps worrying about the condition of his low back. Channel palpation showed that the lower legs have become warmer and the generalized tension is decreasing. The 12 channels still showed the same tendencies, but the tenderness at PC6, PC8 has decreased and I palpated a deficiency at ST36 a deficiency as well as an excess at ST40.

Pulse:

Floating, slightly large and deficient, left chi pulse was intermediate, slightly floating and deficient, the right cun pulse was slightly floating and deficient, the right guan also slightly floating.

Pattern:

Kidney deficiency heat pattern, the channel heat affecting the gallbladder and stomach channels.

Treatment

Same treatment as during the previous session, exempting the small intestine channel, reinforced and reduced the stomach channel and added 5 cones of heat penetrating moxibustion at BL23 and BL26.

Results

The patient reported "the moxa stimulation seems to have been most effective" and the pain had being almost completely alleviated, so that the treatment was terminated.

Discussion

In the past this patient had been diagnosed with a herniated intervertebral disk, but in the absence of numbness of the lower leg, no difference in the circumference of the calf and no atrophy, the condition was considered to be a non-specific low back pain. He usually was performing desk work and although feelings of fatigue and heaviness indicated a chronic condition, he could not think of any triggering events that might have caused a low back pain severe enough to interfere with his social activities. Studies conducted in recent years indicate a correlation between "psychological distress, depressive mood among possible sociopsychological factors" and low back pain in cases of prolonged low back pain¹⁾. The symptoms of the low back pain that developed in this patient during a string of consecutive holidays were characterized in that they aggravated after returning to work so much, that they prevented him from leading his normal social life. While treatment alleviated the low back pain, he could not help being worried about the activities of daily life, suggesting the presence of a mild degree of depressive mood.

The patient had a disposition with a tendency towards kidney deficiency and "fear" as an emotion associated with the kidney was unstable. Anxiety actually developed during daily life, preventing him from taking audacious actions, suggesting the burden on the lower back had increased.

Inspection showed a type of dark and dry skin that has been mentioned in Chapter 10 of the *Jing Mai*, On Channels in the "Ling Shu", where the disease produced by the liver channel being referred to as '*Zu jue yin gan jing shi dong bing zheng*' is characterized by "non-lustrous complexion as if the face is dusted". In case the work related stress leads to a tendency towards depression, heat builds up within the chest that may then be difficult to disperse. This does not only suggest that the kidney deficiency and heart heat form an exterior-interior unity, but it is also possible to view this as a "vexation and fullness"

associated with the liver channel '*Zu jue yin gan jing Suo sheng bing zheng*'. Since the patient requires time to lie down and worries about turning in bed, this may be interpreted as a disease produced by the liver channel described as "low back pain and difficulty in moving the body" as well as the related disease produced by the gallbladder channel described as "pain in the subcostal region, inability to turn the body".

Although in this case the predominant emotion was "fear", it is easily conceivable that an insufficiently smooth dispersion of "anger" may have led to the onset of an acute low back pain as a disease of the gallbladder channel.

Mr. Meiyu Okada said, that "the effective use of command points and local needling is sufficient to achieve recovery from acute but mild conditions depending on the pulse condition"²⁾.

The author interprets the denotation of "acute and mild" as referring to an "acute low back pain, but without any signs of neurologic impairments". Mr. Okada mentioned that in this case the "use of command points depending on the pulse condition" and "local needling" should be sufficient. This remark of him serves as an important suggestion regarding the standard treatment guide for low back in channel therapy.

In this case I initially applied comparatively shallow needling for the yin deficiency heat pathology^{3,4)}, but the pulse condition indicated the need for somewhat greater insertion depth. In general it is important to discern the deficiency-excess and cold-heat condition, perform meticulous channel palpation. After that it is possible to proceed with the appropriate treatment based on an evaluation of the responses observed during the channel palpation as well as the pathology surmised from the pulse condition regarding yin-yang deficiency-excess.

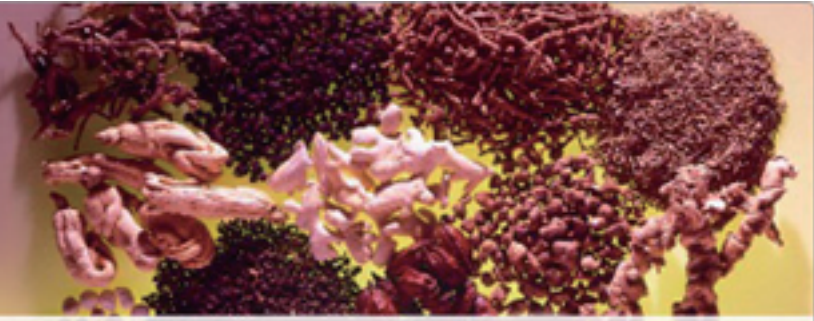
Conclusions

The objective findings were rather scant in spite of the marked subjective symptoms reported by the patient, so that I based the decision whether or not to proceed with channel therapy mainly on the pulse diagnosis and channel palpation. I performed a pulse diagnosis at the three bilateral radial pulses and based my judgment of a "heat pattern" on the evaluation of the classified pulses. Heat was the central feature of the disease pattern, but in case of reduction of the heat through shallow needling I decided to "first reinforce the deficiency and later reduce the excess". Based on diagnosis of the pulse differences between the sided the kidney channel was the primary treatment channel, but I decided that the changes in the gallbladder and bladder channels too have contributed to the development of the low back pain. This is a channel combination frequently encountered in patients with low back pain. Combined with anxiety or tension the inspection of the patients complexion and the results of channel palpation the pulse reveals a close correlation with the kidney channel, so that the treatment of the kidney channel had in this patient marked general effects.

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