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 2, Number 4 · Winter 2007

ISSN:1559-033X

Quality Of Life
OMINEDO

A good motive creates a selfless devotion.

"I just want my customers to feel better, body and soul. Just to see their faces light up with hope and happiness, I'd do anything," remarks Masao Tsuji, President of Ominedo Pharmaceutical Industry Company. He visits various sites where raw herbs and substances for use in their Kampo products are picked. And he believes this is the tradition Ominedo had maintained for over a century now since the company was founded in 1900.

The same philosophy is applied in handling the numerous high-quality formulas created at their labs where highly advanced scientific and pharmacological researches are conducted. The company's state-of-the-art facilities that comply with GMP standards turn out various extracts to be incorporated into their pride products.

"Every merchandise is the by-product of our sincere devotion to delivering a lineup of products that not only work for the customers' body, but also bringing peace of mind as well," Tsuji concludes, "delivering the right product to customers who appreciate our knowledge and devotion is our ultimate goal."

Ominedo Pharmaceutical Industry Co., Ltd.

574, Nenarigaki, Yamatotakada-City, Nara 635-0051, Japan

URL: www.ominedo.co.jp
Contact: info@ominedo.co.jp
FAX (81) 745-23-2540

The Journal of
Kampo, Acupuncture and
Integrative Medicine
(KAIM)

Research on Theory, Practice and Integration

PUBLISHER
Shuji Goto
International Institute of Health and
Human Services, Berkeley
2550 Shattuck Avenue, Berkeley
California 94704-2724, U.S.A.

The Journal of
Kampo, Acupuncture and Integrative Medicine

Volume 2, Number 4 · Winter 2007

TABLE OF CONTENTS

MISSION

To disseminate peer-reviewed information on the use of acupuncture and herbs, and integration with western medicine, based on research from an international perspective; thereby stimulating further research, application of documented therapeutic measures; and facilitating dialogue among health care practitioners worldwide.

Foreword

Guideline for Diagnosing and Treating Lower Back Pain and the Role of Kampo

The Guideline for treating lower back pain was first documented in the U.S. in 1994 and has since been prepared in other countries. The latest Guideline was released in 2004 by experts from 14 European countries (Austria, Belgium, Denmark, Finland, France, Germany, Israel, Italy, the Netherlands, Norway, Spain, Sweden, Switzerland, and England). Each country's efforts are designed to present appropriate interventions for lower back pain since a large population with lower back pain has a significant influence on productivity and incremental medical and social security costs. The 2004 Guideline is the first guideline that refers both to acute lower back pain and chronic lower back pain whereas previous versions refer only to acute lower back pain.

It is said that as long as humans walk on two legs, lower back pain is unavoidable. Recent studies, however, reject this notion as groundless. Although the root causes of lower back pain remain to be explained, some people who experience organic changes do not complain of pain. However, many people who do not exhibit medical abnormalities are plagued by persistent pain. If the cause is identified as lumber spine degeneration for example, patients will undergo treatment no matter how painful it may be, and accept the disease by making necessary changes in their lifestyle. If the cause is not known, patients may try one form of treatment and switch to another. The aforementioned European Guideline contains the additional viewpoint that lower back pain whose onset is associated with stress is pain that is ongoing, or caused by biological or sociopsychological factors including economic insecurity, as well as the conventional viewpoint that regards lower back pain as physiological, structural, or biological damage.

Do YOU recall the male mummy (Ötzi the Iceman), frozen in the ice for 5,000 years, that was accidentally discovered in 1991 near the Austrian-Italian border? The discovery is important in terms of both archaeology and the history of anthropology. From the X-ray analysis of the mummy which indicates lumbar vertebral degeneration and wear and tear of the knee joints, it is easy to assume that he was suffering from lower back pain and knee joint pain. What is further surprising is that the locations of the tattooes on his body closely correspond to the meridian points for treating lower back pain and knee joints.

Although the cause of Ötzi's lower back pain was identified by radiography, today's guidelines do not recommend the use of diagnostic imaging unless there is a strong reason to suspect a certain specific cause. These guidelines also reject all traditional treatments based on common sense, and sound a warning against the trend that operative treatment is easily opted for. The Guideline prepared in the U.S. in 1992 for treating acute lower back pain recommends only administration of acetaminophen and NSAIDs as well as vertebral manipulation for symptom amelioration. Complete rest is rejected, and physical therapy, acupuncture and wearing a corset are not deemed worthy as recommendations. The 2001 Guideline prepared in Japan does not reject diagnostic imaging due to the importance of differential diagnosis of major diseases and recommends as treatment a combination of pharmacotherapy, physical therapy, therapeutic exercise and an educational approach depending on the stage of the disease.

In Japan, acupuncture, moxibustion, and Kampo medicines are frequently used either on their own or combined with other treatments. These are used based on an understanding of general body condition associated with functional improvements or chronicity, with the aim of relieving symptoms as well as enhancing the emotionally and psychologically damaged QOL, as pointed out in the European Guideline. Moreover, Kampo medicines are expected to prevent gastrointestinal disorders and liver function impairment, and to reduce the dosing frequency of NSAIDs.

Akihiro Soma

Editorial Staff

Japanese Acupuncture - Current Research

Acupuncture for Respiratory Disease in Japan: A Review

Masao Suzuki
Department of Clinical Acupuncture and Moxibustion
Meiji University of Integrative Medicine

Abstract

Background: In Japan, studies on acupuncture and moxibustion therapy for respiratory disease have rarely been reported. Additionally, most of the reports are difficult for overseas researchers to access because they are written in Japanese and cannot be located using Medline.

Purpose: To review studies on acupuncture and moxibustion therapy for respiratory disease conducted in Japan.

Data Sources: The results of a literature search using 'Igaku Chuo Zasshi Web' (Japana Centra Revuo Medicina) and the Medical Online Library, both of which are Japanese databases, covering the period between 1983 and 2008.

Study Selection: We reviewed references cited in retrieved documents and selected original articles and case reports on acupuncture and moxibustion therapy for respiratory disease.

Data Excluded: Animal studies, surveys, excerpts and news articles were excluded.

Data Extraction: The search terms used were "acupuncture" and "respiratory disease", along with "respiratory", "asthma", "COPD", "bronchitis" and "common cold".

Result: We retrieved 38 papers on acupuncture treatment for respiratory disease written in Japanese (9 full papers, 22 case reports and 7 case series). The papers dealt with such conditions as asthma (14 trials), cough variant asthma (CVA; 3 trial), chronic cough (2 trials), chronic obstructive pulmonary disease (COPD; 7 trials), chronic bronchitis (1 trial), diffuse pan bronchitis (DBP; 1 trials), usual/idiopathic interstitial pneumonia (UIP; 1 trial), and the common cold (2 trials). We also found 8 trials dealing with cold prevention. The effects of acupuncture treatment on respiratory disease were reported in 33 papers.

Conclusions: A small number of reports on acupuncture and moxibustion treatment for respiratory disease were found in the Japanese databases. Some reported that acupuncture treatment was conducted for refractory respiratory disease, such as COPD, for which modern medicine has, to date, found no remedy. However, we found only inadequate evidence for its effectiveness. Future studies must use more rigorous evaluation methods, such as RCT, to measure the effectiveness of acupuncture and moxibustion therapy for treating respiratory diseases.

Key words: respiratory disease, acupuncture, moxibustion, asthma, COPD.

Introduction

Acupuncture, a non-invasive therapy based on traditional Chinese Medicine (TCM), may be a valuable modality in managing symptoms (1). Moreover, the World Health Organization has recognised that acupuncture may be effective in treating chronic pulmonary disorders (2), and it is widely used in Japan for the treatment of chronic disease. The theory behind the use of acupuncture is to restore the balance of "vital flows" by inserting needles at particular points on the body surface where the "meridians" of these flows lie. The specific points can also be stimulated with pressure or laser application (3).

In many patients, particularly those with advanced pulmonary disease, symptomatic measures are required in addition to other therapies, and may even be the mainstay of treatment (4).

Acupuncture is one of the most popular alternative therapies. Needle acupuncture has been used to treat various complaints for hundreds of years in Japan and has been reported to be of therapeutic benefit in controlling pain. However, in Japan, reports on respiratory disease patients who have received acupuncture and moxibustion therapy are rare and clinical trials intended to assess the effectiveness of the therapy for

respiratory disease are even rarer. Moreover, most of the papers on acupuncture published in Japan are written in Japanese and cannot be retrieved using major English-language medical databases. Thus, the purpose of this review was to evaluate and introduce the current status of clinical trials conducted in Japan on acupuncture in treating respiratory disease.

We are sending before more and used to also update this paper for the information on an acupuncture and moxibustion therapy over a respiratory ailment to this.

Methods

Accessing the literature

A computer-assisted search was used to examine the Igaku Chuo Zasshi (Japana Centra Revuo Medicina) and Medical Online Library (Meteointergate, Inc.) databases. The period covered was from January 1983 to December 2008. We also investigated the references that were cited in each retrieved document and selected relevant papers. The keywords used in the database searches were "respiratory disease", "acupuncture", "asthma", "chronic obstructive pulmonary disease", "bronchitis", "common cold", "pulmonary disease" and "clinical trial". The search was limited to original papers and case reports.

Study selection criteria

Clinical trials (case reports, parallel- or crossover-designed trials and controlled clinical trials (CCTs)) that assessed the efficacy of needle acupuncture were included. Experimental studies, animal studies and duplications of published papers were excluded.

Data extraction

For each study, the following items were reviewed: trial design, randomization, blinding, handling of dropouts, publication year, health condition examined, treatment and control procedures, number of participants, main result, number of treatments, type of control used, main outcome measure, descriptions of informed consent, affiliations of authors and publication types.

Results

We found a total of 38 Japanese papers on acupuncture that was applied to respiratory disease (22 case repots, 7 case series and 9 full papers).

(1) Case reports and case series

1. Diagnosis

A list of 29 case reports and case series is shown in Table 1. The conditions examined in these types of papers were asthma (13 trials) (5–17), cough variant asthma (CVA) (2 trials) (18-19), chronic cough (2 trials) (20,21), COPD (5 trials) (22–26), chronic bronchitis (1 trial) (27), diffuse pan bronchitis (1 trial) (28), UIP (1 trial) (29) and the common cold (2 trials) (30,31). We also found studies dealing with cold prevention (2 trials) (32,33).

2. Intervention

Twenty-one of 29 case reports used TCM as the standard method of acupuncture treatment. Of the rest, some applied special acupuncture treatments, such as electric acupuncture treatment (7,14), roller acupuncture (30), skin implant needles (15), *Doushi* (17) and *ryoudouraku* (8).

3. Duration of treatment

The duration of treatment observation for respective research was over 1 month for 13 reports, but only 1 day in 4 reports (13,15,17,21). The rest did not report the period of treatment observation (5,8,9,16,20,31,33).

4. Outcome measures

The main outcome was not measured by commonly validated methods in 16 papers. These papers measured their outcomes by conducting unstructured individual interviews of the patients. The rest carried out reliable examinations, such as testing improvement in respiratory function, keeping asthma diaries or measuring exercise tolerance (6,7,12,14,18,19,22-26,28).

5. Results

All trials but one indicated positive results (24), although unusual techniques of acupuncture were used in some case reports. In one study, the common cold was treated with roller acupuncture (30). In another study, the Acupoint (*suitotsu*; ST10) was

applied to the frontal cervix to treat bronchial asthma (Japanese: Doushi) (17).

(2) Full papers: Controlled clinical trials

1. Diagnosis

We found a total of nine papers regarding CCTs on acupuncture in treating respiratory disease and in cold prevention. One of the first CCT papers on acupuncture was published in 1996 (34). A list of these CCTs is shown in Table 2. The conditions examined in these CCTs were asthma (1 trial) (35) and COPD (2 trials) (36,37). We also found 6 trials on cold prevention (34,38-42).

2. Study design

Of them, three were regarded as genuine RCTs (38-40). No subjects were blinded. Dropouts or withdrawals from the studies were indicated in three trials (35,38,39).

3. Intervention

The method of acupuncture used was TCM (3 trials) (35-37), specific acupoint needles (4 trials) (34,39,40,42) and moxibustion (2 trials) (38,401).

4. Control

Regarding controls, no trial used sham or placebo procedures, six trials employed drugs or vaccine injections (343-37,41,42) and three trials employed no treatment (38-40) (Table 2).

5. Duration and frequency of treatments

The duration of all trials was over 1 month. The mean frequency of treatments was 16.8 times (range 8–32).

6. Outcome measures

Of six papers that intended to measure the effects of acupuncture and moxibustion therapy on cold prevention, two required research participants to maintain diaries to record changes in cold symptoms and three conducted blood tests that revealed relationships between particular biomarkers (CD4, CD8 and CD53) and patients' cold symptoms. However, one paper measured the effects based solely on self-reports by participating patients.

Two papers measured the effects of acupuncture and moxibustion therapy for COPD using validated tests, such as respiratory function inspection and exercise tolerance. Similarly, one measuring the effects on bronchial asthma used validated measurements, such as requiring patients to keep asthma diaries and conducting respiratory function inspections.

7. Results

The results were positive in five trials (55.6%) (35-37,39,40). In these trials, it was suggested that acupuncture treatment for COPD (36,37) and asthma (35) was very effective. TCM acupuncture was used in all these positive trials for COPD and asthma.

Discussion

〈Design〉

We examined the methodological quality, acupuncture treatment characteristics and respiratory outcome of nine CCTs on acupuncture for respiratory disease in Japan. For most, the research methods used were inadequate or inappropriate (i.e., not randomized, controlled and/or blinded, and without any quantitative measurement). Furthermore, even the CCTs that a third person had assessed them, and thus the validity of their results cannot be guaranteed to be high.

〈Duration and frequency of treatment〉

Most case reports and case series dealt with chronic disease, such as bronchial asthma, COPD and UIP. Chronic diseases require relatively long periods of acupuncture treatment and monitoring. However, several these case reports and case series conducted treatment and monitoring for only short periods of time. Thus, we cannot know the long-term effects, beyond the periods covered by the respective studies. The validity of acupuncture treatment in these studies must be gauged in this light. Nevertheless, a few studies have carried out relatively long periods of acupuncture treatment and monitoring. These studies are of great importance in assessing the realistic effects of acupuncture treatment on these chronic diseases.

〈Results〉

Because only 3 complete RCTs were found out of 38 papers, we cannot strongly argue that acupuncture was effective in treating respiratory disease. As Martin *et al.* argued, the effect of a treatment can be systematically assessed only by improving study quality (43). In this review, the result was positive in 28 papers (case reports and case series). However, in 15 of these 28 papers, the assessment was based solely on patients' complaints, indicating that these results are weak in terms of validity and reliability. This result suggests the publication bias was present, in the sense that only positive outcomes tended to be published.

Our review clarified that weaker study designs may bias study results and overestimate positive effects of the treatment consistent with the findings of Martin *et al.* (43). Despite the weaknesses observed, some studies demonstrated the potential of acupuncture in the sense that it may be effective in treating certain diseases, such as COPD and UIP, which are currently incurable by modern medicine. Likewise, some papers suggested a possibility of using acupuncture in health promotion, such as cold prevention. These cold prevention studies, along with the RCT study of 326 subjects reported by Kawakita *et al.* (44) showing significant improvements in preventing colds in the treatment group, are seminal in that they examined the possibility of applying acupuncture and moxibustion therapy as preventive medicine.

<Comparison between situations in Japan and overseas>

The Japanese CCTs that measured the effects of acupuncture in treating respiratory diseases lag far behind in quality compared to those conducted in the West. Whilst studies in the West began to apply RCTs in the 1980s (45), the Japanese counterparts did not do so until 2000 (40).

The overall scarcity of reports on acupuncture and moxibustion therapies for respiratory disease in Japan is probably due to the medical insurance system. The system enables practically every Japanese citizen to seek mainstream modern (Western) medicine treatments offered by medical institutions at relatively low cost. Because most CAM treatments are not covered by insurance, it is unlikely that Japanese patients with respiratory disease would choose acupuncture or moxibustion therapy as their first choice of treatment. In some Western countries, however, acupuncture treatments for respiratory diseases have been reported to be more effective and less costly than treatments by modern medicine (46-48).

It is, of course, true that acupuncture has been practiced much more widely in Japan than in the West. Of 2,000 respondents, 6.5% had received acupuncture treatment in Japan (49), whilst the number was only 2% in Australia (50) and 1% in the United States (51). However, acupuncture treatment has been used primarily for relieving pains, such as back pains and stiff shoulders in Japan, whilst in Britain and the former Czechoslovakia, the treatment has been used more for bronchial asthma, allergy or mental disorders, than for pain relief (52,53). Particularly interesting is that whilst 3.1% of respondents had received acupuncture treatment for respiratory diseases in the United States, none had done so in Japan.

Another difference is that in Euro-American countries, doctors practice acupuncture treatment at hospitals, whilst in Japan doing so is illegal. That is, when patients seek acupuncture treatment for respiratory diseases in the West, they actually have easier access than their Japanese counterparts who must seek treatment from acupuncturists who largely do not work at hospitals, but at CAM clinics. Moreover, as stated previously, most CAM treatments in Japan are not covered by the universal health insurance, which does cover most modern medicine, making it relatively harder for Japanese patients to seek acupuncture treatment.

Japanese acupuncture has developed some culturally unique methods whilst being practiced for hundreds of years. Some papers reviewed here dealt with such unique methods as roller acupuncture

(*Roller-shin* in Japanese). For roller acupuncture treatment, practitioners apply a roller with a warty surface across a patient's skin, which stimulates cutaneous vessels and results in their dilation. Because no needle penetrates the skin, roller acupuncture is considered to be easier to practice than the orthodox method. Yamashita reported that roller acupuncture was a safe and effective method for cold prevention (30).

〈Conclusion〉

In conclusion, future trials should have larger sample sizes, more rigorous methods and reflect principles and practices of acupuncture as applied in practice today. Furthermore, to complete systematic reviews on acupuncture, we encourage researchers in Japan and elsewhere to publish relevant results of RCTs in English, so that they will be listed in major English-language databases. We believe that conducting English reviews of Japanese papers on RCTs in a collaborative effort amongst researchers from different countries would promote a more thorough scientific evaluation of acupuncture treatments.

References

1. Shiow LT, Juei CW, Kuan CL, Ue-Lin C. Effects of acupressure therapy for patients having prolonged mechanical ventilation support. J Advan Nurs; 52, 142-150.
2. National Institute of Health (1997) Acupuncture (Consensus Statement). Available at: http://odp.od.nih.gov/consensus/cons/107/107_statement.htm.
3. Macioca G. The practice of Chinese Medicine, ed 1. New York, Churchill Livingstone, 1994.
4. Davis CL. ABC of palliative Care "Breathlessness, cough and other respiratory problems." BMJ 1997; 315: 931-4.
5. Oyagi T. Clinical trial report of acupuncture treatment by small number of acupoints. Jap Joun Acup Moxi Thera. 2004;731(9):96-100. (in Japanese)*
6. Egawa M, Yano T. One example of obstinacy bronchial asthma that improvement of variegated whole body symptom was effective to reduction of respiratory organ symptom. Jap Joun Acup Moxi Thera. 2003;718(9):61-66. (in Japanese)*
7. Nakano T, Yamashita H, Sawada Y, Nishijoh K. Example of enforcing new acupuncture moxibustion program to bronchial asthma treatment. Clinical acupuncture. 2002;17(2):32-40. (in Japanese)*
8. Gotou K. Treatment results of asthma and examination of Ryoudouraku chart. Jap Medical Ryoudouraku. 2000;45(3):198-206. (in Japanese)*
9. Matsuzawa M, Kaneko S, Sai S, Oho G, Sugiura H, Go S, Nigel W, Ka K, Shuku, S, Aikawa, Y. Examination of infant bronchial asthma treatment of ST36 and inhalation of oxygen. Oriental Medicine. 1995;21(8):85-87. (in Japanese)*
10. Su, Y, Ozaki T, Nonoi K, Adati S. Two cases of bronchial asthma. Clinical acupuncture. 1995;10(3):19-25. (in Japanese)*
11. Hashimoto K, Kamino H, Oyagi T, Okumura Y, Fujimoto R. Differentiation of asthma and a patient treated by acupuncture with a few needles. Oriental medicine and the pain clinic.1994;24:236-244. (in Japanese)*
12. Shinohara M, Yamauchi N, Nobuara H, Sato T. A case of bronchial asthma improved by acupuncture therapy. Jounal Japa Soci Acup Moxi. 1990;12(1):383-389. (in Japanese)*
13. Hayasaki Y. Acupuncture treatment to asthma attack. Jap Medical Ryoudouraku. 1989;18(2):7-9. (in Japanese)*
14. Tsukada Y, Baba M. Acupuncture treatment to child bronchial asthma. J Pediat pract. 1987;9:151-154. (in Japanese)*
15. Fu Y, Haruki E. Treatment of acupuncture of the inside of the body burial to asthma in childhood. J Pediat pract. 1987;1:145-146. (in Japanese)*

16. Sugiura R, Katou T, Gotou K. Examination by electric acupuncture to bronchial asthma. J Clin Anesthesia 1982;8(6):1074-1076. (in Japanese)*
17. Takishima T. Acupuncture treatment to bronchial asthma. Japan Medical Journal. 1979; 2905: 15-19. (in Japanese)*
18. Egawa M. Cough and acupuncture treatment. Jap Joun Acup Moxi Thera. 2006;758(12):43-49. (in Japanese)*
19. Uematsu Y, Egawa M, Yano T, Namura K. A case of cough variant asthma successfully treated by acupuncture. Jap Joun Acup Moxi Thera. 2004;723(1):118-123. (in Japanese)*
20. Tokuchi J. Two cases of cough that effect is seen in acupuncture treatment. Jap Joun Acup Moxi Thera. 2006;758(12):50-56. (in Japanese)*
21. Murai K. Acupuncture treatment of cough by Hokusinkai method. Jap Joun Acup Moxi Thera. 2006;758(12):35-42. (in Japanese)*
22. Suzuki M, Ohno Y, Namura K, Asai T, Yuugetu H, Sawada M, Akao S, Gotou K, Fujuwara H. A case of chronic obstructive pulmonary disease(COPD) successfully treated by acupuncture. J Jap Respir Soci. 2005;43(5):289-295. (in Japanese)*
23. Suzuki M, Ohno Y, Akao S, Egawa M, Asai T, Yano T, Fujiwara H. A case of successful acupuncture emphysema with bronchial asthma. Kampo Med. 2005;56(4):567-575. (in Japanese)*
24. Tsuru H, Egawa M, Takahashi N, Matsumoto T, Kenzi N. A case of pulmonary emphysema of severe grade treated by acupuncture in a health care facility for the elderly. J Jap Soci Acupu Moxi. 2005;55(2):150-158. (in Japanese)*
25. Katayama Y, Egawa M, Yano T, Namura K. A case of emphysema that breathing difficulties and state of nourishment improved by acupuncture treatment. Jap Joun Acup Moxi Thera. 2004;727(5):53-58. (in Japanese)*
26. Suzuki M, Egawa M, Yano T, Namura K, Yamamura Y. A Case of Chronic Obstructive Pulmonary Disease(COPD) Successfully Treated by Acupuncture. Kampo Med. 2000;51(2):233-240. (in Japanese)*
27. Rin S, Rin G, Ri S. Diagnosis method by the Orient medicine of chronic bronchitis. Oriental Medicine. 1993;21(8):85-87. (in Japanese)*
28. Suzuk M, Ohno Y, Ohno T, Egawa M, Nanura K, Yano T, Akao S, Fujiwara H. A Case of Successful Acupuncture Diffuse Pan-Bronchiolitis. J Jap Soci Acupu Moxi. 2007;57(5):621-632.
29. Uematsu Y, Egawa M, Yano T, Namura K. One case whom UIP symptom improved by acupuncture treatment. Jap Joun Acup Moxi Thera. 2003;715(6):71-76. (in Japanese)*
30. Yamashita Y. A case whom cold improved by roller acupuncture treatment. Clinical. 2006;35(4):40-41. (in Japanese)*
31. Seki K. Examination of effect of acupuncture treatment to cold. Oriental Med. 1992;20(4):71-73. (in Japanese)*
32. Tokuchi J, Tanzawa S. Remarkable Improvement of Chronic Cold Syndrome by the Application of Acupuncture Therapy to a Parient with “fei qi ying liang xiu zhen”. J Jap Soci Acupu Moxi. 2000;50(3):463-469. (in Japanese)*
33. Tanioka M. Two cases who treat acupuncture for infant to bronchial asthma. Clinical Acupuncture. 1998;14(1):58-59. (in Japanese)*
34. Kobayashi Y, Akitsu M, Ohoyama F, Kuribayashi H, Kondou T, Shinohara M, et al. Infection prevention effect of vaccine nose vaccination and acupuncture treatment. J Oriental school Medicine. 1996;20:38-43. (in Japanese)*
35. Suzuki M, Namura K, Egawa M, Tano T. Effect of Acupuncture Treatment in Patients with Bronchial Asthma. J Jap Soci Acupu Mox]. 2006;56(4):616-627. (in Japanese)*
36. Egawa M, Yano T, Namura K. Case whom symptom of emphysema improved by acupuncture treatment. Jap Joun Acup Moxi

Thera. 2005;745(11):85-90. (in Japanese)*
37. Suzuki M. The Effects of Acupuncture in Patients with Chronic Obstructive Pulmonary Disease. Bull Meiji Univ Orient Med. 2004(33);83-97. (in Japanese)*
38. Takahashi N, Tsuru H, Egawa M, Matumoto T, Kawakita K. Effects of Indirect Moxibustion on Common Cold Symptoms in Elderly Subjects Lived in Nursing Home:Single-case Experimental Design. J Jap Soci Acupu Moxi. 2005;55(5):706-715. (in Japanese)*
39. Shichidou T, Isobe Y, Yu S, Kozima T, Inoue E, Kawakita K, Tannzawa S. Protective efficacy of cold that uses acupuncture treatment by randomized controlled trial. Jap Joun of Acup Moxi Thera. 2001;695(12):130-143. (in Japanese)*
40. Isobe Y, Yu S, Inoue E. Protective efficacy of cold that uses acupuncture treatment by randomized controlied trial. J Oriental School Medicine. 2000;24:94-97. (in Japanese)*
41. Tanaka J, Satou Y, Ouji I, Konisi T, Kondou J, Sayama O, et al. Infection prevention effect of vaccine nose vaccination and moxibustion treatment. J Oriental School Medicine. 2000;23:112-117. (in Japanese)*
42. Kaneko I, Asayasu Y, Kaneko T, Kondou A, Saitou K, Saitou H, et al. Infection prevention effect of vaccine nose vaccination and acupuncture treatment. J Oriental School Medicine. 1998;21:72-77. (in Japanese)*
43. Martin J, Donaldson ANA, Villarroel R, et al : Efficacy of acupuncture in asthma: systematic review and meta-analysis of published data from 11 randomized controlled trials. Eur Respir J 2002;20:846-852.
44. Kawakita K, Shichidou T, Inoue E, Nabeta T, Kitakouji H, Aizawa S, et al: Preventive and curative effects of acupuncture on the common cold: a multicentre randomized controlled trial in Japan. Comple Therap Med. 2004;12:181-188.
45. Jobst K, Chen JH, McPherson K, et al. Controlled trial of acupuncture for disabling breathlessness. Lancet 1986; 20: 1416-9.
46. Branco K, Naeser A. Carpal tunnel syndrome; Clinical outcomeafter low-level laser acupuncture, micr) oamps Transcutaneous electrical nerve stimulation and other alternative therapies; An open protocol syudy. J Altern and Comple med. 1999; 5: 5-26.
47. Johansson K, Lindgreen I, Widner H, Wiklund I, Johansson BB. Can sensory stimulation improve the functional outcome in stroke patients?. Neurology. 1993; 43: 2189-2192.
48. Liguori A, Petti F, Bangrazi A, Camaioni D et al. Comparison of pharmacological treatment versus acupuncture treatment for migraine without aura: Analysis of socio-medicalparameters. J Trad Chin Med. 2000; 20:231-240.
49. Ishizaki N, Iwa M, Yano T, Ono N, Nisimura S, Kawakita K, Tanzawa S. Survey research on prevalence, aim and image of acupuncture and moxibustion in Japan(1): Prevalence and aim of acupuncture and moxibustion. JJSAM. 2005; 55: 697-705.
50. MacLennan AH, Wilson DH, Taylor AW. Prevalence and cost of alternative medicine in Australia. Lancet. 1996; 347: 569-573.
51. Eisenberg DM, Davis RB, Ettner SL, Appel S, Wilkey S, Rompay MV et al. Trends in alternative medicine use in the United States, 1990-1997. JAMA. 1998; 280; 1569-1575.
52. Tsuru H, Ishizaki N, Taniguchi K. Analysis of 2967 patients who visited acupuncture clinic of Meiji College of oriental medicine in the U.S.A.(1996-1999). Bulletin of Meiji Univer Orient Med.2003; 33: 61-81.
53. White A, Ernst E. Public usage of acupuncture in the West. In: Ernst E and White A (ed). Acupuncture: a scientific appraisal. Oxford. Butterworth Heinemann. 1999: 5-7.

Table 1 Summary of case reports on acupuncture and moxibustion in the Japanese literature.
COPD, chronic obstructive pulmonary disease; CVA, cough variant asthma; DBP, diffuse pan bronchitis; UIP, usual interstitial pneumonia; +, positive; -, negative.

Author	years	Diagnosis	n	Study design	Intervention	Duration	No.of treatment	Outcome Measures	Result	References No.
Suzuki M	2007	DPB	1	Case report	acupuncture (TCM)	50 weeks	50 times	symptom, Respiratory function, blood test	+	28
Tokuchi J	2006	Chronic couhg	2	Case report	acupuncture (TCM)	unenrolled	unenrolled	sympotm	+	20
Egawa M	2006	CVA	1	Case report	acupuncture (TCM)	12 weeks	12 times	categorical scale	+	18
Murai K	2006	Chronic couhg	4	Case series	medication add on acupuncture(TCM)	1 to 20 days	1 to 40 times	sympotm	+	21
Yamashita Y	2006	Common cold	1	Case report	Roller acupuncture	104 weeks	160 times	symptom	+	30
Suzuki M	2005	COPD	1	Case report	acupuncture (TCM)	10 weeks	10 times	exercise tolerance test, Respiratory function, attack	+	22
Suzuki M	2005	COPD	1	Case report	acupuncture (TCM)	10 weeks	10 times	exercise tolerance test,Respiratory function	+	23
Tsuru K	2005	COPD	1	Case report	acupuncture (TCM)	20 weeks	33 times	exercise tolerance test,Respiratory function	-	24
Katayama Y	2004	COPD	1	Case report	acupuncture (TCM)	7 weeks	33 times	nutrition, symptom	+	25
Uematsu Y	2004	CVA	1	Case report	acupuncture (TCM)	9 weeks	10 times	Asthma diary, PEFR	+	19
Oyagi T	2004	Asthma	1	Case report	acupuncture (TCM)	no description	no description	symptom	+	5
Uematsu Y	2003	UIP	1	Case report	acupuncture (TCM)	50 weeks	50 times	exercise tolerance, Respiratory function, symptom	+	29
Egawa M	2003	Asthma	1	Case report	acupuncture (TCM)	72 weeks	60 times	attack diary, PEFR	+	6
Nakano T	2002	Asthma	10	Case series	Electroacupuncture, acupuncture	10 weeks	10 times	attack diary, Medicine	+	7
Tokuchi J	2000	Cold prevention	1	Case report	acupuncture (TCM)	4 weeks	8 times	symptom	+	31
Suzuki M	2000	COPD	1	Case report	acupuncture (TCM)	61 weeks	60 times	attack diary, PEFR, symptom	+	26
Gotou K	2000	Asthma	17	Case series	acupuncture (ryoudouraku)	no description	13 times	ryoudouraku, symptom	+(availableness: 9, nvariability:7)	8
Tanioka K	1998	Cold prevention	2	Case report	child acupuncture	no description	no description	symptom	+	33
Matsuzawa M	1995	Asthma	30	Case series	acupuncture, Kampo (TCM)	no description	no description	scandding Classification effective: 90%	+	9
Yu S	1995	Asthma	2	Case report	acupuncture (TCM)	12 weeks	26 times	symptom	+	10
Hashimoto K	1994	Asthma	1	Case report	acupuncture (TCM)	28 weeks	47 times	symptom	+	11
Rin S	1993	chronic broncitis	1	Case report	acupuncture, Kanpo (TCM)	8 weeks	8 times	symptom	+	27
Seki Y	1992	Common cold	3	Case report	acupuncture (TCM)	no description	no description	symptom	+	32
Shinohara M	1990	Asthma	1	Case report	acupuncture (TCM)	84 weeks	30 times	Category scale, Emergency outpatient, medication, ABG	Category scale(+), Emergency outpatient(+), medication(+), ABG(-)	12
Hayasaki Y	1989	Astham	3	Case report	acupuncture (TCM)	1 day	Once	symptom	+	13
Tsukada Y	1987	Asthma	12	Case series	Electroacupuncture, acupuncture	56 weeks	28 times	symptom, PEFR, blood test	symptom(+), PEFR(10% improvement), blood test (-)	14
Fu Y	1987	Asthma	21	Case series	acupuncture (implant a needl)	1 day	Once	symptom	+(Effective: 90%)	15
Sugiura R	1982	Asthma	1	Case report	acupuncture (TCM)	no description	no description	symptom	+	16
Takishima T	1979	Asthma	10	Case series	acupuncture (Japanese: Doushi)	1 day	Once	symptom	+	17

Table 2 Summary of controlled clinical trials on acupuncture and moxibustion in the Japanese literature. COPD, chronic obstructive pulmonary disease; RCT, randomized controlled trials;

No	Author	years	Diagnosis	Study design	n	Intervention	Control	Duration	No.of treatment	Outcome Measures	Result	References No.
1	Suzuki M	2006	Asthma	N-of-1	6	A: acupuncture	B: iv (drugs)	40 weeks	20 times	Asthma diary, Respiratory function	A>B	35
2	Egawa M	2005	COPD	N-of-1	1	A: acupuncture	B: iv (drugs)	64 weeks	32 times	exercise tolerance, Respiratory function	A>B	36
3	Takahashi N	2006	Cold prevention	RCT, N-of-1	2	A: moxibation	B: i (waiting lists)	16 weeks	24 times	symptom	A=B	38
4	Suzuki M	2004	COPD	Parallel	37	A: acupuncture	B: iv (drugs)	10 weeks	10 times	exercise tolerance test, Respiratory function	A>B	37
5	Shichidou T	2001	Cold prevention	RCT	24	A: acupuncture	B: i (waiting lists)	4 weeks	9 times	symptom diary	A>B	39
6	Isobe Y	2000	Cold prevention	RCT	24	A: acupuncture	B: i (waiting lists)	4 weeks	8 times	symptom diary	A>B	40
7	Tanaka J	2000	Cold prevention	parallel	60	A: moxibustion	B: iv(wacchin + moxibustion), C: iv(wacchin)	4 weeks	16 times	sympotom, CD4+, CD8+, CD53	A=B>C	41
8	Kaneko I	1998	Cold prevention	parallel	60	A: acupuncture	B: iv(wacchin + acupuncture), C: iv(wacchin)	4 weeks	16 times	sympotom, CD4+, CD8+, CD53	A=B>C	42
9	Kobayashi Y	1996	Cold prevention	parallel	40	A: acupuncture	B: iv(wacchin + acupuncture), C: iv(wacchin)	48 weeks	16 times	virus serum antibody titer	A=B=C	34

Kampo Medicine - Current Research

Can Kampo Formulations become First-Line Drugs for Rheumatoid Arthritis?

Hiromichi Yasui
Japan Institute of TCM Research

Introduction

There are 600,000 to 700,000 patients with rheumatoid arthritis (RA) in Japan (0.4–0.5% of the population, 1% of people aged over 30) with three times as many women as men afflicted by RA. Onset is most frequent between the ages of 30 and 50. The initial symptoms of the disease are symmetrical manifestation of pain in finger and toe joints and swelling of the joints (in some patients these symptoms start from the knee joints or other joints). Subsequently, about 20% of patients achieve remission within one to two years. On the other hand, about 5 to 10% of patients exhibit rapid joint degeneration as well as a strong inflammatory condition in a short period of time. The other 70% of patients experience alternate improvement and exacerbation in symptoms, progressing to gradual joint degeneration.

Pharmacological therapy by Western medicine aims to inhibit inflammation or joint destruction and non-steroid anti-inflammatory drugs (NSAIDs) or steroid drugs are used to manage joint swelling and pain caused by inflammation. In recent years, disease-modifying anti-rheumatic drugs (DMARDS) have come to be used early in the course of the disease, and if these are ineffective, TNF blockers are combined with DMARDS.

Is Kampo medicine able to open a new chapter in the treatment of RA? Although treatment of RA with Kampo formulations is common in Japan, I will introduce research that indicates Kampo formulations used in the early stages could inhibit disease progression.

Ebe's trial

Kampo medicine has long been engaged in RA treatment. "Jinkui Yaolue," written in ancient times, contains a description of RA. Practitioners today use prescriptions from this classical textbook to some effect. After the concept of the disease was clarified in recent years, RA has been treated with Kampo medicine under stricter diagnostic guidelines. Most of the treatments, however, are performed on the basis of short-term follow-ups and there are very few long-term records of the treatments available. This is because a follow-up system for the long-term prognosis of the disease was not established, such as whether joint destruction can be prevented or not.

Koji EBE focused attention on the time within three to four years after onset when it becomes clear whether the disease goes into remission, rapidly worsens, or gradually degenerates. He hypothesised that intervention with Kampo formulations at a very early stage would increase cases of early remission and observed the course of treatment in 10 cases of primary RA onset. He then provided further insights into the results.

Subjects and prescriptions

The subjects are ten individuals that satisfied the "Rheumatoid Arthritis Criteria" (Table 1) of the American College of Rheumatology (ACR) with a duration of one year or less from the start of symptoms. For all subjects, formulae were designed according to "sho" and decoctions were administered (Table 2).

Table 1: Rheumatoid Arthritis Criteria (American College of Rheumatology: ACR)

1	Morning stiffness lasts for an hour or more
2	Swelling of three or more joint areas
3	Swelling of the hand joints (wrist joints, metacarpophalangeal [MCP] joints, proximal interphalangeal [PIP] joints)
4	Symmetrical joint swelling
5	Abnormal hand radiographs
6	Subcutaneous nodules
7	Blood test shows positive for rheumatism RA is diagnosed if 4 items out of the 7 above are satisfied (however, items 1 to 4 must last for 6 weeks or more).

Table 2

	Date of First Consultation	Sex･Age	Disease Duration before First Consultation	Stage	TCM (Traditional Chinese Medicine) Diagnosis	Treatment	Prescriptions	Combined Drug
1	Feb. 9, 1991	Male 81	1.5 months	1	Dampness-heat impediment	Clear heat to transform into dampness	*senpito with adjustment*	Analgesic
2	Jul. 9, 1985	Male 70	5 months	1	Dampness-heat impediment	Clear heat to transform into dampness. Then, reinforce kidney	*senpito with adjustment*	Analgesic
3	Apr. 30, 1999	Female 51	6 months	1	Wind-damp impediment	Dissipate cold to transform into dampness	*Kedishikajutsubuto* with addition of *Ephedrae* Herba, *Asiasari* Radix and *Coicis* Semen	Analgesic
4	May 22, 1955	Male 50	3 months	1	Damp impediment	Transformed dampness to modify statis	*Stephaniae Tetrandrae* Radix *Coicis* Semen, *Atractylodis Lanceae* Rhizoma, *Atractylodes* Rhizoma, *Phaseoli* Semen, *Paeoniae* Radix Rubra, *Clematidis* Radix and others	Analgesic
5	Mar. 27, 1995	Female 58	11 months	2	Wind-damp impediment	Dissipate cold to transform into dampness	*keishikajutsubuto with adjustment*	None
6	Mar. 11, 1987	Female 43	3 months	1	Damp-wind impediemnt	Dissipate cold to transform into dampness	*keishikaryoujutsubuto with adjustment*	None
7	Jan. 12, 1990	Male 70	3 months	1	Wind-damp impediment	Dissipate cold to transform into dampness. Convert damp heat-impediment in mid-course	*keishikajutsubuto with adjustment. Later senpito with adjustment*	Analgesic
8	Apr. 17, 1992	Female 58	12 months	2	Damp-wind impediment	Transformed dampness to dissipate cold	*Stephania tetrandra* Radix, *Armeniacae Semen*, *Coicis* Semen、*Clematidis* Radix、*Aconiti* Radix Processa, *Cinnamomi* Cortex, *and others*	None
9	Apr. 18, 1997	Female 45	7 months	1	Wind-damp impediment	Dissipate cold to transform into dampness	*Keishikajutsubuto with adjustment*	None
10	Jul. 10, 1994	Female 41	3 months	1	Dampness-heat impediment	Clear heat to transform into dampness	*senpito with adjustment later keishikajutsubuto with adjustment*	Analgesic

Assessment (Evaluation Criteria)

Remission criteria developed by Pinals et al. was used for the assessment (Arthritis Rheum 1981).

It is essential that 5 or more of the following be satisfied for at least two months.

1. Morning stiffness does not last for 15 minutes or more
2. No fatigue
3. No joint pain
4. No joint tenderness or no pain on motion
5. No soft tissue swelling in joints and tendon sheaths
6. Erythrocyte sedimentation rate is less than 30 mm/h for males and less than 20 mm/h for females

Results

1. Complete remission was attained in 9 cases out of 10.
2. Case 10 ended in complete remission with 2.5 years of treatment. However, 2 years later in January 1999, the disease recurred. Four months of Kampo treatment starting in April led to another remission.
3. Case 9 ended in incomplete remission after one year of Kampo treatment. The case sometimes satisfied 5 of the 6 remission criteria and sometimes satisfied 3 to 4 criteria. However, 7 months after the start of Kampo treatment, the patient was able to run. About a year later (March 1998), the patient commenced hard work that required steady walking of 10,000 to 20,000 paces a day. As of March 2000, the patient was continuing work of a similar nature.
4. Case 7 ended in complete RA remission after three years of Kampo treatment. Six years later in March 1998, however, connective tissue disease accompanied by vascular inflammation developed. The disease was controlled by Kampo medicines and Predonin (6–20 mg). In March, the disease worsened and the patient was admitted to a university hospital where arthritis nodosa was diagnosed. Chronic renal failure occurred concurrently and dialysis started in June. The patient died in October.

As described above, Ebe reports that remission was attained in 9 cases out of 10 primary RA cases with incomplete remission in one case. Excellent treatment effects are shown.

However, due to the low number of cases available for the research, it is too early to conclude whether these results were produced under biased evaluations or were fortuitous, and that Kampo medicines are extremely effective for cases of primary RA onset. If a number of future primary RA cases yield good results, Kampo medicines could become first-line drugs in the treatment of RA.

Conclusion

This research by Ebe contributes to extending the possibility of Kampo therapy, resulting in increased treatment options available for patients with RA. In assessing the effectiveness of Kampo therapy, DB-RCTs (double blind-randomized controlled trial) are difficult to conduct. Thus, to satisfy a similar level of EBM requirements, Ebe has suggested that investigations use a definite number of subjects who have received Kampo treatment from an initial period (six months to one year from onset). He also suggests that if 10-year follow-up reveals a lower rate of shifting to polyarticular destruction type and mutilans type compared to Western medicine research groups, it could be said that Kampo treatment is efficacious. Later in 2008, he presented an additional report on the research at the 23rd Kyoto Kampo Academic Symposium, which contained more cases that referred to the ACR's "Rheumatoid Arthritis Criteria" and "Early Diagnosis of Rheumatoid Arthritis" prepared by the then Ministry of Health and Welfare of Japan. I will report on this at a later date.

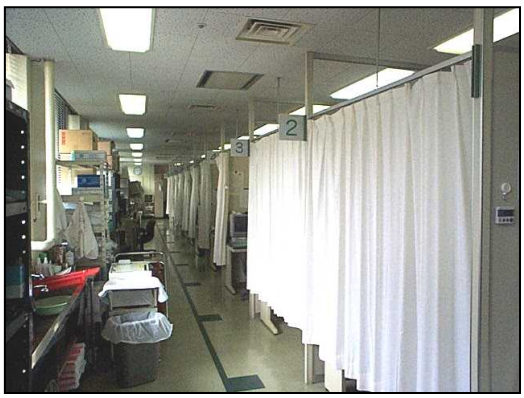
Reference

1) Ebe K.: Φυτο Vol.1 No.4, 4-12,1999

Clinical Report 1 (Japan)

A Case of Acupuncture Treatment for Left Shoulder Pain Thought to be Caused by Neuralgic Amyotrophy

Noriko Hori,[1),2)], Hitoshi Yamashita,[3)] Hiroshi Tsukayama[1)]
1) Tsukuba University of Technology
2) University of Tsukuba
3) Morinomiya University of Medical Sciences



About Our Clinic

The Center for Integrative Medicine of the Tsukuba University of Technology (formerly, the Tsukuba College of Technology Clinic) is an outpatient clinic for both conventional medicine and traditional medicine that was established in April, 1992. It has 2 sections: the Conventional Medical Clinic and the Acupuncture and Moxibustion Clinic. In the latter section, we perform acupuncture treatment for outpatients as well as bedside learning for the college students and acupuncture interns. In the Conventional Medical Clinic, we offer consultations in 5 specialties, Kampo medicine, orthopedics, neurology, radiology and pediatrical.

Between April 1992 and March 2005, 9665 patients (4086 men and 5579 women) visited the Acupuncture and Moxibustion Clinic. During this period, 146 acupuncturists (18 instructors and 128 interns) participated in 132359 acupuncture sessions. The types of acupuncture differed between acupuncturists and included electroacupuncture, modern medical acupuncture, meridian therapy, and moxibustion (direct or indirect). At the Acupuncture and Moxibustion Clinic we treated mainly musculoskeletal pain or discomfort (82.4%); other health problems treated included gynecological and obstetrical (2.5%), otolaryngological (2.4%), circulatory (1.1%), respiratory (1.0%), fatigue and tiredness (1.0%), neurological (0.9%), ophthalmological (0.9%). This pattern of acupuncture use in our clinic may reflect the current pattern of acupuncture use in Japan. However, even in Japan, it is rare that a clinic of a national university corporation provides more than half of its patients with acupuncture treatment.

Keywords: neuralgic amyotrophy, suprascapular nerve disorder, axillary nerve disorder, acupuncture, shoulder pain

I. Introduction

Generally, shoulder pain associated with limitation of motion is caused frozen shoulder, subacromial bursitis, tendinitis, calcific bursitis and so on. These conditions may also cause, depending on the contracture or affected site, muscle atrophy or reduced muscle power. Neurological disorder is generally not included. Reasons for alleviation of symptoms during the course of ordinary acupuncture treatment may include (1) natural course of the disease itself, (2) changes due to other treatment modalities or variations in lifestyle, (3) nonspecific effects based on expectations or assumptions, (4) total sum of effects brought about by the acupuncture treatment, (5) excessive evaluation of the effects of the acupuncture treatment during daily practice. Regardless of whether the condition improves or deteriorates, most of the diseases for which the influence of the acupuncture treatment tends to be excessively evaluated recover spontaneously, such as the well-known example of Bell's palsy. Here, we would like to report a case in which we observed the entire course in a patient treated with acupuncture for shoulder pain thought to be caused by neuralgic amyotrophy and in which neural damage-induced atrophy and loss of muscle power were also observed.

II. Case

Patient: 55-year old woman; first visit on August 17, 1992; chief complaint: left shoulder pain

[Present Illness]

Three days before her 1st visit to our clinic and before going to bed, the patient suddenly fell pain in the lateral left shoulder. The pain during that night was so severe that it prevented the patient from lying down and thus forced her to spend the night in a sitting position on a sofa. Whist the pain was present during both rest and movement, the most comfortable position was with the arm hanging down, and the pain subsided slightly during the day. Before onset she had not sustained any external injuries or fever. The only possible cause she could identify was that 1 week before the onset of the disease she had spent some time in a very cold air-conditioned room.

[Anamnesis] Nothing of particular note

[Complications]

The patient has diabetes, but it is controlled at a different hospital by diet alone. She has some hypertension but has not been prescribed any hypotensives. At another clinic, *Hachimijiogan* and *Kamishoyosan* were prescribed for climacteric symptoms.

[Family History] Mother has diabetes.

[Patient Profile]

The patient is married and has 2 children. She engages in volunteer work and goes to Tai Chi and dancing practice 3 times a week.

[Present Status]

Height: 150 cm; weight: 42 kg; blood pressure: 156/96 mmHg; pulse 60 bpm.

The patient was worried that the pain and chilling of the shoulder might be related and thus refused to uncover the entire shoulder girdle for examination.

The range of motion (ROM) of the left shoulder joint was 135° flexion, 30° extension, and 40° external rotation; during a (posterior) belt-tying motion the left thumb reached the height of the 8th thoracic spinous process (on the right side of the 6th thoracic spinous process), and during a hair-tying motion the left thumb reached the height of the 1st thoracic spinous process (on the right side of the 3rd thoracic spinous process). Restriction of the ROM was in any position due to pain; contraction was not observed.

The patient denied feeling heat or swelling in the left shoulder. Tenderness was found at LI15 and TE14 as well as in the deltoid muscle area but was not very marked. Tenderness was not observed in the intertubercular groove, nor over or around the coracoid process. Palpation revealed an increased

tonus of the ascending part of the trapezius muscle. The ROM of the neck was normal, whilst the Spurling test (pain radiating to the entire left arm) and the Morley test (numbness radiating to the left arm) were positive on the left side.

Biceps and triceps brachii muscle reflexes were normal.

[Auxiliary Diagnosis]

An orthopedist of our center did not detect any anomalies on X-ray films of the shoulder joint (Figure 1). X-ray films of the cervical vertebrae showed degeneration of the $C_{5/6/7}$ intervertebral discs (Figures 2 and 3). However, according to the orthopedist of our center, the degree of these changes was unlikely to be responsible for the sensory disturbances. Furthermore, an evoked electromyogram (EMG) obtained from the suprascapular nerve showed a prolongation of the M-wave latency for the left supraspinatus muscle.

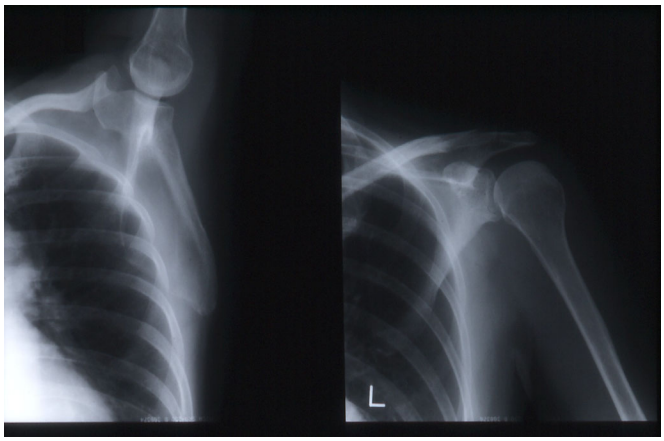


Figure 1

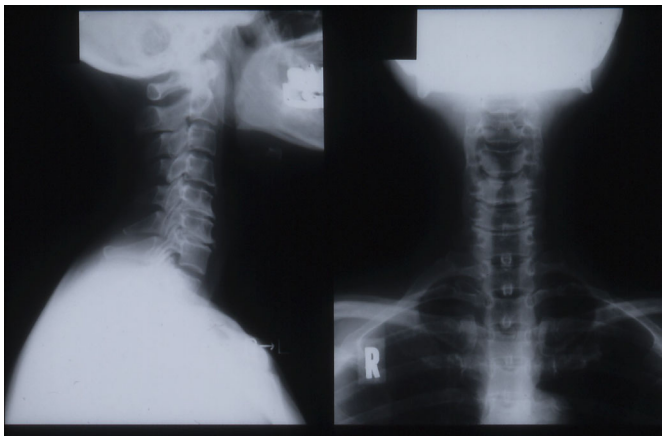


Figure 2

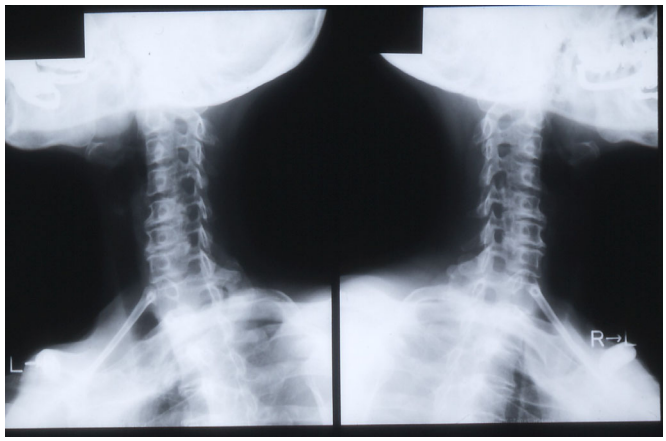


Figure 3

[Course]

Table 1 shows the variations in the pathological condition as well as the main symptoms and findings.

During the first visit we assumed that the condition originated from the cervical spine. On the basis of the findings of pain at rest, during motion, and at night, and of the pain induced by restriction of flexion and abduction, the lack of any feeling of heat, and the age of the patient, we assumed that the pain was probably due to a frozen shoulder. Acupuncture treatment consisted of needling the region of the shoulder joint to a depth of approximately 10 mm and retaining the needles for a certain period of time. Stainless steel 50-mm No.18 or 50-mm No.20 needles (K-type：Seirin) were used. Moreover, from August 18 to August 20 diclofenac sodium (proprietary name: Voltaren) was prescribed as additional treatment by the clinic in our center, with addition of diclofenac sodium suppositories (25 mg) on August 20, and this prescription of diclofenac sodium and diclofenac sodium suppositories was continued until August 27.

At the second (August 20) and third (August 24) visits, treatment consisted of retaining needles and manual needling at GB 22、LI 15、TE 14 and in the axilla. The pain-induced limitation of shoulder motion immediately disappeared, but the resting pain remained as severe as before. However, the patient reported that when she woke up on the morning of August 30, the pain had disappeared and subsequently so had the night pain.

Table 1 Changes in symptoms, findings and assumed pathology

	Symptoms	Findings	Assumed pathology
First visit (92/8/17)	night pain, pain at rest, pain during movement	pain during movement: flexion, external rotation Spurling test, Morris test (+) WBC: 3,500/mm^3 CRP: (-)	so-called frozen shoulder or cervical spondylosis etc.
2nd (8/20)	as above	pain during movement: flexion, external rotation Tenderness: LI 15, TE 14 plain x-ray of the shoulder joint: within normal limits	inflammation of rotator cuff or subacromial bursitis
4th visit (9/1)	pain alleviated, shoulder stiffness, heaviness of the shoulders	muscle tension: M. trapezius	shoulder stiffness
6th visit (9/18)	difficulties elevating left shoulder, heaviness of the shoulders	muscle atrophy: left subscapularis muscle weakness: abduction, external rotation	suprascapular nerve entrapment
9th visit (10/9)	as above	sensory disturbance: dullness from lateral left upper arm to the region posterior to the shoulder plain x-ray of cervical vertebrae: disk degeneration at $C_{5/6/7}$	suprascapular nerve lesion or axillary nerve dysfunction possibility of neuralgic amyotrophy
11th visit (11/2)	as above	evoked electromyogram: decreased conduction velocity of suprascapular nerve	
26th visit (93/4/9)	heaviness of the shoulders	muscle atrophy: left subscapularis sensation: no differences between left and right	

As she continued treatment thereafter, she complained of a persistent dull heaviness in the shoulder.

Examination of the area extending from the back to the arm on the sixth visit (September 18) revealed a marked atrophy of the left infraspinatus muscle, loss of power, and difficulties in raising her arm. We suspected that this was due to an entrapment neuropathy of the suprascapular nerve, so we targeted our needling at the regions of the suprascapular notch and the supraspinatus and infraspinatus muscles. Moreover, we also instructed the patient to exercise the involved muscles at home.

During the ninth visit (October 9), hypesthesia and hypalgia in the region from the left lateral upper arm to the posterior region of the shoulder joint (innervation area of the axillary nerve or the fifth cervical nerve) were observed.

Later, the sensory disturbance disappeared and a recovery of muscle power was observed, but the feeling of dull heaviness in the shoulder continued and the atrophy was present to the same degree as that of the sixth visit.

Because of the patient's feeling easier after the acupuncture treatments and because of her fear of recurrences, we continued the treatment until June 1993, performing approximately 30 treatments, after which slight heaviness in the shoulder still remained.

III. Discussion

According to an investigation by Alfen et al.[1] neuralgic amyotrophy can be classified as idiopathic or hereditary, either of which types involves pain called NA attacks (very severe, relentless neuropathic 'NA pain') that continues for a period of a few days to several weeks in the early phase of the onset and is particularly frequent during the night.[1] Recurrent attacks may also occuer.[1] In most cases, the pain occurs unilaterally in the upper extremities but bilateral occurrences have also occasionally been reported.[1] Other symptoms include hyperesthesia and paresthesia, often seen in the trapezoid muscle and on the lateral arm. Following these symptoms, paresis and muscle atrophy may develop. Muscles prone to the

development of these symptoms include mainly the infraspinatus, serratus anterior, supraspinatus, and the muscles of the upper trunk and arm.[1] Moreover, anomalous findings of EMG in many patients were also observed.[1] A combination of NSAIDs and opiates has been most effective for the pain, whilst other drugs are much less effective.[1] For many patients the prognosis includes residual severe neuropathic stabbing or shooting pain and persisted musculoskeletal pain that often continues for several years after the NA attacks have subsided.[1]

In Japan, limitation of motion induced by pain has been treated as a variety of pathologic conditions. Table 2 shows a representative classification[2] which is used in Japan for painful shoulder with limitation of motion.

Table 2 Classification[3] of painful shoulder joint arrest in Japan

Coracoiditis	Calcific inflammation of the rotator cuff
Inflammation of biceps brachii tendon	So-called frozen shoulder
Subacromial bursitis	Inflammation of the rotator cuff
Rotator cuff tear	Impingement syndrome

In the case described here, a comprehensive observation and detailed examination during the initial phase of the treatment was not performed because of the patient's severe pain and refusal to expose the shoulder region based on her fear of chilling. For this reason, the pathology of the condition could not be correctly identified during the early stage, so that the considerations of the pathology changed again and again. However, on the whole the severe pain of unknown origin and sudden onset resolved spontaneously after a few days without pharmacologic intervention. The symptoms of this case progressed to later atrophy of the infraspinatus muscle and reduced muscle strength for abduction and external rotation, as well as to hypesthesia extending from the posterior shoulder to the lateral upper arm, as indicated by the prolonged latency in the M-wave of the supraspinatus muscle. We suggested that this was a case of neuralgic amyotrophy. Moreover, the prolonged and persistent to be heaviness in the shoulder remained after the pain had subsided in the long term.

During the early phase in this patient, the effects of needling for the shoulder pain with limitation of motion were immediately reproducible after the needling at the second and third visits. So we thought needling to be useful for the relief of the pain. However, in this case the night and resting pain suddenly disappeared between the third and fourth visits. Leading us to conclude that this effect was unlikely to have been brought about by the acupuncture treatment. Instead, alleviation of the shoulder pain whilst not in except during motion and recovery of muscle strength and sensation were probably due to the natural course of the neuralgic amyotrophy.

Since the early symptoms of neuralgic amyotrophy generally resemble diseases of the shoulder joint, it is often carelessly treated continuously as frozen shoulder, tendinitis, calcific bursitis, and so on. Alleviation of the pain during the natural course may be evaluated as the effect of the acupuncture treatment. In Japan, for acupuncturists cannot perform diagnostic imaging or blood tests, so pathological conditions have to be identified by bedside findings. However, because we initially did not examine the shoulder and upper back in this patient, we missed many relevant findings. Given that neuralgic amyotrophy differs from frozen shoulder or tendinitis and runs a different course, acupuncture treatment for patients with shoulder pain should suffice, but when in doubt, acupuncturists should promptly refer these patients to a specialist.

IV. Summary

1) We performed acupuncture treatment for left shoulder pain of sudden onset.
2) It is highly possible that this was a case of neuralgic amyotrophy.
3) In the early stage, the acupuncture treatment in this patient was effective for the pain during motion.
4) In this case, the acupuncture treatment seemed to have been effective in alleviating the night pain and resting pain and in recovering muscle strength and sensation, but these changes were more likely due to the natural course of the neuralgic amyotrophy.

References

1) Nens van Alfen, Baziel G.M. van Engelen. The clinical spectrum of neuralgic amyotrophy in 246 cases. Brain 2006; 129:438-450.
2) Katsuya Nobuhara: Shoulder – Function and Clinics, Sec. Ed., Tokyo 1987

Clinical Report 2

A Patient Suffering from Rheumatism

Yoichiro Ebe
Takao Hospital, Kyoto

Patient: 28 years, female
First visit: June 29, 2007
Past history: head injury at the age of 14
Family history: nothing warranting special mentioning
Present illness: At the end of February 2007 development of exanthema over the entire body. By the end of April with the disappearance of the exanthema a fever (in the range of 37ºC) and arthralgia developed. The patient visited a certain medical university hospital for consultation. There she was told that this is not RA, but when she went to a different clinic in June, she was diagnosed with RA. At that time CRP value was 12.3 mg/dl and MMP-3 1053. Chest x-ray films were said to show no anomalies.
Current status etc.: height: 155 cm, weight: 44 kg
She has a constant low grade fever around 37.1ºC. Chilliness (+), headache (−), cough (+) (since June), dry mouth (−), easy fatigability (+), lassitude (++), restlessness (+), depressive mood (+), insomnia (+), wakes up during the night due to pain, night sweat (+), chilling of finger- and toe tips (+) and due to a marked degree of lassitude, generalized pain she moved awkwardly.
Pale facial complexion (forehead: bluish-yellow hue)

Arthralgia
- Neck pain (+)
- PIP of both hands (all), pain (+), swelling (+), fever (−)
- Bilateral shoulders pain (+), flexion and extension of both elbows (↓)
- Arthralgia of both hands (+)、swelling (+)、deformities (+)
- Pain of right hip joint (+)
- Bilateral gonalgia (+)、swelling on the left (+), fever (+)
- Bilateral ankle pain (+), swelling (+), fever (+)

Stiffness of the fingers of both hands; continues either through morning or even the entire day.
Bowel movements twice/day (soft stools – diarrhea)

Pulse findings:

	Left	Right
Inch	Thin/rapid upon palpation thin and weak	Thin/rapid upon palpation thin and weak
Bar	Thin/rapid upon palpation thin and slightly slippery	Deep and rapid, upon palpation thin and weak
Cubit	Deep and rapid, upon palpation slightly slippery	Weak

Tongue findings: slightly red tongue, white – yellow fur, sublingual veins were engorged.

Abdominal findings

Laboratory data
CRP: 8.75
SAA: 718
RF: 5
Hh: 8.3
Diagnosis: struggle between wind and dampness, deficiency of both qi and blood.
Prescription 1: *Cinnamomi* Cortex 12, *Paeoniae* Radix 12, *Anemarrhenae* Rhizoma 9, *Ephedrae* Herba 5, *Atractylodis Lanceae* Rhizoma 12, *Atractylodis* Rhizome 12, *Coicis* Semen 30, *Stephaniae tetrandrae* Radix 12, *Gentianae Macrophyllae* Radix 10, *Clematidis* Radix 10, *Bombyx* Batryticatus 10, *Astragali* Radix 30,

Angelicae Radix 9, *Zingiberis* Rhizoma Processum 6, *Glycyrrhizae* Radix 6, *Aconiti* Radix Processa 6

Prescription 2: *Uzugan* (one pill contains 0.1 g of *Aconiti* Kusnezof fii Radix powder), 21 pills, three times a day, medication for 14 days

September 14

Healthy

Pain 100→10%,

Prescription 1: same as before

Prescription 2: same as before, for 21 days

Table: Changes in the laboratory data

	CRP	SAA	RF	MMP-3	Hb	W	PLT	
07.6.13	12.3			1053	8.0	5100	50.9	Other clinic
6.29	8.75	718	5		8.3	4800	43.2	
8. 8	5.67	442	1	800	8.4	4600	44.2	
9.14	1.05	78.2	1		8.9	4800	27.1	

Course

July 13 (second visit)

Pain 100→30% reduction, cough (−), chilliness of the body (+), low grade fever (−).

Prescription 1: same as before

Prescription 2: Tsumura Bushi (*Aconiti* Radix Processa) powder 3.0g, three times a day, medication for 14 days

July 27

Prescription 1: same as before, for 14 days

Prescription 2: same as before, for 14 days

August 3

Pain (↓), 100→30%, low grade fever (−), easy fatigability (+)

CRP: 5.07↓ SAA: 442↓

Prescription 1: increased the amount of roasted aconitum in the above described prescription to 9g and that of *Astragali* Radix to 40g, additionally adding 10g of *Psoraleae* Semen.

Prescription 2: same as before, for 14 days

August 24

The patient had become so healthy, she could hardly be recognized.

Pain 100→20%, chilling of the body (⇓), appetite (↑), skin moisture (±)

Prescription 1: same as before

Prescription 2: same as before, for 21 days

Discussion

This patient was a case, in which a sudden aggravation occurred a few months after the onset of the RA. The Kampo medical diagnosis indicated invasion by wind cold evil, the resistance to this invasion by the protective qi, where the evil partial transformed into heat creating a situation of "struggle between wind dampness". Yet, since the fundamental nature of the condition was a deficiency of qi and blood, the basic therapeutic aim was to dispel wind dampness, simultaneously clearing the heat that had been generated by the partial heat transformation of the evil, while the deficiency of qi and blood required some supplementation.

The author regularly prescribes for the treatment of RA *Cassia Twig* Peony *and Anemarrhena Decoction* as base formula and believes, that minor modifications depending on the pathological condition allow the patient to cope with it in most cases. This patient is one such example, where the treatment consisted of heat clearing, dispelling of dampness and strengthening of unblocking the collateral vessels.

As can be seen here, after about 2 months of treatment a remarkable improvement was observed. This is an effect that will be difficult to obtain with extract preparations. In order to obtain short-term effects and depending on the disease condition somewhat larger amounts of crude drugs need to be combined and administered.

Clinical Report 3

A Case of Palpitation in which Hangeshashinto had been Effective

Keigo Nakata
Hosono Clinic

Knotted pulse or palpitations belong to the symptoms frequently treated with Kampo medicine. *Saikokaryukotsuboreito*, *saikokeishikankyoto*, *teikiin*, *keishikanzoto*, *shakanzoto* and similar prescriptions may be named as often prescribed formulas. Yet, in rare cases, like in the present patient, people visit the clinic seeking relieve from arrhythmias that have their origin apparently in the alimentary tract. Below I will describe one such case.

Case: age 55 years, male, employee
Chief complaint: arrhythmia, palpitation
Present illness:

Two years ago the patient noted that his pulse was beating irregularly. This occurred particularly often after meals or when he climbed stairs quickly, or he noticed the occurrence of a knotted pulse walking the streets and suddenly emerged on brightly lit places. He consulted a local physician, who told him based on his electrocardiogram that there is nothing to worry, but the taking ß-blockers did not improve the condition. Later he consulted the department of cardiovascular diseases at a certain general hospital and underwent detailed examination, but no anomalies were found, so he was told there is nothing to worry and was prescribed the same medication. He continued to consult that hospital as an outpatient for more than one year, but because the symptoms did not improve sought consultation in this clinic.

Present status: height: 162 cm, weight: 64 kg, slightly obese, blood pressure 120/70
Tongue diagnosis: thick tongue body, dark red, dental indentations (+), thick white fur

Pulse diagnosis: between floating and deep, wiry, intermediate, forceful, regular
Abdominal diagnosis: thick abdominal wall, strong, elastic, there was some fullness, tenderness or discomfort of the hypochondrium and increased resistance and tenderness of the epigastric region.
Palms reddened and moist
Urinary findings: no anomalies
Electrocardiogram: nothing warranting special mentioning
Prescription and course
Prescription:

The condition was considered to be a *saikokaryukotsuboreito* pattern and thus this formula prescribed, but after one week of medication no changes at all were observed. Thus, I re-assessed the pattern and switched the prescription to *hangeshashinto* plus *Bupleuri* Radix, which then led to gradual improvements.

Discussion

Based on the observation of a wiry and forceful pulse, a white fur on the tongue and fullness, tenderness or discomfort of the hypochondrium during the first visit I diagnosed a lesser yang disease stage. Basically I use *saikokaryukotsuboreito* for excess patterns in patients with lesser yang disease stage complaining of palpitation and *saikokeishikankyoto* in cases of deficiency patterns. Naturally, in this case I diagnosed a *saikokaryukotsuboreito* pattern and prescribed this formula.

In cases for which *saikokaryukotsuboreito* is an indication irritability and restlessness arising from fear are observed, but this patient was calm and did not show any signs of restlessness arising from fear. Yet, the reddening and moistness of the palms

suggested a state of excessive heart consumption, which led me to the conclusion that *saikokaryukotsuboreito* would be appropriate.

Yet, contrary to my expectations, on the second visit one week later the symptoms had not improved at all. My master taught me: "Once you have prescribed something, do not change that prescription without good reason" so that it would probably be in order to continue with that prescription for a little while longer, but my personal experiences showed, that if no improvements at all have been achieved after one week when treating patients with palpitations, continuing the same treatment usually will not lead to improvements. For this reason I reconsidered the prescription.

At that time I focused on the fact that the attacks of knotted pulse occurred after meals. The presence of increased resistance and tenderness of the epigastric region also led me to the conclusion that in this patient not stress or mental tension, but rather stimulation of the stomach triggered the knotted pulse attacks. Thus, I judged that unless the stomach is treated, the patient's knotted pulse attacks are unlikely to be cured and therefore prescribed *hangeshashinto plus Bupleuri* Radix.

Occasionally I use *hangeshashinto* with added *Bupleuri* Radix. This is an addition based mainly on the abdominal pattern. In this way a combination of *hangeshashinto* and *shosaikoto* is achieved, extending the range of indications for *hangeshashinto* and enhancing its effects.

One week after switching the prescription to *hangeshashinto plus Bupleuri* Radix *decoction* the patient visited the next time and reported "This time I have the feeling the medicine suits me. The palpitation attacks also have markedly improved." This gave me the confidence to continue with that prescription. Later the patient visited my clinic in intervals of approximately 2 weeks and showed at each visit gradual improvements of the symptoms. Three months later the knotted pulse attacks had disappeared completely.

Hangeshashinto is frequently use for various diseases of the digestive tract and can be said to be almost never used for cardiovascular diseases. However, while complaining of knotted pulse attacks and palpitation, these attacks were considered to be triggered in this patient by abdominal factors. Under these circumstances *hangeshashinto* too can be considered to be a very useful prescription.

This was an interesting experience that naturally brought the expression: "All five organs and six viscera can cause palpitation. It is not limited to Heart.

Introduction of Japanese Acupuncture

Considering the Therapit's Hand (8)

Shuichi Katai, Ph.D., L.Ac., Professor
Dept. of Acupuncture and Moxibustion
Tsukuba University of Technology, Ibaraki, Japan

VII. Correlation between palpation target and treatment

The reactions found during palpation represent some form of vital response. Yet, regarding the classification of pathologic conditions these individual responses represent, proposals include: there is still no unified theory. Some of the meridian and acupoint theory within the science of acupuncture and moxibustion, the theory of alarm and back transport points, abdominal diagnosis according to the Gosei-ha (a school of Kampo medicine in Japan influenced by the medicine of Li Dong yuan) or Koho-ha (a school of Kampo medicine antagonistic to the Gosei-ha school, advocating a return to the practical type of medicine of the Shang Han Lun), tender points, trigger points etc. Each of these has their relevant theories, but a theory summarizing palpation in general has not yet been proposed.

Naturally, the meridian and acupoint theory represents a theoretical systematic correlation between the internal organs and the skin, but the actual existence of meridians and acupoints has not yet been thoroughly substantiated anatomically and physiologically. Clinically, the effective use of meridians and acupoints is very important, but from the standpoint of a "reaction theory" empirical evidence is desirable.

For this reason it has been considered necessary to systematically organize the correlations between pathological conditions and repeatable physical findings on the one hand and using those findings with effective therapies on the other hand.

The so far described reactions appearing on the body surface are each related to some form of anomaly within the body and as such have been organized as (1) organs/viscera-meridian system, (2) Head's zones, (3) tender points, (4) viscerosomatic reflexes and (5) propagated sensation along channels or similar phenomena.
I will try to provide some brief explanations about these below.

(1) Organs/viscera-meridian system

Meridians are the pathways along which Qi energy, environmental influences enter the body from the outside as well as the path between problems arising from organs that are then propagated to and expressed on the body surface. Accordingly, not only the channels and collaterals of the body surface, but also the vessels extending from the body surface to the organs are included in the relevant examinations. These are associated with organs and viscera, or else connected to these organs and viscera. Therefore, the concept that "the connection between acupoints, meridians, organs and viscera is organized into a system allowing comprehension of the pathological condition(s) and their correlation with the therapy" represents the fundamentals of the organs/viscera-meridian system. This concept has been described in the section about environmental qi of the "Su wen" (plain questions) and can be called a fundamental assumption not only for acupuncture and moxibustion, but for oriental medicine in general.

The designation of organs/viscera-meridian system implies that the meridians connect the organs and viscera with the body surface, i.e., forms a coordinated connection between the interior and exterior of the body. Katsusuke Serizawa liked to use the above expression in particular because it can be said to express the point of view of western

medicine and attempts to define scientific acupuncture and moxibustion very well. It also bears some resemblance with the viscerosomatic reflexes concept described below.

(2) Head's zones

The Head's zones have been described by the British physician Henry Head and refer to hyperalgesic zones apparently associated with diseases of internal organs. The underlying nature of this phenomenon is defined as referred pain. The theory holds, that the input of afferent fibers from internal organs produces hyperaesthesia, in particular hyperalgesia in zonal distributions corresponding to the innervation of the posterior spinal roots, so that not only hyperalgesia, but also reddening and swelling may appear. These zones are the dermatomes. For this reason it may be said, as detailed below, the Head has viscerosomatic reflexes.

(3) Tender points

This is a concept that was pointed out in the 1920s and refers to locations on the body surface that are painful when pressed. The underlying nature of this phenomenon is mainly a correlation with internal organs in which anomalies may have arisen. Most of these points are named after the person who discovered them, for example Boas point or Onodera's gluteal point.

It is unclear how the concept of these tender points has evolved, but they resemble the acupoints observed in oriental medicine. However, acupoints form groups of points that are related to each other via channels, whereas for all tender points the relationship is completed between the point and the internal organ. In this regard tender points may be said to resemble the transport and alarm points defined within the hypothesis of meridians and acupoints.

(4) Twelve Hirata style body surface zones

These zones have been suggested by Kurakichi Hirata, who was a student at the Kyoto University medical facility, and are belt-like zones on the body surface. The head, neck, arms, trunk and legs are divided into 12 zones and zones of similar names in each region are considered to be interconnected. Using his "Hirata psychotherapy – hot needling technique" to develop therapies not relying on moxibustion, he also proposed the "doctor in each family movement" aiming at universal health coverage under which the entire population would be able to become healthier.

(5) Viscerosomatic reflexes

Viscerosomatic reflexes are reflexes mediated via autonomic nerves and theoretically express the status of internal organs on the body surface (skin, muscles etc.). The pain appearing on the ulnar side of the left arm in case of heart disease is a representative example. These autonomic nervous reflexes appear within the dermatomes, and so they are theoretically easy to comprehend.

Again, there are also autonomic nerve reflex mediated somatovisceral reflexes, so that the theory about viscerosomatic and somatovisceral reflexes may be considered, from a western medical position, very important for explaining acupuncture and moxibustion effects.

Research into somatovisceral reflexes started in Japan with research into heart rate and later reports dealing with digestive organs (stomach and intestines), gallbladder, kidneys, uterus and the like have been published.

(6) Propagated sensation along channels

Reports on the propagated sensation along

channels have been published in China [雄渾社]. The quality of the provided images is extremely poor and there may be often signs of modifications made after pictures were taken, so that their contents cannot be considered acceptable but with some of these pictures the idea still comes through to a certain degree.

Masao Maruyama et al. performed "research into Hibiki (needling sensation)" in Japan prior to research into the propagated sensation along channels phenomenon performed in China. In Japan Shoji Yoshimoto followed these lines and presented later his book illustrated with photographs, but subsequent research has not been affected by it.

There is no doubt that lines are appearing on the body surface very closely resembling the course of the meridians, but further investigations in the future are necessary to determine what pathological conditions they relate to and what clinical significance they have. In other words, etiologic factors and their reflection on the body surface (reactions), as well as the correlations between these reactions and the treatments performed in response to their need to be systemized. Since this line of reasoning represents the fundamental theoretical system for the training of the hands of therapists, it needs to be established as soon as possible.

VIII. Conclusion to this series

The reactions identified during palpation represent some form of vital physical response. Yet, unless it is clear to what pathological conditions the body is reacting, this cannot be applied therapeutically. And, in the past many different systems of reactions have been proposed, but there is still no unified theory.

Naturally, the theory of meridians and acupoints represents within the system of acupuncture and moxibustion a systematic theory of the correlation between internal organs and body surface, but the actual existence of meridians and acupoints has not yet been substantiated anatomically and physiologically. Unless there is at least some empirical evidence, this theory cannot be even lightheartedly expounded based on the prevailing assumptions.

For this reason the relationship between pathologic condition and reaction on the one hand and reaction and therapy on the other hand should be systematically organized and a suitable theory established. Once this has been accomplished, the clinical development of acupuncture and moxibustion will most probably advance to the next stage. Future studies dealing with these questions are desirable.

This being said, at the present moment the concepts pertaining to meridians and acupoints offer us an enormous wealth of possibilities. Although we should not accept the practical concepts without question, they definitely serve as a valuable reference and may well be used to achieve reproducible clinical results.

Medical History in Japan

Todo Yoshimasu and his Medicine (2)

Hiromichi Yasui
Japan Institute of TCM Research

In the last issue, I introduced the biography and the medical theory of Todo Yoshimasu who radically changed Japanese Kampo medicine. His theory replaced the pathophysiological parts needing elucidation — which is the most important aspect of TCM — with a black box that quickly spread across the country and has since become the tradition of Japanese Kampo medicine. In this issue, I will introduce how he administered treatment using case reports from his book, "Kenjyuroku" (1763).

CASE 1: Cold Injury (Shang han)

An old man, aged over 90, never believed in medicine, thinking that it was useless. But he came to admire our master's medicine recently, saying to his family members that when he got ill, the only doctor who could be relied on was Yoshimasu. A few years later, he began suffering from exogenous febrile disease. He began to feel malaise and heat in his chest, and to talk in delirium. There was no urination, he lost his appetite for 6 days. His family members asked Yoshimasu to examine him. There were stuffiness in the chest, and his limbs were a little swollen. Yoshimasu made *bukuryoin* to give him. After vomiting much water, the patient was cured.

Since he was 60, he used to wear thick clothes even in summer time. Nevertheless he felt chilly. He thought it was necessary to wear thick clothes because of his age. But after that treatment, the old man was able to wear thin clothes an when he was younger. So the case was not due to senility, but disease.

CASE 2: Dysphasia

A servant to the lord of a clan, 20 years old, was suffering from dysphagia for 2 years. Every 5 or 10 days, it occurred. He came to feel turgor in his chest and abdomen and his physical condition was getting worse. No doctor could cure him. Hearing of Yoshimasu 's reputation, he decided to ask his treatment, saying: life and death are decided by destiny. If I have to die, I would like to die by Yoshimasu's treatment. Yoshimasu provided *daihangeto*, which made him vomit. Everytime he vomited, there was sputum. After 8 or 9 days, the medicine began to work, letting the bowels loose, and his vomiting stopped. Within 2 months, he was cured completely.

CASE 3: Hematemesis

A merchant of Karasuma in Kyoto, Ihei lzumiya was suffering from hematemesis for 20 years Almost every 10 days, he vomited blood. In autumn of one year he was very sick and almost unable to breathe. No doctor could do anything to cure him. Family members, crying, were preparing his funeral. Yoshimasu happened to come and examine him. The patient was not dead yet, for when our master put a thread in front of his nose, the thread moved, although the merchant was motionless. When Yoshimasu touched his abdomen, it moved a little. judging that Qi was not dead yet, he made *san'oshashinto* in haste. Then, after taking the medicine, the patient began to have loose his bowels and after 10 times, then stopped. Within 20 days, he was completely cured. Since then, almost 10 years passed, and there was no recurrence.

CASE 4: Tuberculosis

A daughter of a merchant, Denbei Masuya of Kawara-machi in Kyoto got ill, and all the doctors diagnosed her symptoms as tuberculosis. No

treatment worked. She got thinner day by day, and almost died. From the beginning, the merchant was afraid of the treatment of Koho (ancient prescription in "Shang han lun"). He could not bring himself to Yoshimasu to examine her. Yoshimasu, learning that the merchant did not believe in Yoshimasu's intention, just left them alone. A few months later, this girl died. Two years later, a sister of the girl got ill. The merchant said: "I have 5 children, and 4 among them have died due to tuberculosis. In the year when they turned 17 years old, in spring, they got ill, and in August, they died. Now the youngest girl is 17 years old, and infected with tuberculosis. Although I know the efficacy of Koho, I am afraid that very-strong laxative medicines are used. But prescription of slow-acting and reinforcement could not work for this disease, as far as I remember. So please cure her disease. If she would die, I will not regret it." Our master examined her. For enervation, dullness in limbs, alternate spells of fever and chills, and cough, he made *shoseiryuto* and *kontangan*, which he used in mixed form. Before August, she was cured completely.

CASE 5: Edema

A chief Buddhist monk of the Kosai-Temple in Bungo suffered from swelling of his body. He could not urinate. Stuffiness in his chest made it almost unable to breathe. His feet became very weak. For him, a doctor made eppikajutsubuto which did not work at all. Yoshimasu examined him. As there was unconsolidation in the lower abdomen, for which to correspond, he made *hachimijiogan*. With one dos-age, the stuffiness in his chest disappeared. With a second dosage, he was able to urinate. With less than ten dosages, he was cured completely

CASE 6: Pain of the heel

A medical student, aged about 20, suffered from pain of the heel. The pain was like being pierced by an awl or the blade of a sword, unbearable to the touch. Many doctors tried but could not cure him. A surgeon thought that there was pus, so he cut out that part. But that was not effective. Yoshimasu was called to see him.

There was a contracture of the abdominal wall. There was no softness felt by his hand on abdominal palpitation. He made *shakuyakukanzoto* to give him. With one dosage, the pains disappeared.

CASE 7 : Soliloquy

An ambitious, poor student studied very hard and read a lot of books without sleeping for 7 days. He started to talk to himself in delirium, laughing, rebuking his master. Everybody thought that he had become insane. Yoshimasu examined him. There was swelling in the sternocostal, a fast throbbing of heart and ki went up and could not come down. He made *saikokeishikankyoto* to give this patient, sometimes attacking poison by shien. Within a few days, the student was completely cured.

CASE 8 : Eruption on the head

A merchant in Kyoto, Kichigoro Yamatoya, every spring had a fever in his head and face. On his head, he had a sore, which was very itchy. If he scratched it, it became infected. When autumn came, the symptoms disappeared, without any treatment. He wanted to be completely cured though. Yoshimasu examined him. There was slight palpitation, fullness in the chest and hypochondrium, and an abnormal rising of Qi. To correspond to the symptoms he prepared *saikokeishikankyoto* and *kyuosan*[6]. In a month, all symptoms disappeared. Since then, there was no recurrence.

CASE 9 : Dumbness and convulsive fit

A soldier of the Yamashiro-yodo clan, named Heizaemon Yamashita met Yoshimasu, and said. “I have a 5 year old boy. He cannot speak, and he has convulsive fits once or twice a day. His body has become very thin, he seems to be very exhausted, and close to death. His agony seems to increase day by day. As his parents, we cannot bear to see him in pain. We would be very much obliged if you could treat him. If fortune favors us, and if we will be able to see him well again, even if it will be only once, we will never regret it. ”Accepting their wish, Yoshimasu examined the boy. He recognized an abdominal symptom of stuffiness in the gastric region, which was soft when he palpated it. He made *daio'orenshashinto*, which he provided for 100 days. The stuffiness in the gastric region disappeared, and convu1sive fits also stopped. Nevertheless, there was still swelling in the sternocostal, fullness is the upper abdomen, and dumbness. He made *shosaikoto*, and together with *san'ogan*, he continued his treatment. Sometimes he provided *deikankyogan* to treat those symptoms. In this way, about 6 months passed. One day, his nurse was leaning against the entrance gate with this child in her arms. Someone passed in front of them, leading a horse. Suddenly the child uttered “uma.” Being overjoyed to know this, his parents took the child with them to Yoshimasu to tell him this. And when Yoshimasu showed a piece of sweets to the child, he said “uma” again. (In Japanese, “uma” means “a horse” and “sweet taste.” It is a homonym.) The parents were very glad. So he continued with the prescriptions mentioned above. Within a few months, the boy's language ability became normal.

Since the last case is interesting, one that adorns the first page of “Kenjuroku”, I will add some explanation from the standing of Modern TCM. The 5-year-old patient mentioned in the book must now be considered to be about 3 years old when various factors relevant at that time are taken into account. From the modern medical point of view, the diagnosis might be a developmental disorder, although the cause is not known.

Todo, however, administered *daio'orenshashinto*, targeting a “distressed and soft epigastrium.” Epigastric distress abated in about 100 days and rib-side distension, and hypochondrium fullness,” with occasional use of *daikankyogan*, which achieved the desired effect.

From the present traditional medical point of view, what Todo tried to clear out of the body was primarily “retained phlegm” accumulated in the chest, diaphragm, and epigastrium, and secondarily, retained qi in the epigastrium. There is no way to tell from the foregoing if he was aware of pathological products and pathological phenomena, and if he thought they were toxins or a kind of toxin as he asserted. It is conceivable that, depending on the pathological condition, targeted and accurate administration of the four foumulae (*daioorenshashinto*, *shosaikoto*, *san'ogan*, and *daikankyogan*) dispelled physical and non-physical afflictions and improved the flow of qi and body fluids.

This is a brief study of Yoshimasu's methods of treatment, citing from his book Kenju-roku. We can see that his methods of treatment were based on his own medical theory, and at the same time he was a very efficient clinical doctor with keen insight.

Anyway, what he said and what he did put the medical world of that time into great turmoil.

Maintaining his motto of relating symptoms to medication, he denied all theories of traditional medicine. He insisted upon the administration of treatments to expel poison, sometimes using very intense laxatives and mercurial medicine. It will continue to be one of our important themes to know how to grasp the meaning of Yoshimasu, and how to make the most of his ideas and methods of treatment in current medicine.

Prescription (Japanese, Chinese Character, Pinyin)

bukuryoin 茯苓飲 Fulingyin
daihangeto 大半夏湯 Dabanshatang
san'oshashinto 三黄瀉心湯 Sanhuangxiexintang
shoseiryuto 小青竜湯 xiaoqinglongtan
kontangan 滾痰丸
eppikajutsubuto 越婢加朮附湯
hachimijiogan 八味地黄丸 Baweidihuanwan
shakuyakukanzoto 芍薬甘草湯 Shaoyaoganzaotang
saikokeishikankyoto 柴胡桂枝乾姜湯 Chaihuguizhiganjiantang
shien 紫円
kyuosan 芎黄散
daio'orenshashinto 大黄黄連瀉心湯 Dahuanhuanglienxiexintang
daio'orento 大黄黄連湯 Dahuanghuanglientang
shosaikoto 小柴胡湯 Xiaochaihutang
san'ogan 三黄丸 Sanhuantang
daikankyogan 大陥胸丸 Daxianxiongwan

Quality Of Life
OMINEDO

Ominedo is the only professional manufacturer of herbal extracts.

Poria Powder with Five Herbs

Wu-Ling-San

goreisan

Composition

- Arisma rhizoma
- Tuckahoe
- Atractylodes ovatae rhizoma
- Umbellate pore fungus
- Cinnamon bark

Ominedo Pharmaceutical Industry Co., Ltd.

574, Nenarigaki, Yamatotakada-City, Nara 635-0051, Japan
URL : WWW.ominedo.co.jp
Contact : info@ominedo.co.jp
Phone: (81) 745-22-3601 Fax: (81) 745-23-2540

Kanebo Pharmaceutical, Ltd.

Like the cherry trees along Potomac River, Kanebo wishes to play a role of the bridge for friendship and health between Japan and U.S.A.

History of the Cherry Trees in Washington, D.C.

The plantings of cherry trees originated in 1912 as gift of friendship to the United States from the people of Japan. In Japan, the flowering cherry tree or "Sakura", as it is called by the Japanese people, is one of the most exalted flowering plants. The beauty of the cherry blossom is a potent symbol equated with evanescence of human life and epitomizes the transformations Japanese Culture has undergone through the ages.

Excerpted from National Park Service