## Kampo Medicine - Current Research

*Kampo Treatment for Psychosomatic Disorders –*
*1. Functional Dyspepsia (FD)*

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### Disease concept

Cases in which in spite of complaints of epigastric pain, epigastric distension and similar symptoms of the upper gastrointestinal tract gastroscopy etc. cannot show explicable organic lesions are called (functional dyspepsia: FD). This comes close to what has been called chronic gastritis or neurogenic gastritis in the past. FD is a very common disease and the international epidemiological study DIGEST showed, that 9% of the adult Japanese population experiences this condition at a rate of once a week, presenting with moderate or stronger symptoms of dyspepsia, and among those people 34% reportedly visited medical facilities[1].

Currently, the Roma III criteria (Table 1) are widely used worldwide for the diagnosis of FD. Moreover, in this connection the condition in patients presenting with epigastric pain or a burning sensation in the epigastric region is classified into (1) epigastric pain syndrome (EPS) and postprandial distress or a feeling of early satiety as (2) postprandial distress syndrome (PDS). There are patients, in whom both EPS and PDS coexist at the same time[2]. Regarding the cause of FD (1) anomalies of gastric motility (derangement of appropriate gastric fundus relaxation, decreasing the pooling capacity of the stomach etc.), (2) visceral hypersensitivity (patients with FD are hypersensitive to gastric stretching stimuli as compared to healthy persons) and (3) central nervous problems (presence of depression or anxiety and similar psychological symptoms) are conceivable. Otherwise excessive secretion of gastric acid, *H. pylori* infection, affection by food contents and a variety of other causes are involved.

Western medical pharmacological treatment aims at bacteria elimination in cases of *H. pylori* infections, in the group of patients with epigastric pain syndrome drugs inhibiting gastric acid secretion and in the postprandial distress syndrome group drugs to promote gastrointestinal motility are used. If these measures are not effective, tricyclic antidepressants are administered[3].

**Table 1 FUNCTIONAL DYSPEPSIA (Rome III)**

**Diagnostic criteria* Must include:**

1. One or more of the following:
   a. Bothersome postprandial fullness
   b. Early satiation
   c. Epigastric pain
   d. Epigastric burning
2. No evidence of structural disease (including at upper endoscopy) that is likely to explain the symptoms

* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

**Postprandial Distress Syndrome**

**Diagnostic criteria* Must include one or both of the following:**

1. Bothersome postprandial fullness, occurring after ordinary-sized meals, at least several times per week
2. Early satiation that prevents finishing a regular meal, at least several times per week

* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

**Supportive criteria**

1. Upper abdominal bloating or postprandial nausea or excessive belching can be present
2. Epigastric pain syndrome may coexist

**Epigastric Pain Syndrome**

**Diagnostic criteria* Must include all of the following:**

1. Pain or burning localized to the epigastrium of at least moderate severity, at least once per week
2. The pain is intermittent
3. Not generalized or localized to other abdominal or chest regions
4. Not relieved by defecation or passage of flatus
5. Not fulfilling criteria for gallbladder and sphincter of Oddi disorders

* Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

**Supportive criteria**

1. The pain may be of a burning quality, but without a retrosternal component
2. The pain is commonly induced or relieved by ingestion of a meal, but may occur while fasting
3. Postprandial distress syndrome may coexist

## Treatment

In Chinese medicine FD is understood according to concepts of conditions like "epigastric pain" (wei wan tong), "epigastric stuffiness" (xin xia pi), "eructation" (yi qi), "anorexia" (na dai), "frequent vomiting" (fan wei), "gastric upset" (cao za). Possible causes for the pain are stomach heat, stomach yin deficiency, stomach cold, disharmony of liver and stomach or blood stagnation and in relation to the stomach upset stomach qi deficiency and phlegm-dampness.

In Japan *shigyakusan* and *saikokeishito* are used in particular for EPS patients with marked stress factors (disharmony of liver and stomach). Moreover, for asthenic patients with chilling of the epigastric region (stomach cold) Anchusan or Ninjinto are used. In Patients with PDS with the development of phlegm-dampness due to an irregular diet including excessive ingestion of water, alcohol, dairy products and meat or the like *heiisan, bukuryoin, bukuryoingohangekobokuto* are used. Also, when in people with a weak constitution a qi deficiency induced by a deficiency of spleen and stomach has led to the development of phlegm-dampness, *rikkunshito* is used. Moreover, the presence of both epigastric pain and gastric upset is a form of EPS and PDS overlap for which *hangeshashinto* is used.

## EBM

In Japan almost all research reports are based on the use of *rikkunshito*. In some studies attempts were made to classify the FD according to the type of morbidity, while others did not distinguish between pathologies[4]. FD has in the past also be called non ulcer dyspepsia (NUD) and there are many trials based on the relevant diagnostic criteria.

According to Harasawa et al. DB-RCT showed, that *rikkunshito* had therapeutic effects for the postprandial distress syndrome[5]. *Rikkunshito* in the normal dose and a 1/40$^{th}$ dose was administered over a period of 2 weeks to 235 NUD patients with postprandial distress syndrome and the two groups then compared. The results showed, that the ratio of symptom alleviation in the group treated with the normal dose was significantly higher. Classified according to symptoms a marked improvement was observed in particular regarding the inappetence, gastric discomfort and fatiguability present prior to the treatment and regarding the usefulness too a significant difference was observed between the 58.8% in the regular dose group and the 39.3% in the low dose group. Patient background factors influencing the elimination effects were an age in the 60s, leptosomatic body type, SRQ-D<10 points, weak muscle tone of the abdominal wall, regular facial color, for all of which significant differences were observed.

Regarding RCTs there is a comparative study, treating NUD patients with *rikkunshito* and cisapride[6] by Miyoshi et al. In this study 246 NUD patients received the drugs at random. As a result significant differences were observed, showing a 'better than improvement' regarding the general condition in 81.3% patients in the *rikkunshito* group (marked improvement 49.5%), as compared to 75.0% in the cisapride group (similarly 34.0%). Regarding the usefulness too significant differences were observed for the ratio of 'better than useful', which was 80.7% in the *rikkunshito* group (extremely useful in 45.9%), as compared to 73.3% in the cisapride group (similarly 31.7%).

References


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