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Acupuncture Treatment for Parkinson's Disease

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Abstract: Parkinson's disease (PD) Many patients with PD are reported using acupuncture as an alternative treatment at some points of their life. This review summarise recent development in acupuncture research of Parkinson's disease (PD), in particular, focused on effects of acupuncture and its underline mechanisms on Parkinson's disease.
Manual or electro-acupuncture treatment enhances motor function recovery and significantly relieves motor symptoms and many non-motor symptoms. Recent studies have shown that acupuncture stimulation at the assigned acupoints protected dopaminergic neurones. This action is mediated by stimulating expression of neurotrophic factors in the brain substantia nigra and striatum. Acupuncture therapy was found to slow cell death process by acting as antioxidant to protect dopamine neurones against oxidative stress-induced neurodegeneration.
Study also showed to relieve non-motor symptoms of PD. Significant improvement on Beck's Depression Inventory (BDI), an assessment about the depression, has been observed following acupuncture treatment.
Additionally, both preclinical and clinical studies suggest that acupuncture reduce the side effects of levodopa on motor function and alleviates levodopa-induced motor complications by lowering the dose of levodopa and restoring neurochemical imbalance in the brain.
Future studies needs to look other potential acupoints which modulate dopamine and other neurotransmitter transmissions in the basal ganglia to enhance the efficacy of acupuncture treatment. More importantly we need to explore the acupoints that improve motor function and enhance neurotrophic factors releasing to slow down dopaminergic degeneration in particular at the early stage of the disease.

Introduction

Parkinson's disease (PD) is an age-related, progressive neurodegenerative disorder that affects approximately 1 in 1000 population over age of 60 years. PD is caused by inability of brain to produce dopamine, a neurotransmitter that affects the regulation of movement and our mood as well. The main motor symptoms of PD include slow movement, resting tremor, muscular rigidity, postural imbalance (Jankovic, 2008). The non-motor symptoms are found in majority of PD patients and consist of autonomic dysfunction, neuropsychiatric disturbance, sleep disorders and gastro-intestinal symptoms and many others (Chaudhuri et al., 2006). Clinic treatment with levodopa, the precursor of dopamine, provides only a symptomatic relief with limited time rather a cure. Long-term treatment with levodopa induces adverse effects such as motor fluctuation and dyskinesia within approximately 50% of patients with PD within 3-5 years following medication (Ahlskog & Muenster, 2001; Stocchi et al., 2008).

Acupuncture is one of the most popular types of complementary medicines because it has been reported to be very safe and well-tolerated treatment with only minor side effects (Shulman et al., 2002; Rabinstein & Shulman, 2003). Many patients with PD are reported using acupuncture as an alternative treatment at some points of their life. It has been estimated that more than a quarter of patients with PD in the United States (40%), Britain (38.7%), Singapore (61%) and Argentina (25.7%) have used at least one form of complementary medicine for PD, while 7-49% of them have used acupuncture as an alternative therapy (Rajendran et al., 2001; Tan et al., 2006; Pecci et al., 2010). Recently it has been reported that acupuncture treatment to patients with PD significantly improved the motor function of affected hand following acupuncture treatment (Shulman et al., 2002; Cristina et al., 2005; Eng et al., 2006). Here, we summarise recent development in acupuncture research of Parkinson's disease, in particular, focused on effects of acupuncture and its underline mechanisms on Parkinson's disease.

Potential mechanisms of acupuncture treatment in Parkinson's disease

Recent studies on Parkinson's models reported that acupuncture stimulation at the assigned acupoints protected dopaminergic neurones in the substantia nigra in the middle brain against toxic insults and restored dopamine expression in the striatum, a brain area playing a pivotal role in modulating movement (Park et al., 2003; Kim et al., 2005; Yu et al., 2010). Further, acupuncture stimulation enhanced motor function recovery in the PD models following acupuncture treatment (Park et al., 2003; Kim et al., 2005). This suggested that acupuncture has neuroprotective property helping dopaminergic neurons against toxic insults (Liang et al., 2002; Jia et al., 2009). More studies revealed that the effects of acupuncture-induced neuroprotection are mediated by stimulating expression of neurotrophic factors in the substantia nigra and striatum (Liang et al., 2002; Park et al., 2003). Acupuncture therapy slows cell death process by acting as antioxidant agent to protect dopamine neurones against oxidative stress-induced neuro-degeneration (Choi et al., 2009). In addition, acupuncture stimulation inhibited expression of inflammation markers in the relevant brain regions and enhanced its protective effects (Liu et al., 2004; Kang et al., 2007). Further, studies on neuronal activity of motor circuits in the brain reported that acupuncture rebalanced output of neuronal

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activity and improved behavioural functions in Parkinson's models (Jia et al., 2009; 2010). The results of those studies suggest that early application of acupuncture treatment to PD patients may be helpful in slowing down cell death process in Parkinson's disease.

Clinical study of acupuncture therapy for Parkinson's disease

Acupuncture is effective in alleviating PD symptoms

Acupuncture is an effective treatment for Parkinson's disease. Manual- or electro-acupuncture treatment reliefs both motor symptoms and many non-motor symptoms. There have been a few clinical studies of acupuncture therapy for Parkinson's in the past 15 years (Shulman et al., 2002; Cristina et al., 2005; Eng et al., 2006). Although the results are encourage but remain inconclusive due to many factors such as smaller number of patients recruited, study design with many flaws. Recently, a clinical study, aimed to investigate the efficacy of acupuncture as an alternative therapy for Parkinson's, was carried out, with 43 patients with PD, the largest number of patients recruited in a single study so far (Cho et al., 2012). The patients in the treatment group underwent acupuncture treatment twice a week for 8 weeks. The patients in control group did not receive any treatment. The results showed that the PD patients in treatment group experienced significantly greater improvement on the Unified Parkinson's disease rating scales (UPDRS), including total UPDRS scores and part III scores which assess individual's motor function such as rigidity, finger tapping, hand movements, arising from chair and gait etc (Cho et al., 2012). In addition, patients receiving acupuncture showed a significant improvement on Beck's Depression Inventory (BDI), an assessment about the depression. However, patients in control groups did not show any significant changes in both UPDRS and BDI assessments. Although the number of patients participated in this clinical study is still quite smaller compared the clinical studies of other subjects, its results are promising, indicating acupuncture treatment is effective in alleviating symptoms of patients with Parkinson's disease.

Combination of acupuncture and levodopa alleviates levodopa-induced adverse effects and reduces effective dose of levodopa in Parkinson's model

Since its introduction in the 1970s, levodopa has remained the most effective treatment for the motor symptoms of PD (Stocchi et al., 2008). However, as PD patients receive chronic treatment with levodopa they gradually develop two main clinical phenomena: fluctuation in motor response and a variety of involuntary movements, known as levodopa-induced dyskinesia (Bargiotas & Konitsiotis, 2013). The frequency of these motor complications has been estimated between 40-60%, after approximately 5 years of levodopa medication, but increase to 90% after 10 years of treatment (Ahlskog & Muenster, 2001; Stocchi et al., 2008). Those adverse effects of levodopa medication are often disturbing and have huge impact on quality of life of PD patients. In China, combination of acupuncture and levodopa is often used to treat patients with PD. Many clinical studies reported that combined treatment had better therapeutic effects than levodopa treatment alone. The combined treatment showed prolonged and better alleviation of motor symptoms and reduced the occurrence of motor complications, while reducing the effective dose of levodopa (Jiang et al., 2006; Chang et al., 2008; Sui et al., 2010).

Very recently a group of Korean scientists investigated the effects of combined acupuncture and levodopa on adverse effects of levodopa treatment on PD model (Kim et al., 2014). They reported that the combined treatment maintained a comparable improvement in motor function with half dosage (7.5mg/kg) of levodopa compared levodopa treatment alone group (15mg/kg), and a reduction in abnormal involuntary movement in PD model. Further they found that combination of acupuncture and levodopa diminished levodopa-induced changes in biomarkers of motor complications in the brain. Their findings confirmed the results of clinical studies in China (Jiang et al., 2006; Chang et al., 2008; Sui et al., 2010). Together, both preclinical and clinical studies suggest that acupuncture enhances the benefits of levodopa on motor function with reduced dose of levodopa and alleviates levodopa-induced motor complications by restoring neurochemical imbalance in the brain.

Acupuncture therapy for non-motor symptoms of Parkinson's disease

Non-motor symptoms (NMS) of Parkinson's disease (PD) are common but often are not well recognized in clinic practice due to the lack of spontaneous complaints from patients and of effective procedures of identification. NMS occurs throughout the course of the disease. Some of them, such as depression, fatigue and smelling dysfunction, may appear at the earliest stage of the disease in not treated patients. Others appear at the advanced stage of the disease. At the time of diagnosis, the prevalence of NMS among PD patients is 21% (pain, urinary symptoms, depression and anxiety) and goes up to 88% after 7 years disease progression (Shulman et al., 2001; O'Sullivan et al., 2008). NMS of PD ranges from autonomic dysfunction, neuropsychiatric disorders, sleep disturbance to gastrointestinal syndromes and many others and are under-treated (Chaudhuri et al., 2006). Indeed, non-motor aspects of PD have greater influence on quality of life and institutionalization rates, and healthcare cost (Chaudhuri et al., 2007). In general NMS of PD respond poorly if at all to dopaminergic treatment, indicating the involvement of other neurotransmitters besides the dopamine.

Acupuncture including manual and electro-acupuncture is effective in treating depression, anxiety, insomnia, pain, orthostasis, constipation, fatigue and vomiting. Studies about the mechanisms of acupuncture reported that acupuncture stimulation modulates the expression of neurotransmitters such as serotonin, glutamate and gammaaminobutyric acid etc in the brain (Longhurst & Tjen-A-Looi, 2013; Takahashi, 2013; Zhao, 2013).

Depression is one of the most common NMS in patients with PD. Patients with depression feel sad, anxiety, irritable and restless, and may lose interest in activities once enjoyable etc. The causes of depression in

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PD patients are not clear but the decreased levels of serotonergic and noradrenergic and dopaminergic neurotransmission in brain are implicated as relevant factors (Pilkington, 2013). In clinical studies, one of the prominent responses to acupuncture treatment in PD patients is the reported effect on depression (Shulman et al., 2002; Cristina et al., 2005; Eng et al., 2006). Many patients experienced great improvement in their symptoms and this is reflected on the results of Beck Depression Inventory, one of the most widely used instruments for measuring severity of depression, which showed a significant decrease in the scores in patients with acupuncture therapy compared with control treatment group (Shulman et al., 2002; Cristina et al., 2005; Eng et al., 2006). It has been reported that acupuncture stimulation caused activation of serotonergic neurons in the dorsal raphe neuclei in the midbrain leading to elevated levels of serotonin which is confirmed by neuroimaging studies (Pilkington, 2013).

So far the results from acupuncture studies in PD models suggest that acupuncture may act as neurotrophin release enhancer, anti-oxidant and anti-inflammation agents and the modulator of neuronal activity in the basal ganglia circuits which ultimately protects dopaminergic neurons against degenerative process and modulates the outcome of neuronal activity of basal ganglia circuit. Future studies needed to look other potential acupoints which modulate dopamine and other neurotransmitter transmissions in the basal ganglia to enhance the efficacy of acupuncture treatment. More importantly we need to explore the acupoints that improve motor function and enhance neurotrophic factors releasing to slow down dopaminergic degeneration in particular at the early stage of the disease. It is hopeful that translation of achievement in acupuncture research in animal models into clinical treatment of Parkinson's will maximise the effectiveness of acupuncture treatment.

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The Yin Yang of the Five Elements and their energetic relationships in relation to levels of consciousness

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Abstract: The Theories of Chinese Medicine have evolved over the centuries to reflect the increasing awareness of the natural world and the role human beings play within it. Comparing the Shang Han Lun Theory with the Pulse Position Theory and Anatomy, some discrepancies can be found regarding the Yin-Yang relationships between Kidney and Liver, Liver and Spleen, and Heart and Spleen. Analyzing the Five Element Zang Organs systematically, the order from most Yang to most Yin is Lung, Spleen, Heart, Liver, Kidney. The implication proposed is that a similar order exists in respect to the related levels of consciousness from Body, Intellect, Spirit, Soul, and Will.
Key words: Yin-Yang comparison of Five Elements, Order of levels of consciousness, comparing theories of TCM

Scholars, familiar with the various theories of Chinese Medicine, are aware of various discrepancies in the ancient theories, and how they were adjusted over the centuries to accommodate new and improved levels of awareness of the natural world. For example, prehistoric people were aware of the four seasons and directions, yet managed to implement a Five Element Theory by introducing the concept of the Middle and Late Summer. Having the Earth as the Center is a sophisticated leap towards recognizing the connection that human beings play in the consciousness link between heaven and earth. The fifth direction indicates that we have a choice of not only walking North, South, East or West, but also that we can remain in the center and do not walk at all. In contrast to this revolutionary idea, the introduction of a fifth season called Late Summer strikes me as somewhat arbitrary in particular in respect to the huge climatic variations that exist in a large country such as China.

Furthermore, it was quickly recognized that the time span called a day on earth has 24 hours, and can be subdivided into neat 12 two hour segments. A new theory of the Meridians tried to match this by postulating the existence of 12 regular acupuncture channels. This conveniently mapped the four limbs of the human being with 3 meridians on each aspect and even managed to incorporate aspects of the ancient Yin Yang Theory in a way that Yin Meridians would be on the inner aspect of the limb and the Yang Meridians on the outer aspects. Therefore, all the Fu Organ meridians of the Hand such as Large Intestine, San Jiao, and Small Intestine, and the Fu Organ meridians of the Foot such as Stomach, Gall Bladder and Bladder can be found on the lateral or outer aspects of those limbs. Similarly and in typical Yin Yang fashion, all the Zang Organ meridians of the Hand such as Lung, Pericardium, and Heart, and the Zang Organ meridians of the Foot such as Liver, Spleen and Kidney can all be found on the medial or inner aspects of those limbs.

Dividing the number of the 12 regular meridians, however, gives 6 Yin meridians and 6 Yang meridians. Apparently, the Five Element Theory avoided the problem of the fifth direction by introducing the Middle or Center direction, as discussed above. A much greater challenge posed the number 6 resulting from the 12 daily segments to the Five Element theorists. The introduction of the somewhat mysterious concepts of the Pericardium and the San Jiao seems to me as a less convincing attempt to square the circle. It tries to emphasize the importance of the Heart or Fire element in human existence by giving it double the time in the 24 hour clock with the Pericardium channel, and it elevates the nebulous idea of Qi with an overarching concept of the San Jiao or Triple Energizer neatly organized according to Yin and Yang with a Triple Energizer theory a few centuries later.

Zhang Zhong Jing in his Treatise on the Treatment of Diseases caused by Cold (Shang Han Lung) expanded on

this by organizing the 12 organs into a theory of disease progression from the outside inwards or from superficial and less dangerous to the deep and life threatening. He postulated that the Taiyang Meridians of Bladder and Small Intestine lie most superficial and guard against the invasion of outside pathogenic factors with the help of Wei Qi. The Yang Ming Meridians of Stomach and Large Intestine symbolize the ability of the antipathogenic qi to muster a strong defense by raising body temperature causing a fever in the patient. Zhang Zhong Jing further suggests the pivoting role of the ShaoYang Meridians of Gallbladder and San Jiao as being neither exterior nor interior completely.

This brilliant theorist of Chinese medicine further explained a similar structure to the Yin meridians representing the Zang organs. The TaiYin Meridians of Lung and Spleen seem to suggest the importance of air and food in the creation of post natal Qi. The Shao Yin meridians of Heart and Kidney recognize the important duality of fire and water in typical Yin Yang style. Finally, the Jue Yin or terminal Yin meridians of Liver and Pericardium represent the final or end stage of the disease progression in this famous textbook.

In the following analysis, I would like to build upon the theories of the Five Elements and the 12 regular Meridian channels and examine them in light of the much older theory of Yin and Yang. I would like to show a structure of conceptual levels of the 5 organs associated with the five elements and their related consciousness energies of Body, Intellect, Spirit, Soul and Will. In the process of this, I will disregard the Pericardium as the sixth Zang organ as well as all Fu organs. I will limit myself to the analysis of the Five Elements and their most directly related organs. For the purpose of simplicity, I will assume that the corporeal soul can be seen as the concept of body. Therefore, I will base my considerations on the theory that the Lung houses the bodily soul, or named Po in Chinese. In this essay I will call this simply body, yet recognizing additional explanations of what actually Po is. According to the same theory The Spleen houses the Intellect, or Yi in Chinese. The heart houses Spirit, or Shen; the liver houses the ethereal soul, or Hun in Chinese; and the kidney houses the Will, or Zhi. For simplicity, again, I will call the ethereal soul, simply soul in this essay.

In the analysis of Lung, Spleen, Heart, Liver and Kidney I will use the anatomical positions of those organs known in medicine, the order proposed by Zhang Zhong Jing in his famous text, and the pulse positions of those 5 organs. Underlying my considerations will be the theory of Yin and Ying in terms of external versus internal and upper versus lower comparisons. It will be shown that there are expected discrepancies and contradictions between these theories as it is often the case in the evolution of Chinese Medicine.

To establish some basic premises, the three parameters of Anatomy, Zhang Zhong Jing's theory, and the Pulse positions need to be briefly explained. In terms of anatomy, the lungs and the heart lie above the diaphragm, while the liver, spleen (pancreas), and kidneys lie below it. The lungs lie above and lateral to the heart, the spleen and liver lie above the kidneys. Spleen and Liver could be viewed as lying at somewhat equal height. Zhang Zhong Jing postulated that the lung and spleen (Taiyin) lie more superficial than the kidney and heart (Shaoyin) which in turn lie more superficial than the liver and pericardium (Jueyin). In terms of pulse reading, the left hand, containing heart, liver, and kidney yin pulses, is considered yin, while the right hand, containing lung, spleen, and kidney yang pulses, is considered yang.

The Lung is anatomically viewed the uppermost of those 5 organs, has the pulse position of most distal on the right wrist, and is part of the Taiyang concept by Zhang Zhong Jing. Comparing the lung element to the other 4 elements in terms of YinYang Theory, the following becomes apparent. The lung lies anatomically above all the others, can be found at the most distal (outer) pulse position of the right (yang) hand, and in Zhang Zhong Jing's theory is the hand (or upper) meridian of Taiyang, while the spleen is the foot (or lower) meridian of Taiyang. Therefore, the following table summarizes the relationship of yin versus yang of the lung element to the other 4 elements as seen in the three different theories.

Theories of TCM	Yin	Yang	Comments
Anatomy: Lung versus Spleen	Spleen	Lung	The lung lies above the diaphragm, the spleen below.
Anatomy: Lung versus Heart	Heart	Lung	Although both lie above the diaphragm, the lung reaches higher than the heart and surrounds it.
Anatomy: Lung versus Liver	Liver	Lung	The lung lies above the diaphragm, the liver below.
Anatomy: Lung versus Kidney	Kidney	Lung	The lung lies above the diaphragm, the kidney below.
Pulses: Lung versus Spleen	Spleen	Lung	Although both lie on the right (yang) wrist, the lung is more distal than the spleen.
Pulses: Lung versus Heart	Heart	Lung	The Lung lies on the right (yang) wrist, while the heart lies on the left (yin) wrist.
Pulses: Lung versus Liver	Liver	Lung	The Lung lies on the right (yang) wrist, while the liver lies on the left (yin) wrist.
Pulses: Lung versus Kidney	Kidney	Lung	The Lung lies on the right (yang) wrist, while the kidney yin lies on the left (yin) wrist, and the kidney yang lies more proximal (more yin) than the lung on the right (yang) wrist.
Meridians: Lung versus Spleen	Spleen	Lung	In Zhang Zhong Jing's theory, both are considered Taiyin, but

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			lung is hand Taiyin and therefore above spleen, which is foot Taiyin.
Meridians: Lung versus Heart	Heart	Lung	Heart as hand Shaoyin is considered more interior (yin) than lung as hand Taiyin.
Meridians: Lung versus Liver	Liver	Lung	Lung as hand Taiyin is more exterior (yang) than liver as foot Jueyin.
Meridians: Lung versus Kidney	Kidney	Lung	Lung as hand Taiyin is more exterior (yang) than kidney as foot Shaoyin.
Overall : Lung	0	12	Lung is most yang of all elements.

It can be seen, that all three theories agree, that the Lung is the outermost and uppermost of the five elements, and would therefore be considered the most yang.

By comparing the next element, the Spleen, it becomes apparent, that discrepancies appear among the theories of TCM. Although the Heart lies anatomically above the Spleen, and would be considered yang, in terms of the pulses the Heart is yin, because it is found on the left wrist, while the Spleen is on the right.

Theories of TCM	**Yin**	**Yang**	**Comments**
Anatomy: Lung versus Spleen	Spleen	Lung	The lung lies above the diaphragm, the spleen below.
Anatomy: Spleen versus Heart	Spleen	Heart	The heart lies above the diaphragm, the spleen below.
Anatomy: Spleen versus Liver	Spleen	Liver	The spleen lies on the left side, the liver on the right.
Anatomy: Spleen versus Kidney	Kidney	Spleen	The spleen lies above the kidneys.
Pulses: Lung versus Spleen	Spleen	Lung	Although both lie on the right (yang) wrist, the lung is more distal than the spleen.
Pulses: Spleen versus Heart	Heart	Spleen	The spleen lies on the right (yang) wrist, while the heart lies on the left (yin) wrist.
Pulses: Spleen versus Liver	Liver	Spleen	The spleen lies on the right (yang) wrist, while the liver lies on the left (yin) wrist.
Pulses: Spleen versus Kidney	Kidney	Spleen	The spleen lies on the right (yang) wrist, while the kidney yin lies on the left (yin) wrist, and the kidney yang lies more proximal (more yin) than the spleen on the right (yang) wrist.
Meridians: Lung versus Spleen	Spleen	Lung	In Zhang Zhong Jing's theory, both are considered Taiyin, but lung is hand Taiyin and therefore above spleen, which is foot Taiyin.
Meridians: Spleen versus Heart	Heart	Spleen	Heart as hand Shaoyin is considered more interior (yin) than spleen as foot Taiyin.
Meridians: Spleen versus Liver	Liver	Spleen	Spleen as foot Taiyin is more exterior (yang) than liver as foot Jueyin.
Meridians: Spleen versus Kidney	Kidney	Spleen	Spleen as foot Taiyin is more exterior (yang) than kidney as foot Shaoyin.
Overall : Spleen	5	7	Spleen is more yang than yin.

Similarly, for the Heart follows this analysis. Although Heart and Spleen have the same number of yin and yang points, 2 of the 3 theories agree that the Heart is yin in respect to the Spleen, because it can be found on the left (yin) wrist pulse, and Heart foot Shaoyin is considered deeper (more yin) than Spleen foot Taiyin.

Theories of TCM	**Yin**	**Yang**	**Comments**
Anatomy: Heart versus Spleen	Spleen	Heart	The heart lies above the diaphragm, the spleen below.
Anatomy: Lung versus Heart	Heart	Lung	Although both lie above the diaphragm, the lung reaches higher than the heart and surrounds it.
Anatomy: Heart versus Liver	Liver	Heart	The heart lies above the diaphragm, the liver below.
Anatomy: Heart versus Kidney	Kidney	Heart	The heart lies above the diaphragm, the kidney below.
Pulses: Heart versus Spleen	Heart	Spleen	The heart lies on the left (yin) wrist, while the spleen lies on the right (yang) wrist.

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Pulses: Lung versus Heart	Heart	Lung	The Lung lies on the right (yang) wrist, while the heart lies on the left (yin) wrist.
Pulses: Heart versus Liver	Liver	Heart	The heart lies more distal (yang) than the liver on the left wrist.
Pulses: Heart versus Kidney	Kidney	Heart	The heart lies more distal (yang) than the kidney on the left wrist.
Meridians: Heart versus Spleen	Heart	Spleen	Heart as hand Shaoyin is considered more interior (yin) than spleen as foot Taiyin.
Meridians: Lung versus Heart	Heart	Lung	Heart as hand Shaoyin is considered more interior (yin) than lung as hand Taiyin.
Meridians: Heart versus Liver	Liver	Heart	Heart as hand Shaoyin is more exterior (yang) than liver as foot Jueyin.
Meridians: Heart versus Kidney	Kidney	Heart	Heart as hand Shaoyin is above (yang) kidney as foot Shaoyin.
Overall : Heart	5	7	Heart is more yang than yin.

Similarly, for the Liver follows this analysis, showing that it is considered much more yin than yang among the theories. The interesting discrepancy here is that anatomically the Liver lies on the right (yang) side of the body and the Spleen on the left, while Zhang Zhong Jing's theory and the pulse positions clearly indicate that the Liver is more yin than the Spleen. The Liver is found on the left (yin) wrist, and the Spleen on the right. The Liver foot Jueyin is considered deeper (more yin) than the Spleen foot Taiyin.

Theories of TCM	**Yin**	**Yang**	**Comments**
Anatomy: Liver versus Spleen	Spleen	Liver	The liver lies on the right (yang) side of the body, the spleen on the left (yin).
Anatomy: Liver versus Heart	Liver	Heart	The heart lies above the diaphragm, the liver below.
Anatomy: Lung versus Liver	Liver	Lung	The lung lies above the diaphragm, the liver below.
Anatomy: Liver versus Kidney	Kidney	Liver	The liver lies above the kidneys.
Pulses: Liver versus Spleen	Liver	Spleen	The liver lies on the left (yin) pulse, while the spleen lies on the right (yang) pulse.
Pulses: Liver versus Heart	Liver	Heart	The liver lies more proximal (yin) than the heart on the left wrist.
Pulses: Lung versus Liver	Liver	Lung	The Lung lies on the right (yang) wrist, while the liver lies on the left (yin) wrist.
Pulses: Liver versus Kidney	Kidney	Liver	The liver lies more distal (yang) than the kidney yin pulse on the left wrist.
Meridians: Liver versus Spleen	Liver	Spleen	Liver as foot Jueyin is considered more interior (yin) than spleen as foot Taiyin.
Meridians: Liver versus Heart	Liver	Heart	Heart as hand Shaoyin is considered more exterior (yang) than liver as foot Jueyin.
Meridians: Lung versus Liver	Liver	Lung	Lung as hand Taiyin is more exterior (yang) than liver as foot Jueyin.
Meridians: Liver versus Kidney	Liver	Kidney	Liver as foot Jueyin is more interior (yin) than kidney as foot Shaoyin.
Overall : Liver	9	3	Liver is more yin than yang.

Similarly, for the Kidney follows this analysis. The interesting discrepancy here is that although anatomically the Liver lies above the Kidneys, and the Liver pulse is more proximal (yang) than the Kidney pulse, Zhang Zhong Jing postulates that the Liver foot Jueyin lies deeper than the Kidney foot Shaoyin. It is still clear, however, that the Kidney is the most yin of all the five elements.

Although the 3 analyzed theories of TCM agree in most yin-yang comparisons of the 5 element organs, they disagree in the comparison of Heart versus Spleen, Liver versus Spleen, and Liver versus Kidneys.

Theories of TCM	**Yin**	**Yang**	**Comments**

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Anatomy: Kidney versus Spleen	Kidney	Spleen	The spleen lies above the kidney.
Anatomy: Kidney versus Heart	Kidney	Heart	The heart lies above the diaphragm, the kidney below.
Anatomy: Kidney versus Liver	Kidney	Liver	The liver lies above the kidney.
Anatomy: Lung versus Kidney	Kidney	Lung	The lung lies above the diaphragm, the kidney below.
Pulses: Kidney versus Spleen	Kidney	Spleen	The kidney yang lies more proximal (yin) than the spleen on the right wrist.
Pulses: Kidney versus Heart	Kidney	Heart	The kidney yin lies more proximal (yin) than the heart on the left wrist.
Pulses: Kidney versus Liver	Kidney	Liver	The kidney yin lies more proximal (yin) than the liver on the left wrist.
Pulses: Lung versus Kidney	Kidney	Lung	The Lung lies on the right (yang) wrist, while the kidney yin lies on the left (yin) wrist, and the kidney yang lies more proximal (more yin) than the lung on the right (yang) wrist.
Meridians: Kidney versus Spleen	Kidney	Spleen	Kidney as foot Shaoyin is considered more interior than spleen as foot Taiyin.
Meridians: Kidney versus Heart	Kidney	Heart	Heart as hand (yang) Shaoyin is above kidney as foot Shaoyin.
Meridians: Kidney versus Liver	Liver	Kidney	Kidney as foot Shaoyin is more exterior (yang) than liver as foot Jueyin.
Meridians: Lung versus Kidney	Kidney	Lung	Lung as hand Taiyin is more exterior (yang) than kidney as foot Shaoyin.
Overall : Kidney	11	1	Kidney is most yin of all elements.

	Anatomy	**Pulse Position**	**Zhang's Meridians**
Heart versus Spleen	Heart yang, Spleen yin	Heart yin, Spleen yang	Heart yin, Spleen yang
Liver versus Spleen	Liver yang, Spleen yin	Liver yin, Spleen yang	Liver yin, Spleen yang
Liver versus Kidney	Liver yang, Kidney yin	Liver yang, Kidney yin	Liver yin, Kidney yang

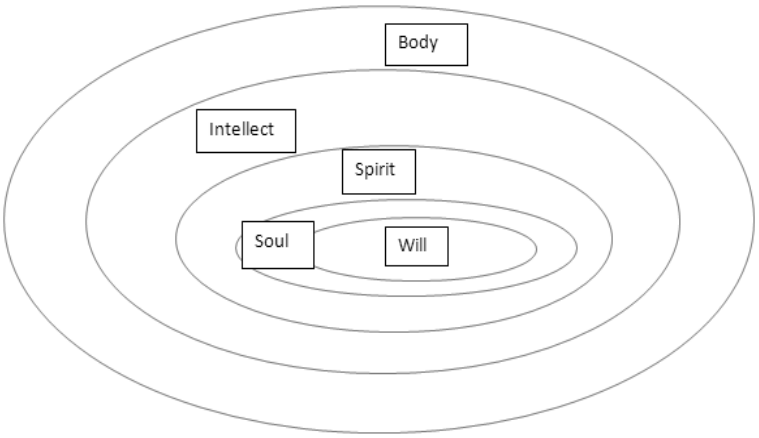
From the analysis, it can be concluded, that despite some discrepancies in the theories used to compare the 5 element organs in terms of yin and yang, the lungs are the most yang, and the kidneys are the most yin. The Liver is almost as yin as the Kidneys. The Spleen and the Heart are almost equal in terms of yin and yang, although a majority of theories postulates that the Heart is somewhat more yin than the Spleen.

Superimposing the theory of the related consciousness levels of Body (Po), Intellect (Yi), Spirit (Shen), Soul (Hun), and Will (Zhi), some interesting aspects are revealed. The Body (Lung) is the most yang or most exterior. The Will (Kidney) is the most yin or most interior. The soul (Liver) is almost as yin or interior as the Will. The Spirit (Heart) is pretty much on equal footing with the Intellect (Spleen), although some argument can be made that the Spirit is slightly more interior (yin) than the Intellect.

I propose therefore the following theory.

The Intellect or the thinking part of consciousness is closer related to the body (more exterior and yang), while the spirit or the feeling part of consciousness is closer related to the soul (more interior and yin). The body is the most superficial (yang) aspect of consciousness, while the will is the most deep (yin) aspect.

If those levels of consciousness can be thought of as yang contains yin, or outer levels contain inner levels, it would mean that the body contains the intellect (thinking) which contains the spirit (feeling) which contains the soul which contains the will. That is, when we become aware of levels of realities, we sense with our bodies first. When we think deeper, we understand more, but feelings of understanding come from deeper levels of consciousness still. Yet, deeper levels of awareness exist in the levels of the soul and the will, where the will can reach the deepest layers of existence.



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Current Opinion in Acupuncture on Stroke Rehabilitation

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Abstract: Disability rate is very high after stroke attack. Motor function deficits, aphasia, post stroke depression and urinary incontinence are very common conditions in post stroke patients. To maximise recovery from stroke, reduce disability, improve quality of life for post stroke patients, acupuncture is commonly used for stroke rehabilitation in China. Usually acupuncture is one of approaches in combined rehabilitation programmes. Current research from China also provided some evidences to support the effectiveness of acupuncture on post stroke complications. Acupuncture improved motor function and helped with aphasia recovery. Also acupuncture was reported to effectively treat post stroke depression and urinary incontinence which leads to better quality of life for post stroke patients. The mechanisms of acupuncture treatments include that first acupuncture increased brain network connectivity and increased brain network activity and second acupuncture improved blood supply to the brain.

Key words: Acupuncture, Stroke, Motor function deficits, aphasia, post stroke depression, urinary incontinence,

Stroke is a life threatening condition due to disturbance of blood supply to the brain. It is the leading cause of death and disability globally. The death rate following stroke is up to 37% depending on different countries [1]. Stroke is divided into two types: ischemic or hemorrhagic. Ischemic stroke is caused by either thrombosis (blood clotting) in the blood vessels of the brain or arterial embolism in which clot is formed in the blood vessel elsewhere and travelled to the blood vessel of the brain. As a result the affected brain region is damaged by lack of blood supply and is not working properly. Hemorrhagic stroke is caused by rupture of a blood vessel of the brain. The brain is damaged by compression of blood, loss of blood supply, toxic effect of blood, and the inflammation surrounding the bleeding area. For stroke survivors, brain damage leads to impairment of brain function causing physical and mental disabilities. Majority of stroke survivors experience motor function deficits linked with lowering quality of life. Aphasia is common if dominant hemisphere is affected. Post stroke depression is usual. In 2010 there were 33 million stroke survivors worldwide [1]. Functional recovery and improving quality of life remain challenging in the health care of post stroke patients. Stroke rehabilitation is aiming to achieve the maximal mental and physical function recovery. Most of the neurological function recovers during the first 3 to 6 months after stroke and there is still continuing progress of recovery for years after stroke [2].

Motor function deficits are a common problem in stroke survivors. Motor function is controlled by the frontal lobe of the brain. The motor function is damaged after stroke causing motor disability, weakness and spasticity which is unusual increased muscle tone. To improve motor functions many new rehabilitative techniques have been developed in recent years which include constraint-induced movement therapy, mental practice, mirror therapy, virtual reality, robotics and brain stimulation techniques. Acupuncture is widely used in stroke rehabilitation in China, though it is not broadly accepted in Western countries and the efficacy is still in debate. There are many clinical trials of acupuncture on stroke rehabilitation most of which were carried out in China. There are some promising results from these randomized controlled trials showing that acupuncture played a role in motor function recovery in patients with stroke.

Acupuncture helps recovery of motor function in post stroke patients by adding on the routine rehabilitation programme. For example, acupuncture points were prescribed at Taiyuan (LU 9), Zusanli (ST 36), Xuanzhong (GB 39), Waiguan (TE 5), Shousanli (LI 10), Quchi (LI 11) and Jianyu (LI 15). 4 weeks of daily acupuncture at these points significantly improved the upper limb pain, the systematic motor function of the upper limbs, the nerve function defect, nailfold microcirculation compared with that before the treatments [3]. Acupuncture had better effects on motor function recovery compared with that for routine rehabilitation only [3]. Adding acupuncture on the routine rehabilitation also helps reduce limb spasticity. Tong et al studied the effect of acupuncture on spasticity in post stroke patients. They added acupuncture on routine rehabilitation and found that two course of 10 acupuncture treatments significantly improved motor function and reduced spasticity in post stroke patients with spasmodic hemiplegia [4] . Also a study has shown that acupuncture alone can improve spasticity in post stroke patients. For this purpose four acupoints at Neiguan (PC6), Shaohai (HT3), Zeqian (Ex-UE, A32), and Shounizhu (EX-UE), were selected near the motor points of the muscles for elbow flexion, forearm pronation, and finger flexion. After 6 weeks of acupuncture treatments muscle reaction (R1), passive range of motion (R2), and dynamic component (R2-R1) which is used to evaluate the joint spasticity for elbow joint was improved significantly [5]. Adding acupuncture on a routine stroke rehabilitation programme achieved equivalent improvement as adding massage on a routine stroke rehabilitation programme in the aspects of limb motor function, the independent activity of life, the activity of daily life and the quality of life [6].

Within the brain there is wide range of network connectivity between different brain regions. This network connectivity of patients with stroke was weakened and different brain regions lost interactions with each other compared with that of healthy subjects. There was less communication between different brain

regions during motor task. A recent study with fMRI scan has shown that acupuncture at Yanglinquan GB34 enhanced the brain network connectivity between different regions in the brain in post stroke patients with hemiparesis. Consequently, this could contribute to improvement of movement coordination and motor learning in post stroke patients [7]. In patients with left hemiplegia in stroke recovery, needling at Yanglinquan GB34 acupoints induced passive finger movement. fMRI scan has shown that motor sensory cortex on the right side was activated in these patients and brain acitivity was increased significantly [8]. Increasing brain network connectivity and increasing brain activities could be the mechanisms of the effect of acupuncture on motor recovery after stroke. Animal experiments have suggested that acupuncture improved cerebral blood flow and reduced moderate ischemic injury [9].

Aphasia is a condition in which language skill is impaired and patients with aphasia cannot use or comprehend language as they used to. Stroke is a leading cause of aphasia which could affect up to about 30% stroke survivors. The symptoms of aphasia include that patient has difficulty to speak, understand language, read, write or use numbers and calculate etc. Acupuncture is also widely used in this condition to shorten recovery time and maximise the degree of recovery of post stroke aphasia in China. Clinical research on post stroke aphasia developed in China from early stage of case study to recent clinical randomised controlled trials. Sun et al analysed 104 research studies on post stroke aphasia and the results were encouraging. Some controlled clinical studies with subjective measurements and large sample size have shown positive therapeutic effects of acupuncture on post stroke aphasia. To achieve best outcome, selection of acupoints was important. The ten most frequently used acupoints for aphasia were Lianquan (RN 23), Jinjin (EX-HN 12), Yuye (EX-HN 13), Tongli (HT 5), Fengchi (GB 20), Neiguan (PC 6), Baihui (DU 20), No. 1, 2 and 3 language sections, Sanyinjiao (SP 6) and Yamen (DU 15). Styles of acupuncture were various including tongue, scalp, body and combination acupuncture. Acupuncture was recommended as an adjunct therapeutic approach to language training programme for patients with post stroke aphasia [10].

There were a few possible mechanisms of acupuncture on post stroke aphasia. First, acupuncture increased cortical blood flow, improved cortical oxygen supply, provided brain cells with good nutrients and took away toxin from brain cells. Second, acupuncture facilitated re-establishing cortical blood circulation and neural connections. Third, acupuncture improved blood viscosity. At last acupuncture accelerated processing external signals in the brain and enhanced brain network connectivity [10].

Post stroke depression can affect quality of life and have negative impacts on functional recovery in patients with stroke. Antidepressants can be used for the treatments, but there are many side effects which may be unbearable for post stroke patients. Recently acupuncture was recognised as a possible effective treatment option for post stroke depression and much research had been done in this aspect. Zhang et al analysed 15 clinical randomised controlled trials of acupuncture on post stroke depression. In these trials there were 1096 patients aged 38-79 with post stroke depression involved. The effect of acupuncture was compared with Western medicine used in the studies. It indicated that acupuncture had better curative rate than Western medicine such as fluoxetine hydrochloride used in the particular researches [11].

Post stroke urinary incontinence is a common problem that can affect over 30% of post stroke patients [12]. Medications and application of catheter are commonly used to manage this condition. Acupuncture was reported effective in treating post stroke urinary incontinence. Song et al conducted a clinical trial which was involved in 136 post stroke urinary incontinence cases. These patients were treated with acupuncture [13]. After 4 weeks of acupuncture treatments, the interval of urination, nocturia frequency, urination difficulty, urinary incontinence severity, bladder capacity and patients' satisfaction were all significantly improved. The efficacy for acupuncture was better than that for indwelling catheter (68 cases). Another study was conducted by Chu et al. This study was involved in 111 post stroke urinary incontinence patients and the effect of acupuncture was compared with medications control including calcium ion antagon, angiotensin-converting enzyme inhibitor, angiotensin II receptor antagonist, compound thromb-clearing agent [14]. These patients were allocated into two groups acupuncture group 56 cases and control group 55 cases. Frequency of urination, urgency of urination and urinary incontinence were measured. 7.1% patients were cured in acupuncture group compared with 0 in control group. Effectiveness rate was 62.5% for acupuncture group compared with 36.4% for control group. The infection rate for acupuncture group was much lower than that for control group.

Due to improved diagnosis techniques and advanced medical treatments, stroke surviving rates have increased [1]. Post stroke medical care, reducing disability and improving patient's quality of life are very important in stroke rehabilitation. Current research shed a light on the effectiveness of acupuncture on stroke recovery. Acupuncture could potentially be a treatment option on stroke rehabilitation, though there are more high quality of clinical trials and evidences needed to support the application.

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History in Brief: the Introduction of Chinese Acupuncture to Britain – From Scepticism to Acceptance

Kan-Wen Ma

Acupuncture was a popular traditional therapy in China when it was introduced to neighbouring countries such as Korea and Japan in the 6th century AD. Later, in the 17th century, acupuncture was discovered and described by surgeons working with the Dutch East India Company, who then brought this information to the West. The earliest such reference is by the Dane Jacob de Bondt who, in the last chapter from his *Historia Naturalis et Medica India Orientalis* (1958) entitled "Certain miraculous works of Nature which future medical researchers must investigate further", mentioned the miraculous cure resulting from acupuncture in the treatment of chronic head pain that he witnessed in Japan. This was followed by a more detailed description of acupuncture by William ten Rhine, a Dutch medical officer of the East India Company in Deshima, Japan, in his work *Dissertatio de Arthritide* (1863), which is considered the first detailed work on acupuncture in the West. Engelbert Kaempter, a German naturalist and qualified doctor of medicine, who worked for the Dutch East India Company also observed the practice of acupuncture in Deshima. In his work *Amoenitaltum Exoticarum*, he gave an excellent description of acupuncture in the treatment of illnesses such as arthritis. Both ten Rhine and Kaempter remarked on the gentle character of acupuncture in comparison with the drastic therapeutic measures of the day in the West such as bleeding, purging, actual cautery and similar procedures.

However, despite these encouraging eye-witness accounts and the actual introduction of acupuncture to European medicine by the likes of Bondit, ten Rhine and Kaempter, very little attention was paid to this therapy in Europe until the end of the 18th century.

In Britain the negative descriptions of Chinese physicians' practice of acupuncture by Western travellers contributed to a reluctance to adopt it. For example, Sir John Staunton, a member of the first British official delegation to the Chinese Empire headed by George Macartney in 1793, described acupuncture as a method which caused exquisite pains and suffering to the patient.

The end of the 18th and the beginning of the 19th century saw changing attitudes to acupuncture in major European countries. Credit for the first clinical use of acupuncture in Europe might be given to the French physician L.V.J. Berlioz who published reports for treating gastralgia, whooping cough, contusion, febrile headaches, severe muscle aches, pains and other conditions with good results. This was followed by accounts by other French doctors in the use of acupuncture for other kinds of diseases including asthma, various forms of paralysis, rheumatism and arthritis with good effect. Here the emphasis was very much on analgesic effects, including the relief of facial neuralgia and other conditions of intractable pain as well as the treatment of sciatica and arthritis. Furthermore, acupuncture was quickly adopted by Cloquet and Sarlandiere in French hospital clinics. Similarly there were clinical reports of acupuncture in Italy, Germany and other parts of Europe.

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Britain followed this trend in the first half of the 19th century. Acupuncture was even familiar to a country general practitioner like Coley who reported in 1802 on the performance of paracentesis on an infant with tympanites. Other reports were provided by James Morss Churchill, who published articles and two books describing his clinical experience with acupuncture. His achievements were chiefly on the treatment of rheumatic conditions, sciatica, back pain, muscle strains and the like. He also had good results in treating dropsical states, oedema, anasarca and similar conditions.

Thus, as a result of its clinical efficacy, from the 19th century onwards acupuncture gradually became a popular therapy in Britain; however attitudes towards it varied, particularly within the medical establishment. Some were sceptical or even scornful, some were objective and positive.

British medical journals at first resisted publishing reports of acupuncture, because most British doctors, especially those in China, viewed it as quackery. For example, acupuncture was described in The Diseases of China by the American medical missionary W. Hamilton Jefferys and his British co-author James L. Maxwell as "the deadly acupuncture needle, which is the favourable Chinese instrument of professional torture."

Things changed from the early 20th century onwards and it is gratifying to see that within British medicine more positive attitudes arose that were based on rational reasoning and practical experience. In the China Medical Journal published in 1916 and edited by the China Medical Missionary Association there was an article written by Dr. James Cantlie, an eminent British physician entitled "Needling Painful Spots as Practised by the Chinese". The article starts by saying:

"From the immemorial the Chinese have practised 'needling' the body for the relief of pain, of swelling, of stiffness, and the treatment of many ailments. The practice has become with them an art – an exact science, in fact, if the term science can be applied to such a proceeding.

The model of the human body in brass, with its many indicated puncture points, is a well-known feature of wonder to the northern Chinese, and the pictures of the model are met with throughout the Empire.

To each one of the hundreds of puncture points indicated in the model a curative effect is attached, and the modern student of surface anatomy may well stand aghast when asked to interpret the several structures any particular puncture might traverse when pushed deeply; and the clinician will be puzzled to explain the possible effect likely to be produced thereby. We may and do say: 'There is something in it'; but we seldom if ever venture to practise it, except occasionally in an experimental and tentative fashion, as, for instance, by placing an electric needle in the sciatic nerve."

Dr Cantlie said that he was very impressed by the use of "needling" for many ailments, such as rheumatic pains in the gluteal region and in the neighbourhood of the hip-joint when the pain was not relieved in any other way, and also for lumbago due to injury or rheumatism and the like. He concluded his article by saying:

"The benefit of this treatment was apparent, and its repetition still further continued to do good, this short account of 'needling' may serve to bring up for discussion a practice which has tradition – that is, experience – for its justification; and there can be no doubt that as a rational treatment it has much to recommend it".

Dr Cantlie's article was published in parallel with an editorial entitled "Chinese Medicine and Surgery" in the same issue of the journal, which commented that Dr Cantlie's interesting paper was a plea based on sound reasoning for the increased use of acupuncture in certain well-defined conditions.

Moving on, acupuncture continued to hold its ground in Britain. In the 1970s there was a new wave of acupuncture in Britain triggered by the eye-witness reports of American doctors visiting Beijing of the use of acupuncture as analgesia for surgical operations, including major operations like open-heart surgery. This boosted the popularity of acupuncture in the West, which was furthered by experimental research on endogenous peptides. In Britain, the British Medical Acupuncture Society was founded in 1980, which was followed shortly afterwards by the appearance of its journal Acupuncture in Medicine. Consequently practitioner numbers grew in the UK. Several acupuncture organisations have been established and acupuncture training courses have been set up, and significant numbers of British doctors have been to China to learn to practise. Estimates suggest that there are several thousand acupuncture practitioners in Britain who can be broadly divided into two types. One consists of those who adhere to the traditional Chinese medical model of needle insertion and selection of acupuncture points based on diagnostic methods and disease classification in accordance with traditional Chinese medicine principles and theories. These include those who were trained in China and graduates from a five or six year traditional Chinese medicine course in a university or college. The other consists of doctors trained in conventional medicine who adopt a modified version of acupuncture based on the understanding of neurophysiology and anatomy rather than fundamental traditional Chinese theories such as Yin and Yang, Qi, Channels and Collaterals in the clinical application and interpretation of the effects of acupuncture.

Either way, acupuncture has been accepted in some parts of the British National Health Service, which is a good illustration of how it has been recognised and appreciated in this country, two centuries after it was first introduced, and despite consistent scorn and scepticism.

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对孙真人《养生铭》的现代诠释

温长路

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在我国医学发展史上，孙思邈可谓一位集众多学说之大成者，除了传统意义上的医学理论和实践外，把养生防病纳入人类的健康大系，并使他成为具有理论与实际一体的特色医学，不能不说是孙氏的一大功劳。孙思邈一生对养生问题有过许多精辟的论述，并在《千金方》和《千金翼方》中两次作过专门总结，这是有典可据的。除此以外，有关孙思邈的养生著述以诗歌为载体在民间流行的内容也甚多、甚广，《养生铭》就是其中的一首。此文收于《全唐书》和后人整理的孙氏的《摄生咏》中，也有称为《保生铭》和《孙真人铭》的。宋代温革的《琐碎录》和 14 世纪朝鲜出版的《医方类聚》及日本的相关著作中也都有反映。这些版本在文字上虽然有些出入，但其基本内容是一致的。陕西耀县的药王山上，也保存有这首诗的石刻件，还不时被中外游人转抄和效法。其诗全文如下：

怒甚偏伤气，思多太损神。神疲心易疫，气弱病相因。
勿使悲欢极，当令饮食均。再三防夜醉，第一戒晨嗔。
亥寝鸣云鼓，寅兴漱玉津。妖邪难犯己，精气自全身。
若要无诸病，常当节五辛。安神宜悦乐，惜气保和纯。
寿夭休命论，修行本在人。若能遵此理，平地可朝真。

时过境迁，从公元 6 世纪至今，历史的隧道已经向前穿越了 15 个轮回，科学已经发展到了人类从地面走向太空的时代，膏粱厚味之外，琳琅满目的各色保健品足以让人眼花缭乱，孙氏的这些原则还能够适应今人的养生需要吗？这是需要科学者正面回答的问题，也正是本文要用现代观点诠释孙真人《养生铭》的立意所在，相信事实会给人们一个有说服力的答案。

为了方便叙述，本文将孙真人的这首诗分为五段进行剖析，每两句为一节，先从第一节说起。

1. 怒甚偏伤气，思多太损神。神疲心易疫，气弱病相因

这一节总体上是讲精神养生的，怒之所伤，肝气也；思之所伤，脾胃之气也；喜之所伤，心气也。气乃肺、肾所主，神依气血所存，正气损伤，岂不心“疫”、病“因”吗！对于此，孙思邈在他的《千金方》中曾引用魏晋时期养生学家嵇康的话说：“养生有五难，名利不去为一难（实乃最大的心病），喜怒不除为二难，声色不去为三难（确为耗心神、伤肾气之大虑），滋味不绝为四难（吃也是非常费脑筋的活），神虑精散为五难。五者必存，虽心希难老，口诵至言，咀嚼英华，呼吸太阳，不能不回其操、不夭其年也。五者无于胸中，则信顺日跻，道德日全，不祈善而有福，不求寿而自延，此养生之大旨也。”在孙氏反复论证的这段话中，重点强调的都是情志对养生的决定性作用。

就孙氏诗中所说之怒伤肝言，它是人情志受损的一种表现。《黄帝内经》中有明确地论述：“大怒则形气绝，而血菀（涌）于上。”（《素问•生气通天论》）“怒则气逆，甚则呕血及飧泄。”（《素问•举痛论》）也就是说，怒因气生，气则怒发，生气——发怒——生气，构成了一条恶性循环链。正如《淮南子》所言：“人之性，有所侵犯则怒，怒则血充，血充则气激，气激则发怒”。唐代诗人白居易在他在一首制怒诗中也阐明了雷同的观点：“自知气发每因情，情在何由气得平，若问病根深与浅，此身应与病齐生”。

怒气大发，相应的疾病就会因之而生，受害最直接的是肝胆系统。因怒导致的机体的气血逆乱，会使人出现头痛、目胀、面红、耳赤、呕血、憋气等症状。甚则使人昏厥卒倒，因此致死者也不罕见。《三国演义》中诸葛亮三气周瑜的故事，就是一个典型的案例：血气方刚的周瑜性情急躁，容易发怒。深谙心理学的诸葛亮故意用计让他动气，结果没有用真枪实弹就放倒了这位年仅 36 岁的英雄汉。临床上遇到的因突然动怒而导致血压升高、不省人事，甚至发生脑溢血死亡的病例，在国内外媒体上都不时有过报道。“气是杀人贼”，老百姓的说法一语道破了生气对人类健康的严重危害。

美国医学专家的一项调查说，一个人经常发怒或心身承受的压力太大，机体会分泌出一种代谢类固醇——皮质醇，它会直接损害人的记忆力和对事物的专注力。不良情绪还会增加胃中盐酸的流量，影响人的食欲，使人发生胃痛、恶心，甚至导致溃疡病的发生。发怒和绝望的情绪是造成血压升高的主要原因，引起血管收缩，导致舒张压明显上升。芬兰科学家的研究证实了这一点，他们对 616 名男性对象的调查发现，每发一次怒或绝望值增加 1 分，高血压的危险性就增加 16%。而高血压又可成为新的病因，引发其他更严重的疾病发生。癌症的发生也与经常发怒有直接联系，有统计证实，癌症患者中易发怒的人明显高于性格温和的人。

再说孙氏诗中说的思伤神，神指的是人的精神意识，是人类区别于其它动物、独具聪明智慧表现的主要指征之一。神志的主宰者是心，《灵枢•大惑论》中有“心者，神之舍也”的话。思为心所主，《孟子•告子上》中有“心之官则思”的话。心的主神、主思功能处于正常状态，人就表现出聪明、理智、敏捷、灵活，健康长寿的机会相对就多；反之，人就会表现出愚笨、粗鲁、迟钝、固执，疾病和灾难的发生率相对就要高些。实践证明，大凡有雄心壮志的人、聪颖灵透的人、豁达大度的人、善于处世的人，都是有“心计”的；而那些碌碌无为、傻头笨脑、鸡肠小肚、无朋无友的人，或多或少都缺了点“心眼”。很显然，心的这些功能里，包括了大脑的某些功能。把心与脑的部分功能混而谈之，不能片面

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地归结为古人认识上的局限性，重要的是如何透过这一现象去认真挖掘其中存在的必然性联系。在现代临床上，一些心脑疾患在发病机制上表现出的相关性和对心脑疾病同治收到的理想效果，越来越使人们认识到心与脑关系的不可分割性和中医认识的科学性。

在心境平和的状态下，充足的心血供应和灵活的神志发挥，使人的五脏六腑处于平稳运行中，人体这个小天地保持着相对平衡的环境，疾病就很少发生。一旦人的这种平和心境被打破，心理因素造成的机体失衡状态立即就会发生了。各种不平静因素形成的兴奋灶不时成为人思维中的优势中心，并不断通过大脑皮层的作用操纵植物神经系统和内分泌系统发挥作用，使人生出多种疾病来。有人对应考的高中毕业生进行了胆固醇浓度变化的系统测定，发现在高考前一年的平静状态下，其浓度处于最低值；在备考的一年中，处于不断升高的变值；在参加高考的前夜，达到最高值；然后，又逐渐下降。日常生活中这样的例子也不少见，当一个人心情不好时，常表现出山珍海味也难下咽、暖床柔被也难入睡、幽默逗笑也难开心等现象，由此引发的疾病就在所难免了。糟糕的心境轻则使人食欲减退、大便紊乱、月经不调、头痛眩晕、心慌汗出、失眠健忘，重则形成神经官能症、胃及十二指肠溃疡、慢性结肠炎、高血压病、血管硬化症等疾病，其后果是不堪设想的。

对于这些由于心境不好造成的疾病，药物治疗是很难奏效的，最好还是通过心理疗法。《黄帝内经》对这一问颇具高见，在它的第一篇《上古天真论》中就为人们开出了“恬淡虚无，真气从之，精神内守，病安从来”的心理处方，让人们用平常心看待平常事，进而达到体健不病或少病的目的。

2. 勿使悲欢极，当令饮食均。再三防夜醉，第一戒晨嗔

在这一节所谈的内容中，孙氏既说到了在上节中未说尽的情志因素“悲欢极”，又进一步强调了怒的危害，提出了“戒晨嗔”的告诫。可以肯定地说，这些都是符合科学道理的至理明言。“人有五脏化五气，以生喜怒悲恐惊。”(《素问•阴阳应象大论》) 情志为病多多，这里不再多费笔墨去全面论述它。而孙氏提出的另外两个问题“饮食均”和“防夜醉”的问题，倒是需要我们重点加以论述一下的。

何谓“饮食均”？狭义地讲，就是饮食要合理。广义上说，是包括衣食住行在内的全方位科学。关于这一点，孙思邈在他的《千金方》和《千金翼方》中都有过相应的说法。如说到穿衣，孙氏说：“衣服但粗缦，可御寒暑而已，第一勤洗浣，以香霑之。”“湿衣及汗衣，皆不可久着，令人发疮及风瘙。大汗能易衣佳，不易者急洗之，不尔令小便不利。凡大汗勿偏脱衣，喜得偏风、半身不遂。春天不可薄衣，令人伤寒、霍乱、食不消”等。其义非常明确，衣料是棉织的好，勤洗换是卫生的基本要求，在衣物上用点芳香之品对机体有利，汗出时要及时换衣、防止受风吹，春天的棉衣不能脱得过早，衣服不卫生或穿着不科学是许多疾病发生的根源，这里孙氏所说的内容与现代人们追求的穿要纯棉，勤洗勤换，以香料辟汗、杀菌及出汗时不要马上对着电扇、空调纳凉，春捂秋冻等穿着上的习惯有何两样？说到住处，孙氏说：“山林深远，固为佳境。”“背山临水，气候高爽。”“居处不得绮靡华丽，令人贪，目禁无厌，乃患害之源。”“衣食寝处，皆适能顺时气者，始尽养生之道”等。智者爱山，仁者爱水，孙氏所倡，与现代人提出的居住要环境优雅、污染少、空气负粒子多、回归自然的标准如同出一辙。

孙氏对饮食与养生的关系论述最多，也颇为精辟。如“勿使脯肉丰盈，常令约俭为佳”，说的是“食宜俭”，荤食不可少，但要少而精；“所有资身，在药菜而已。料理如法，殊益于人”，说的是“食宜素”，“菹酱而已，其人少病而寿”；“若得肉，必须新鲜，似有气息，则不宜食”，说的是“食宜鲜”，食用新鲜食物的营养、不新鲜食物的危害尽都说到了；“若贪味伤多，人肠胃皮薄，多则不消，彭亨短气，必致霍乱”，说的是“食忌过量”，暴饮暴食或过食肥腻必然伤及脾胃，出现病变；“鱼脍、生菜、生肉、腥冷物多损于人，宜常断之”，说的是“食忌生冷”，背逆季节、背逆正常吃法，一味吃生、吃冷是有害身体健康的；“咸则伤筋，酢（醋，可引申为酸味）则伤骨，故每学淡食”，说的是“食忌咸酸”，口味偏嗜都是对机体有害的，要养成以淡味为主的生活习惯。凡此等等，无法将孙思邈对饮食科学的论述逐一进行列举，仅透过以上说的“三宜”、“三忌”，不也足可以反映出他说的“饮食均”的广泛含义了吗？

大家知道，机体需要包括蛋白质、脂肪、碳水化合物、维生素、矿物质、水和纤维素在内的多种营养物质，这些物质都是通过广义的“饭”——饮食物获得的，它们包括粮食、蔬菜、肉类、豆类、蛋类、奶类、鱼类等食品。在通常情况下，一般性食物在胃里只能停留 3～5 小时，高脂肪的肉类、油炸食物可能稍长一些，但最多在 6 个小时内排空。此时，胃就开始收缩，饥饿感随之也就产生了。正常的进食时间大体在 4～5 小时之间，一日三餐是比较科学的饮食模式。长时间饥饿，会引起对胃粘膜的恶性刺激，影响胃的正常收缩功能，造成胃的病变，有可能导致胃痛、胃炎、胃溃疡、胃癌等疾病的发生。如累及到肠、胆、肝、脾、胰等整个消化系统，发生的疾病会更多、更严重。一次性进食过多或过食鱼香肉美的油腻性食物，会加重胃肠的负担，造成消化过程的速度加快、质量下降，消化不良、急性胃肠炎、胰腺炎、胆囊炎、泄泻、痛风等疾病都有随时发生的可能。还会使胃在短时间内极度膨胀，导致急性胃扩张的出现，极有丧命的危险。有调查认为，50%以上的胃肠病患者与不良进食习惯有关，其中主要的就是时饥时饱和暴饮暴食。过食生冷和饮食不洁造成的危害显而易见，这里就不再陈述。

主副搭配，以主为主；荤素搭配，以素为主，是中国人在长期生活实践中总结出的科学饮食规则，也是孙思邈反复强调的养生法则，与《黄帝内经》中提出的“五谷为养，五果为助，五畜为益，五菜为充，气味合而服之，以补精益气”(《灵枢•五味》) 的原则一脉相承，与现代研究得出的结论是完全一致的。素食的构成主要是指粮食、蔬菜、水果、豆制品类，它们含有丰富的维生素、不饱和脂肪酸、纤维素、果胶和微量元素，具有增强对肠蠕动的良性刺激、促使机体排毒过程的顺利进行和卵磷质的充分合成、胆固醇的正常代谢等作用。以素食为主确实具有减少血管硬化、净化血液、调整血脂和降低胆固醇、避免机体中毒的效果，从而使人们

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从中获得健康。但素食中缺乏含高热值的营养素——脂肪，它的缺乏和不足会严重影响人体的正常生长发育。从导致性激素含量降低、影响性器官成熟开始，就为人的低质量种下了祸根。同时，也影响蛋白质、维生素和其他营养物质的代谢、吸收和利用，使机体无法得到充足的养分。如人体中的铁质有 80%来自肉类和蛋黄，钙质 80%来自奶类食品，它们都属于荤食的内容。孙思邈非常重视这类食物的摄入，指出：“鱼酪酥等，常食之令人有筋力胆干，肌体润泽。”“牛奶性平，补血脉，益心长肌肉，令人身体康健，润泽，面目光锐，志气不衰。故为人子者，须供之以常食。”“此物胜肉远矣。”看来，提倡食素为主又同时适量配以荤食的思想是中医所倡导的一贯饮食模式。说白了，荤食长期摄入不足，人就不可能长出健壮的身体来。因此，必须保持荤食在饮食结构中的适当位置，使膳食中脂肪的含量控制在总热量的 25%左右，以维护机体运转的正常需要。权衡利弊，科学家们的结论性建议是：在合理安排好素食与荤食比例的前提下，限制荤食的摄入量是必要的，鸡鸭鱼肉之类的动物性食品不仅含的脂肪多、胆固醇高，而且大都属于酸性食物，食用过多势必会导致机体肥胖，增加血管负担，使血液中的胆固醇增高、血液粘稠度增大，从而导致高血压、冠心病一类的疾病发生。同时，会因血液酸碱度的改变，导致胃肠和肾脏的功能受损，使大量的氨基酸在腐败分解过程中产生的毒素危害机体，造成人的疾病和短命。按照近期编制的《中国居民膳食指南》中建议的标准，营养全面的饮食比例是，每个成人每天应进食谷类食物 300～500 克、蔬菜 400～500 克、水果 100～200 克、鱼虾类 50 克、畜禽肉类 50～100 克、蛋类 25～50 克、奶类及奶制品 100 克、豆类及豆制品 50 克、油脂类 25 克。我们在研究孙思邈养生思想之际，不妨把它再特色化一些。

孙氏诗中提出的“防夜醉”的观点，也是非常具有科学道理的经验之谈。醉酒就是酒精中毒，对人体的毒副作用是人所共知的。明代医学家李时珍认真领会了孙思邈的思想，在他的《本草纲目》中一口气列举出了醉酒使人表里为病的 15 大“罪状”：“或呕吐，或自汗，或疮疥，或鼻鼾，或泄利，或心脾痛，尚可散而去之。其久也病深，或消渴，或内疽，或肺痿，或鼓胀，或失明，或哮喘，或劳瘵，或癫痫，或痔漏，难名之病”。为了加深人们的印象，李氏还特意在书中写进了一则实例：过去有个叫周顗的人，非常好客。有一晚他家来了一位朋友，他拿出两石美酒招待，结果把这位朋友灌得酩酊大醉。第二天早上一看，这位朋友“已胁穿而死矣”。无独有偶，梁章钜在《归田琐记》中也记述了醉酒致死人的故事：清•嘉庆年间，两江总督协办大学士松筠，与负责河务的官员费淳聚饮，其副将“陪酒”，三人全部醉倒。那“副将昨夜回署，即不言动，今晨已奄逝”。

上述两则饮酒夜醉导致死人的故事，与孙思邈提出的“防夜醉”的观点存在着必然的联系，或者说是对孙思邈“防夜醉”理论的有力证明。这是因为，一、夜晚醉酒会造成对睡眠的直接影响，给机体健康带来危害，有可能诱发多种病变；二、夜晚是男女兴房事最多的时段，酒后又容易引起兴奋，而醉酒后进行房事既有损于男性正气，又会给未来胎儿的形成埋下隐患，因此得畸形儿、痴呆儿者屡见不鲜。三、更重要的是，夜晚人的机能活动状态处于相对平静的弱势，器官新陈代谢的速度放慢，酒精进入人体后更不容易挥发，使人中毒的程度会相应加重，死亡的几率自然会随之增大。

现代研究指出，醉酒对消化系统的伤害是首当其冲的，对心血管系统、中枢神经系统、呼吸系统、生殖系统和骨骼、运动系统的危害也相当严重，是最终导致人生病、短命、死亡的原因之一。从许多疾病发病原因的调查中看，酗酒者的发病率明显高于不饮酒者或有节制的少量饮酒者。

当然，用辩证的观点看，把酒说得一无是处也是不公正的。客观地说，酒具有扩张皮肤血管、增加胃液分泌、杀灭病菌和加速热挥发的作用，并且能释放出一定热量，以加强机体的新陈代谢。除了作为药物直接被运用之外，酒还经常进入复方或作为辅料与其它药物一起，共同参与对多种疾病的治疗。酒与药的这种有机结合，起码有五个方面的作用：一、改变药性，引药归经；二、增强温补肝肾的作用；三、增强活血通络的作用；四、矫正药物的不良气味，降低药物的毒副作用；五、增加药物有效成分的析出。一句话，作为治病、健身之用，酒是具有一定益处的，问题的关键是如何正确掌握饮酒的度和量了。孙思邈不反对适量饮酒，提出了“饮酒不宜使多，多则速吐之为佳”和“适性服之，勿至醉吐”的观点。他还特别推荐以葡萄为基质的甜酒，赞“其酒常饮益人”，这与现代研究得出的结论是不相悖的。他还强调酒剂的防疫作用，说“一人饮，一家无疫；一家饮，一里无疫”。在他的《千金方》和《千金翼方》中，除直接用酒送服丸、散剂和作为制作丸、散剂的原料外，所列举出的酒剂方就有 90 余种。

（本文分两部分刊出，第二部请看下期）

温长路，中医主任医师、教授、作家，享受国务院特殊津贴专家，中华中医药学会学术顾问。国家中医药管理局中医药文化建设与科学普及委员会专家、科技期刊审读专家，中国科协精品期刊评审专家，中华中医药学会首席健康科普专家，科学技术进步奖评审专家，《世界中西医结合》、《环球中医药》、《西部中医药》、《中医研究》、《中医药文化》、《中医文献》、《光明中医》、《大众医学》、《现代中医药》、《中国中医药现代远程教育》、《陕西中医学院学报》等多家期刊的编委、顾问。已公开发表学术论文 100 多篇，文史、政论、科普等各类文章 1000 余篇，出版著作 60 余种。主要事迹被国内外几十家媒体报道，并载入《英国剑桥名人录》、《中国科学家传记》等 30 余种辞书。

基于老中医经验对大肠癌癌毒病机的中层理论探讨

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摘要: 文章首先简述了《内经》对于肠中积聚“阳虚寒凝”的认识，进而尝试运用扎根理论方法，通过开放式编码、主轴编码、选择性编码等三级编码过程，对32位老中医对于大肠癌病机的认识进行了理论研究，初步归纳出了大肠癌癌毒的中层理论。文章最后探讨了现代社会生活方式对癌毒病机的影响、脏气虚寒与大肠癌毒病机、大肠癌毒理论对于治疗的启示等问题。

[Abstract] The understandings of deficiency of Yang and accumulation of cold in the large intestine from Neijing were described briefly in the first part of the article. Then, after open coding, axial coding and selective coding, the ground theory method was used to study 32 veteran traditional Chinese doctors’ opinions on the pathogenesis of large intestine cancer, and sum up the middle-range theory of large intestine cancerous toxin initially. The last part of the article discussed the effect of the modern lifestyle and deficiency of Yang in organs on the pathogenesis large intestine cancerous toxin, and the treatment based on this theory.

关键词：老中医；大肠癌；癌毒；病机；中层理论

大肠癌是指包括盲肠、全部结肠、直肠等部位发生的恶性肿瘤。如今，结直肠发病现已居我国癌证发病的第三位 [1]。上海居民大肠癌发病数已从上世纪70年代初的第6位上升到目前的第2位 [2]。中医学对大肠癌的病因病机及其论治的理论与实践已有二千多年的历史，随着当代中医学对于大肠癌防治实践的不断深化，中医学对大肠癌病机的认识也更加深入。有别于内经时代人们对肠中积聚多从“阳虚寒积”认识，当代中医从上世纪90年代即提出了“癌毒”的概念 [3]，治疗思路随之产生了较大的变化。为更加贴近当今肿瘤临床的实践去归纳、理解大肠癌的病机，形成介于中医抽象理论与具体临床经验之间的关于大肠病机的中层理论，进而指导临床实践，我们尝试运用扎根理论方法，研究了一批老中医对大肠癌的认识和实践，借助三级编码研究过程，逐步理清了其中的要素及其相互联系，较清晰地呈现了老中医对相关问题的总体认识，并进而提出了大肠癌癌毒病机的中层理论，希望能够对于探索肿瘤的中医临床基础理论有所帮助。

1 《内经》对大肠癌病机的认识简述

大肠癌在临床上出现症状，多有大便习惯改变、便血、腹部肿块、局部症状等，《内经》对大肠癌的认识散见于对“肠中积聚”、“积”、“聚”以及“肠风”的讨论中。对其病因病机的认识主要可概括为因受虚邪贼风或暴饮暴食，加之起居不节、七情忧怒等致气机不调、血脉不畅、阳气不行，寒凝日久而邪气留蓄、汁沫或凝血留著，积久成积。如：《灵枢•百病始生》谓：“积之始生，得寒乃生，厥乃成积也”，“虚邪之中人也……留而不去，传舍于肠胃之外，募原之间，留著于脉，稽留而不去，息而成积。”又云：“卒然多食饮则肠满，起居不节，用力过度，则络脉伤……肠胃之络伤，则血溢于肠外，肠外有寒汁沫与血相搏，则并合凝聚，不得散而积成矣”、“卒然外中于寒，若内伤于忧怒，则气上逆，气上逆则六腧不通，温气不行，凝血蕴里而不散，津液涩渗，著而不去，而积皆成矣。”《灵枢•五变》又谓“人之善病肠中积聚者……则肠胃恶，恶则邪气留止，积聚乃伤。脾胃之间，寒温不次，邪气稍至，蓄积留止，大聚乃起。”《素问•风论》“久风入中，则为肠风飧泄。”

通过分析《内经》对相关病机的论述，可以看出，在秦汉时期当时的历史环境和生活习惯条件下，古人认为肠中积聚有一个缓慢的形成过程，其病因以感受邪气、饮食无度、起居不节、七情内伤为主，且以经络阳虚寒积、凝血汁沫蕴结为病机要素。

2 运用扎根理论方法探析老中医对大肠癌癌毒病机认识

2.1研究资料的收集、整理与编码步骤

在CNKI以及万方等文献数据库中，通过“大肠癌”、“肠癌”、“老中医”、“中医”、“经验”等关键词搜索，收集近5年来国内学术期刊公开发表的传承人或学生介绍老中医的大肠癌治疗经验的文章，将其中有对大肠癌病因病机认识内容的文章纳入研究，共55篇；（2）从对治疗癌证有丰富临床经验的老中医，如周仲瑛、刘嘉湘、周岱翰、庞德湘、孙桂芝等的大肠癌经验入手，提取文章中关于病因、病机、病理因素等内容进行资料整理，并进行内容整合与归纳，必要时再收集所需老中医的5年前相关资料作为补充。当老中医经验样本数达到32位时已近理论饱和，不再出现新的类别；（3）运用扎根理论方法依次进行开放式编码（对收集到的资料进行逐字逐句分析与分解，进行初始概念化）、主轴编

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码（在从开放编码中得到范畴的基础上，找出范畴之间联系，通过对比分析建立关联，确定主范畴）、选择性编码（选择核心范畴把它系统地与其它范畴加以联系，验证其间的关系，补充完备范畴，初步形成相关理论）。

2.2研究结果

2.2.1开放式编码

首先对老中医的表述不断凝练、概括，然后运用开放性编码对所得到的关键表述、句子进行概念化提练，进而进行概念化加工及其范畴的考察、归类，最终从资料中抽象出41个病机概括和6个范畴。

得出的6个范畴（A1～A6），分别为“外邪犯内产生癌毒的病机”、“始于内生湿（痰）邪的癌毒蕴迫大肠的病机”、“始于气滞血瘀的癌毒蕴迫大肠的病机”、“大肠传导失司自酿癌毒的病机”、“蕴结癌毒伤害大肠的病机”、“邪毒复又伤正生毒的病机”。对大肠癌病机资料所进行的开放式编码如表1所示（限于篇幅，只截取部分编码表）。

2.2.2主轴编码

运用主轴编码对范畴进行关系归类并建立关联，形成了三大类主要的关系。具体见表2。

2.2.3选择性编码

经过选择性编码及不断补充完善范畴、分析隐含的相互关系，我们将大肠癌癌毒病机的核心问题范畴化为“邪气的产生”“邪气与癌毒”“癌毒与大肠癌的发生”，并进而进行理论建构，初步阐发一些相比内经积聚理论更为贴近当今中医肿瘤临床实践的中层理论。

3.大肠癌癌毒病机的中层理论及其探讨

诚如花宝金教授指出的，大肠癌的病机是多因素的复杂过程，当代关于大肠癌的病机有气滞学说、血瘀学说、热毒学说、湿聚学说、正虚学说等，均不免失于片面。[4] 我们研究发现，老中医对大肠癌癌毒的病机从不同角度提出了许多看法，显示了癌毒病机多环节、多要素而又相互钩连的特点。经过三级编码过程，我们初步概括出了大肠癌癌毒病机的中层理论。

3.1大肠癌癌毒病机的中层理论简述

癌毒是形成恶性肿瘤的特异性病邪，具有猛烈、顽固、流窜、隐匿、损正等特性。[5] 大肠癌癌毒的主要病机有二：（1）来自体内传毒：外邪来犯或缘起内因，五脏（脾肾肝为主）受伤，虚而不主，功能失调，内生痰、湿、瘀、热之

表1 开放式编码表

概念化	范畴化	范畴的性质
a1 五脏失常，外邪入内，积聚于肠 a2 五脏失常，湿邪内生，积聚于肠 a3 五脏失常，湿热痰结，阻络生瘀，痰瘀成癌毒，毒侵大肠	将 a1 、a8、a34、a36、a37 范畴化为 A1“外邪犯内产生癌毒病机”	外邪与癌毒
a4 体内瘀毒，久成癌毒，毒侵大肠 a5 体内痰湿，久成癌毒，毒侵大肠 a6 气滞血瘀，久成癌毒，瘀毒侵犯大肠 a7 癌毒滋增，瘀助癌毒，浸润转移	将 a2 、a3、a5、a9、a16、a17、a18、a19、a21、a22、a23、a35、a38、a41 范畴化为 A2 “始于内生湿（痰）邪的癌毒蕴积大肠的病机”	湿（痰）邪内生与癌毒迫于大肠
a8 外邪化火，火聚成癌毒，侵犯大肠 a9 五脏失常，湿热内生，湿热邪毒侵，犯大肠 a10 五脏失常，气滞血瘀，瘀结大肠 a11 邪毒侵肠，气血受阻，气滞血瘀，湿毒瘀滞凝结	将 a4 、a6、a7、a10、a13、a28、a30、a39 范畴化为 A3 “始于气滞血瘀的癌毒蕴积大肠的病机”	气滞血瘀与癌毒迫于大肠
a12 痰、湿、瘀互结久成癌毒，损害脏腑经络功能 a13 五脏失常，虚而致积，气机不畅，毒邪蕴结脏腑，侵犯大肠 a14 腑气不通，关格壅塞，邪热下迫大肠 a15 五脏失常，大肠传导失司，湿热蕴毒 a16 五脏失常，湿邪内生，气机阻滞，络阻生瘀，湿瘀犯肠……	将 a14 、a15、a20、a24、a26、a31、a40 范畴化为 A4“大肠传导失司自酿癌毒的病机”	大肠腑滞而自生癌毒
（共计 41 种概括）	。。。。。。 （共计 6 个范畴）	

注：表中“a”表示从资料中提炼出概括表述的编码；“A”表示从概括中归纳出范畴的编码。

表 2 基于主轴编码的三大类关系

编号	关系类别	影响关系的范畴
1	外邪与癌毒	“外邪犯内产生癌毒的病机”
2	内生癌毒蕴迫大肠	“始于内生湿（痰）邪的癌毒蕴积大肠的病机” “始于气滞血瘀的癌毒蕴积大肠的病机” “邪毒复又伤正生毒的病机”
3	大肠失司自生癌毒	“大肠传导失司自酿癌毒的病机” “外邪犯内产生癌毒的病机” “蕴结癌毒伤害大肠的病机” “邪毒复又伤正生毒的病机”

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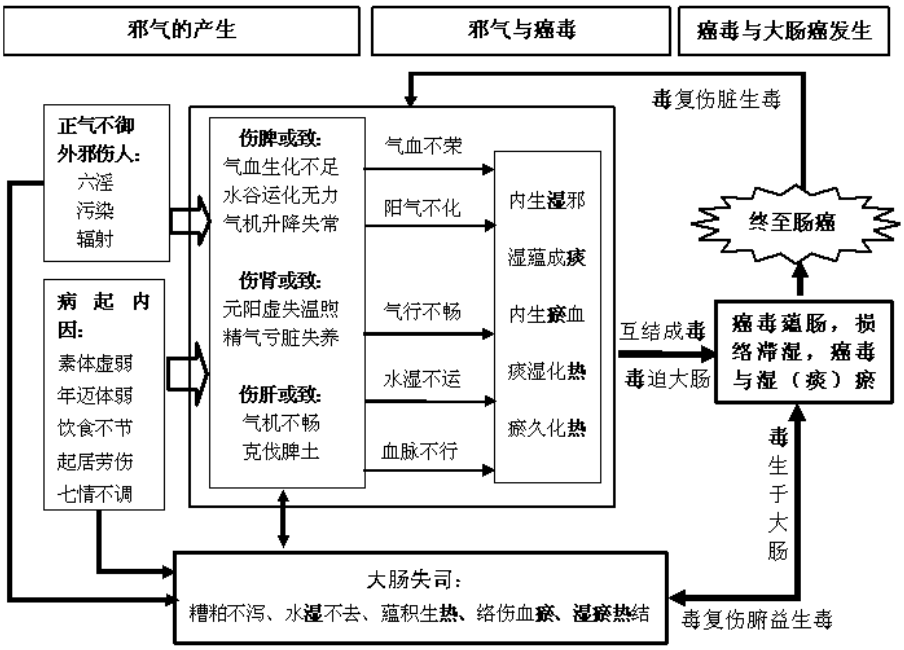

图1 基于老中医经验的大肠癌癌毒病机理论示意图

邪，积久成毒，蕴成癌毒，毒迫大肠，大肠络伤湿滞，毒与湿（痰）瘀胶结，终至大肠癌，大肠癌毒复再伤脏而益生毒；（2）本于大肠生毒：外邪来犯或邪起内因直害大肠，或五脏不调使大肠不利，大肠传导失司，实而失畅，湿瘀热结，蕴而成毒，久成癌毒，大肠癌毒益使络伤湿滞，复再伤腑益生毒，终至大肠癌。试以图1详示之。

3.2几点讨论

3.2.1现代社会生活方式对癌毒病机的影响

“大肠者，传导之官，变化出焉”，大肠为六腑之一，泻而不藏，具有排泄人体糟粕的作用。现代社会饮食习惯与运动习惯出现较大变化，高脂、高蛋白、低纤维素、含化学物品饮食，缺少运动，以及排便不畅等均可直接造成大肠腑气不通而糟粕久留、气血不畅、久而成毒。这一因素与内经时代积聚发生的病因病机已有较大不同，老中医对此已有较普遍的认识，因此在理论中成为重要的病机之一。

3.2.2脏气虚寒与大肠癌毒病机

人体中精气、津血的生成和运行无不靠阳气的化生与推动，是以阳气在人体中“若天与日”般重要。在大肠癌的病机中，凡内外因致病，或致脾肾阳气不足或不行，则易导致精气津血不生或不行，使人体气血亏虚并生湿生瘀，湿瘀又成为蕴毒的所在。因此，大肠癌毒初期蕴生的阶段多有脏气虚寒的过程，这与内经关于阳虚寒凝积的理论是一致的。在湿瘀已蕴成癌毒的阶段，则癌毒成为致病的主要因素，癌毒并非简单的寒凝所能概括，而是多邪胶结、寒热相抟的过程，这一点无疑是当代老中医对内经理论的发展之处。

3.2.3大肠癌毒理论对于治疗的启示

《素问•至真要大论》言：“谨守病机，各司其属”。大肠癌毒病机理论所揭示的病机要素及其联系，启示我们治疗大肠癌应重视四个环节，即（1）针对传邪而来的五脏调养、津血调治；（2）针对大肠传导不利的调畅气机、通调腑气；（3）针对体内蕴结之邪的清湿化痰、逐瘀散结；（4）针对癌毒特别是大肠癌癌毒直接致病的抗癌解毒。这四个环节构成了治疗大肠癌的框架思路，至于到具体患者，又需根据其中西医治疗的阶段、病情的缓急、兼证的变化等灵活变化施药，犹如毛笔虽同，但随立意不同而笔峰运用有异。

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“一分为三”看“经络”（下部）

王以胜

北京同仁堂（英国伦敦）

四. 探讨“任督二脉”

中医典籍以及中国中医高等教育教材，都是把“督脉、任脉”划归于“奇经八脉”范畴。

前面“总论”提出：“督脉、任脉”都有自己的“穴位”和“络脉”，而其余“奇经六脉”则无自己的穴位，更别说“络脉”了。显然“任督二脉”与“奇经六脉”有明显区别。

元朝滑伯仁先生已经把“任脉、督脉”另列而与“十二正经”相提并论，著有《十四经发挥》（1341 年）一书。

以胜主编的《针灸推拿学》于 1995 年出版时，用作国家中医药学校教材使用，为避免学术异议，还是沿用传统文献说法，把“任督二脉”归入“奇经八脉”论述。

实际上以胜是把“任脉、督脉”另列一类，以示与“奇经六脉”有区别，表明“经脉”也是“一分为三”： 分为“十二正经”、“任督二脉”、“奇经六脉”。

在《黄帝内经•素问》“骨空论篇第六十”有专门论述“任脉、督脉”和“冲脉”的循行、主病的经文：“任脉者起于中极之下--冲脉者起于气街--任脉为病男子内结七疝女子带下瘕聚冲脉为病逆气里急督脉为病脊强反折”，是把“任脉”放在“督脉”之前论述，叙述过“任脉”、“冲脉”之后，才叙述“督脉”。完全符合春秋战国之前的哲学、文化习惯和行文风格，母系氏族遗风明显，先阴后阳，故称“阴阳学说”而不是“阳阴学说”。十二经脉也是从手太阴经开始论述，到最后还是足厥阴经再注入手太阴经。所以在讨论“督脉、任脉”时，其顺序应当是“任督二脉”，而非“督任二脉”。

丹道家也是“一分为三”理论，认为人体真气运行的经脉主要有三条：一是赤道，即任脉；二是黑道，即督脉；三是黄道，即中黄。他们认为“任督二脉”为“人道”，可以兼容先、后天之精气运行，督脉运行是由脑向下到尾闾；任脉由会阴向上至天门。丹家逆“人道”而修炼“仙道”，导真气逆行“任督二脉”，此称为“河车搬运”或“小周天”。督脉有尾闾、夹脊、玉枕三关，精气过三关才能上入“泥丸宫”。任脉有上田、中田、下田三窍；此外还有天门（眉心）、重楼（气管）、生门（脐门）等要穴。

“中黄”又称黄中、中道、黄道、正黄、正脉、黄脉、真黄等，是处于人体正中的大脉，而通络于四肢，被丹家视为不传之秘。其特点是只有先天真精、真气可以通过，故称为“仙道”。先天精气自“虚危穴”（即会阴穴，也称阴蹻、尾闾关、生死窍、复命关）透入，过中黄，直达顶骨（即天灵盖、囟门）。顶骨乃人身生气所凝结，上应镇星，其光华称“意珠”，可护卫婴儿，即未成熟之阳神。黄道（黄脉）与佛教密宗中的“中脉”暗合，可见人体的奥秘是统一的。只是因为佛家、道家用各自不同的理论解释同一个“人体”而已。正如中医学、西医学哲学理念、基本理论和说理工具不同，但是研究的都是相同的“人体”。

本文也遵循中医经典，把任脉放在督脉之前论述。

“任脉、冲脉、督脉”都是“起于胞中”，故有“一源三岐”之说。临床实践证明，有关性功能、生殖系统、泌尿系统、妇科疾病都与“任脉、冲脉、督脉”有关。

任脉：任即担任一身之阴气、阴经，故称“阴脉之海”。任通妊，故有“任主胞胎”之说。

(一) 大体循行：起于胞中，出会阴绕前阴，沿腹、胸正中线上行，至口唇内，环绕口唇，分二支至双目下。首穴会阴，末穴承浆。

(二) 基本功能：调节阴经气血；调节、促进生殖机能；宽胸理气，健脾和胃。

(三) 主要病症：疝气、癥瘕积聚。月经不调、带下、流产、不育不孕等。

督脉：督即总督一身阳气和阳经，故称“阳脉之海”。

(一) 大体循行：起于胞中，出会阴后行于腰背正中，经项入脑，属脑，由项沿头正中线，经头顶、额、鼻到上唇系带处。并有支脉络肾、贯心。首穴长强，末穴龈交。

(二) 基本功能：调节阳经气血；调节泌尿生殖功能；反映脊髓和脑功能。

(三) 主要病症：脊柱强直，角弓反张，脊背疼痛，惊厥，精神失常。

五. 探讨“奇经六脉”

按照“一分为三”看“经脉”理论框架，“经脉”分为“十二正经”、“任督二脉”、“奇经六脉”三部分。在探讨过“十二正经”和“任督二脉”之后，继续探讨“奇经六脉”。

“奇经六脉”是指：冲脉；带脉；阴跷脉、阳跷脉；阴维脉、阳维脉等“六脉”，因为这六条经脉与“十二正经”不同，在内不络属于脏腑，在外彼此不形成配偶关系；又与“任督二脉”不同。“奇经六脉”在上肢没有本经分布。故称为“奇经”，“奇”而非“偶”，又有“异”意。

（一）冲脉：又叫“太冲脉”。“冲”意指上冲，冲脉上走头，下走足，总领诸经的气血，故有“十二经之海”之称。

大体循行：冲脉与任脉、督脉都是起于胞中，下出会阴。

冲脉“一分为三”分为三支而行：1、出会阴，环绕后阴，沿腹腔后壁上行于脊柱内。2、出会阴，环绕前阴，沿腹腔前壁，挟脐上行，经咽喉络口唇上至两目下。3、出会阴下行，沿股内侧下行经内踝后入足下，其别支经足背至足大趾、次趾之间。

基本功能：1、调节十二经气血，为“十二经脉之海”。2、调节月经，特别是初潮、绝经时期，以及月经的量的多少。因为冲脉与月经有关，又涵蓄十二经气血，所以又称冲脉为“血海”。3、调节气机升降。

主要病症：1、妇科疾病：月经不调、崩漏、经闭、乳少等。2、泌尿、生殖系统疾病。3、气机升降失常病症，如吐血、气逆、上呃等。

（二）带脉：带脉起于季肋下，环行腰一周，状如束带，故称“带脉”。有约束诸经之功能。带脉是唯一横行的经脉。其余都是纵行的经脉。

大体循行：起于季肋（约在第十二肋骨端），斜向下行到带脉穴，横行绕腰一周复至季肋。并且于带脉穴处再向前下方沿髂骨上缘斜行到少腹。

基本功能：1、约束纵行的所有经脉。2、主司带下。3、强壮腰部。

主要病症：1、妇女带下病、子宫脱垂。2、腹部胀满。3、腰

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软无力。(《难经•二十九难》“带之为病腰溶溶若坐水中”)。

（三）阳跷脉、阴跷脉：“跷”原意是“脚向上抬”，有轻灵矫健之意。因为阴跷脉、阳跷脉其功能是令人行动跷捷，故称跷脉。

大体循行：阴跷脉是足少阴经之别脉，起于足中出然谷穴，经照海穴上至内踝上二寸以交信为郄，沿下肢内侧后方上行，入阴部，经腹部、胸部，出人迎，过喉结交叉到睛明，与手足太阳、足阳明、阳跷五脉相会。

阳跷脉是足太阳之别脉，起于足跟中，出于外踝下申脉穴，经仆参穴上行外踝上三寸以跗阳穴为郄，沿下肢外侧上行，经居窬穴，沿胁后、胸部后外侧，上肩部过三穴（手太阳小肠经之臑俞穴；手阳明大肠经之肩髃、巨骨穴），经颈部上口，再向上经承泣穴，过睛明穴、风池穴、风府穴入脑。

基本功能：1、阴跷脉、阳跷脉主一身左右之阴阳，使身体左右阴阳趋于平衡。2、协调下肢肌肉运动。3、控制眼睑开阖。阴跷脉与阳跷脉交会于两目，属于脑，其功能与睡眠有关。阳跷阳气盛则躁动不安，目张，不寐。阴跷阴气盛则精神不振，目合，嗜睡。

主要病症： 1、下肢运动不协调。阴跷病则会足内翻。阳跷病则会足外翻。2、眼睑开阖异常：阴跷病则嗜睡，阳跷病则不寐。3、阴跷病则喉痛，阳跷病则癫狂、目内眦赤疼痛。

（四）阴维脉、阳维脉：“维”即“维系”意。

大体循行：阴维脉起于小腿内侧足三阴经交会处，沿下肢内侧上行到腹部与脾经同行，到胁部与肝经相合，上行至咽喉与任脉相合。阳阳维脉起于外踝下，与胆经并行，经躯干后外侧到肩、颈、颊、额、项部，与督脉会合，循行期间与手足太阳、少阳、阳跷等交会。

基本功能：联络维系阴阳经脉。

主要病症：“阳维为病苦寒热，阴维为病苦心痛”（难经•二十九难）。阳维脉病症为寒热表证。阴维脉病心、胃、胸腹疼痛等里证。

六．探讨“络脉和经属”

在“总论”里我们把“经络”一分为三：“经络”由“经脉”、“络脉”、“经属”（以胜新拟名）三部分组成，各自又“一分为三”：

“经脉”分为“十二正经”、“任督二脉”、“奇经六脉”。

“络脉”分为“别络、孙络、浮络”。

“经属”分为：“十二经别”、“十二经筋”、“十二皮部”。

前面我们分别讨论了“ 经脉命名、循行交接”、“经脉循行主病”、探讨“任督二脉”、 探讨“奇经六脉”，本文将《探讨“络脉和经属”》。

（一）络脉：“络脉”也是“一分为三”，分为“别络、孙络、浮络”三部分。

1、别络、十五络脉：通常说的“络脉”、“别络”就是指“十五络脉”，又叫“十五别络”。即十二正经、任督二脉各有一支别络，再加上“脾之大络”，合为“十五别络”。

“十二正经”的“络脉”从一定部位发出，经过一定的循行路线后，或从阳经入于相表里的阴经；或从阴经入于相表里的阳经，加强“十二经脉”在四肢的表里联系和十二经脉的循环传注。

“十五络脉”是以发出的腧穴名称命名的，具体名称如下：

手三阴经：肺经手太阴络列缺；心经手少阴络通里；心包经手厥阴络内关。

手三阳经：大肠经手阳明络偏历；小肠经手太阳络支正；三焦经手少阳络外关。

足三阴经：脾经足太阴络公孙；肾经足少阴络大钟；肝经足厥阴络蠡沟。

足三阳经：胃经足阳明络丰隆；膀胱经足太阳络飞扬；胆经足少阳络光明。

脾之大络大包；任脉之络鸠尾；督脉之络长强。

2、孙络：络脉最细小的分支称为“孙络”。就如“经络”系统是一个“大网络”，一层一层细分下去，一直到最基层分支，就如“愚公移山”寓言里“愚公”所说的“子又生子，子又生孙，子子孙孙，无穷匮也”。所有的“子子孙孙，儿孙之辈”的最细小的络脉，相当于西医学所说的“毛细血管”、“神经末梢”之类都叫“孙络”，“经络系统”正是通过这些“孙络”联系、滋养、调控机体五脏六腑、四肢百骸的阴阳气血。

3、浮络：络脉之浮行于机体浅表部位者，叫做“浮络”，“浮络”是“孙络”的一部分，仅仅是因为其位于“浅表”“浮而可见”而名之“浮络”。

（二）经属：经属也是“一分为三”，分为“十二经别、十二经筋、十二皮部”。

1、十二经别：是十二经脉别行分出的一种循行于人体深部的经脉干线，也是十二经脉别出的正经，属于经脉范畴，其作用，除了加强表里两经联系之外，并能通达某些正经未能行经的器官与形体部位，以补正经之不足。还有濡养脏腑的功能和作用。

过去的中医学高等教育教材，即全国中医药大学教材对于“十二经别”都是非常简单几句话表述，现代许多针灸学著作也没有认真讨论过“十二经别”有关知识，更没有认真告诉学生和读者有关“十二经别”的具体内容。实际上《黄帝内经•灵枢》“经别第十一”篇专门探讨“十二经别”。例如“足太阳之正，别入于腘中，其一道下尻五寸，别入于肛，属于膀胱，散之肾，循膂当心入散；直者，从膂上出于项，复属于太阳，此为一经也。足少阴之正，至腘中，别走太阳而合，上至肾，当十四椎，出属带脉；直者，系舌本，复出于项，合于太阳，此为一合。成以诸阴之别，皆为正也。”

2、十二经筋：是十二经脉循行部位上分布的筋腱和肌肉系统的总称，行于体表，不入内脏；有联缀四肢百骸、维络周身、主管全身关节运动。《黄帝内经•灵枢》“经筋第十三”篇专门探讨“十二经筋”。

3、十二皮部：是十二经脉在体表相应的皮肤部位的反应区域，即通过络脉把皮肤分为十二部，纳入十二经脉所支配的范围，十二经脉发生病变，在相应的皮部也会有所反应。

七．经络的生理功能

按照“三元论”理论，“经络”由“经脉”、“络脉”、“经属”三部分组成，“经脉”是经络系统的主要组成部分。“经络功能”主要通过“经脉”体现出来，所以《黄帝内经•灵枢》“经脉第十”说：“经脉者，所以能决死生、处百病、调虚实，不可不通。”

经络的生理功能活动称为“经气”，平时人们在做“针灸、按摩”时所说的“得气”，就是指激发的“经气”。当针灸或按摩刺激经脉循行部位或穴位时，人体可以感觉到“经气”按一定方向和路径传导，即表现为酸、麻、重、胀等感觉的传导。这种“经气”在经脉中的传导，是经络维持正常生理功能活动的动力，也是实现经络功能活动的基础。

《黄帝内经•灵枢》“本脏第四十七”所说：“经脉者，所以行血气而营阴阳，濡筋骨，利关节者也”。以胜认为，这就是告诉人们有关“经脉的生理功能”。

按照“一分为三看世界”方法论，经络生理功能也是大体分为三个方面，

（一）沟通内外，网络周身：十二正经源于脏腑，通过络、属、贯、注等方式，把互为表里的脏腑联系在一起，并且使脏与脏、

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腑与腑、脏与腑之间互相联系，使各脏腑之间彼此协调，使“经气”顺序传递，如环无端，周流不息，共同完成机体各种复杂的生理活动；达到“阴平阳秘，生命乃治”的健康状态。

由于“十二经脉”及其分支纵横交错，出表入里，通达上下，相互络属于脏腑之间；“任督二脉”和“奇经六脉”联系沟通于十二正经、十二经筋、十二皮部，联络筋脉皮肉，经络循行于身体躯干、四肢、头面部位，联系到眼、耳、口、舌、咽、喉、二阴以及所有脏腑器官。全身各个部位通过经络互相沟通，形成一个有机整体。

（二）运行气血，滋养全身：气血是脏腑生理活动的产物，又是机体脏腑器官、全身各类组织正常生理活动的物质基础。气血的生化依赖脏腑生理功能正常而实现，但是气血的运行输布全靠“经络”生理功能正常来完成。即“经脉者，所以行血气而营阴阳，濡筋骨，利关节者也”。机体依靠网络周身、四通八达的“经络”，把气血输送到全身各处，滋养全身各种组织、器官、四肢百骸；完成“行血气、营阴阳、濡筋骨、利关节”的生理功能。

如果因为各种原因导致经络功能失常，气血运行发生障碍，经脉阻滞不通，就会形成“气滞血瘀”，机体会出现疼痛、肿胀、瘀斑等实证；或者气虚血少，经脉失养，会出现局部麻木；或某些脏腑虚证；或血虚生内热，烁阴生风，出现筋脉拘急、抽掣。无论虚实，机体日久失去经络气血濡养，都会枯废。

（三）调节平衡，防护自身：经络对机体各组织器官的生理活动具有调节作用，使彼此之间相互协调，保持阴阳气血相对平衡，即“阴平阳秘，生命乃治”，使机体处于健康状态。

“十二经脉”本身左右对称，也会互相调节；例如临床治疗偏瘫、面瘫，一边有病，可以通过针灸另一边进行治疗，即“左有病而右畔取”的治疗方法。

“任督二脉”和“奇经六脉”对于“十二经脉”气血的调节功能，古人以“溢蓄”二字表述，用“湖泊”、“大海”、“水库”与“河渠”形象比拟：例如“冲脉”能够调节十二经气血，故称“冲脉”为“十二经脉之海”。当“十二经脉”气血不足时，“任督二脉”和“奇经六脉”会“溢出”气血而保障各经脉气血的供应；当“十二经脉”气血有余时，又能“蓄入”，如此调节机体的气血在不同状态下的需要量，保持阴阳气血相对平衡，使机体处于健康状态。

经络能够“行血气、营阴阳”，而且是“营行脉中，卫行脉外”，经络使“卫气”密布于皮毛肌肤，具有卫外功能。经络是运行气血的通路，也是病邪入侵机体的通路。正如《黄帝内经•素问》“皮部论篇第五十六”所说：“邪客于皮则腠理开，开则邪入客于络脉，络脉满则注于经脉，经脉满则入舍于腑藏也”。只要正气足，“正气存内，邪不可干”，所以经络系统具有防护自身的功能。

八．经络的应用

按照“三元论”理论，“经络的应用”可归纳为“病理、诊断、治疗”三部分论述。

（一）病理：

1、经络是运行气血的通路，也是外邪入侵由表入里的通路；还是正气逼迫邪气外出的通路。经络在病理方面的作用，主要是关于“疾病的发生和传变”。在张仲景《伤寒杂病论》体现最多。

2、经络可以反映病候。脏腑病变通过经络会反映在五官九窍或体表相应的区域和穴位。如肝火盛可见目赤；心火盛可见舌尖红、甚至溃疡疼痛；胃火可见牙龈肿痛；胆火可见耳暴鸣、暴聋等。两胁疼痛多为肝胆疾病，肾病见腰痛，胆囊炎患者在胆经的阳陵泉穴位处有压痛点，肠痈（阑尾炎）在足三里穴下阑尾穴处有压痛点。

3、脏腑病变互相影响的途径：如足厥阴肝经“属肝”、“挟胃”、“注肺中”，故有“肝气犯胃”、“肝火烁肺”等证候。足少阴肾经“属肾”、“入肺”、“络心”，所以“肾虚水泛”时，会“水气凌心”、“水气射肺”；足太阴脾经“属脾”、“络胃”、“注心中”，所以会“胃热熏心”，出现神志昏迷症状，如大热、大渴、大汗之阳明热病。互为表里的两经联系更为密切，如“心火移热于小肠”；大肠实热，腑气不通可以引起肺气不利而咳喘、胸满等。

（二）诊断：经络有脏腑络属和循行部位，会反映相关证候，结合“四诊”知识，就可以诊断疾病。

1、分经辨证：根据经络理论，依据脏腑功能和病理变化特点，可以诊断属于何经脉病变。临床出现咳嗽、气喘、胸闷胀满、小便频数而量少等证，是肺主气、司呼吸、通调水道等功能失常的表现；再有缺盆疼痛、烦心、掌中热、挠侧臂痛、肩背痛等症，是肺经循行部位病变。《伤寒杂病论》的“六经辨证”就是运用“经络理论”结合“藏象学说、病因学说、阴阳五行学说”建立的“辨证施治”理论体系。

2、分部论经：依据病变部位，诊断何经病变。如头痛部位不同，属于不同经脉病变：前额痛，属阳明头痛；头两侧疼痛，为少阳头痛；头后部痛，为太阳头痛；头顶疼痛，为厥阴头痛。再如牙痛，上牙痛与足阳明胃经有关，下牙痛，与手阳明大肠经有关。

3、经穴辨病：依据在经络循行通路和穴位周围，出现明显的压痛点、结节状或条索状反应物、或局部电位变化，进行诊断疾病。如上面所说“经络可以反映病候”， 胆囊炎患者在胆经的阳陵泉穴位处有压痛点，肠痈（阑尾炎）在足三里穴下阑尾穴处有压痛点。

（三）治疗：

1、循经取穴：经脉循行线上有穴位，针灸就是通过刺激穴位“经气”，通过经络系统使机体相应的脏腑功能恢复正常而治疗疾病或养生保健、延年益寿。例如治疗头痛，除了取头痛局部穴位外，一定要“循经取穴”：太阳经头痛，取手部后溪穴、足部昆仑穴；阳明经头痛，取手部合谷穴、足部内廷穴；太阳经头痛，取手部中渚穴、足部临泣穴。再如胃疼痛，取胃经的足三里穴；肝病取肝经的期门穴。

2、药物归经：药物治疗也是以经络为通路，药物经过经络的传导转输而发挥作用。古人经过长期使用和观察总结，推出了“药物归经”理论。如太阳经头痛，可用羌活、藁本；阳明经头痛，可用白芷；少阳经头痛，可用柴胡；厥阴经头痛，可用吴茱萸。这些药物归属于相关的经脉，同时它们还能引导其它药物归入相应的病变经脉，加强治疗作用，故又叫做“引经药”。

3、六经论治：中医治疗和养生理论，是“灸法”在“针法”前、“食物疗法”在“药物疗法”前，其发展顺序为：灸—针，食疗—药疗；针灸治疗早于药物治疗。

中医药学知识在汉朝之前已经处于比较完善状态，张仲景《伤寒杂病论》的“六经论治”就是把疾病分为三阴三阳“六经辨证”，概括了脏腑十二经的病变。太阳主表、阳明主里、少阳主半表半里，而三阴统属于里。

张仲景提出六经病“提纲证”，如太阳病“脉浮头项强痛而恶寒”、阳明病“胃家实是也”、少阳病“口苦咽干目眩”等，建立了“六经辨证论治”体系。

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从痰辨证施治顽固性胃食管反流病体会

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摘要：胃食管反流病是指胃酸、胃蛋白酶、胰液、胆汁等胃及十二指肠内容物反流到食管中引起的疾病。本病病程较长，容易反复发作，西医认为本病需长期治疗甚至需要终生服用抑酸剂维持治疗。笔者认为胃食管反流病病因与七情失和、饮食不节、禀赋不足有关，顽固性胃食管反流病病机与脾虚痰阻有关，治疗时应健脾化痰，和胃降逆。

关键词：胃食管反流病；顽固性；痰邪

1.胃食管反流病西医治疗概述

胃食管反流病是指胃酸、胃蛋白酶、胰液、胆汁等胃及十二指肠内容物反流到食管中引起的疾病，常见的临床表现有反酸、烧心、胸骨后灼痛、反食、咽异物感以及食管外症状如咳嗽、哮喘等。胃食管反流病可分为内镜下阴性的胃食管反流病、内镜下阳性的胃食管反流病和 Barrett’s 食管。内镜下阴性的胃食管反流病虽有胃食管反流的临床表现，但内镜检查食管黏膜未见异常，内镜下阳性的胃食管反流病可见食管黏膜的炎症、糜烂、溃疡甚至食管狭窄等，Barrett’s 食管为食管黏膜正常的鳞状上皮细胞被胃的柱状上皮细胞所替代，并伴有肠上皮化生，进一步发展可成为食管腺癌。

胃食管反流液中胃酸、胃蛋白酶为酸性液体，胰液、胆汁为碱性液体。所以反流有以混合型反流为主的，也有以酸性反流为主或碱性反流为主的。西医治疗多以碱性药物、抑酸剂、促动力剂以及保护食管黏膜剂为主。碱性药物有碳酸氢钠、碳酸钙、铝碳酸镁等，抑酸剂有质子泵抑制剂、H2 受体拮抗剂，质子泵抑制剂有奥美拉唑、兰索拉唑、埃索美拉唑、雷贝拉唑、泮托拉唑等等，组织胺 H2 受体拮抗剂有西咪替丁、雷尼替丁、法莫替丁、尼扎替丁、罗莎替丁等。黏膜保护剂有硫糖铝、枸橼酸铋钾、米索前列醇、麦滋林-S、替普瑞酮、瑞巴派特、惠加强--G 等。胃食管反流病病程较长，容易反复发作，故被认为是一种顽固性疾病。西医认为需长期治疗甚至终生服用药物来抑制胃酸，但临床上可见长期服用抑酸剂的患者可发生霉菌性食管炎、胃肠功能紊乱、肝功异常、白细胞减少、血小板减少等。

2.胃食管反流病中医病因病机

胃食管反流病属于中医“吐酸”、“嘈杂”范畴，与以下几方面因素有关：

2.1 饮食不节，患者嗜食肥甘厚腻、辛辣刺激之品，如甜食、巧克力、韭菜、红薯、油煎油炸食物等，暴饮暴食、嗜烟、饮酒过度等也易导致脾胃受伤，脾失健运，水湿不化，日久化热，导致湿热内阻，脾胃升降失常，胃失通降，胃气上逆而发生反酸烧心。正如朱丹溪在《丹溪心法》中说：“吐酸，是吐酸水如醋，平时津液随上升之，气郁积而久，湿中生热，故从火化，遂作酸味”。湿邪郁积化痰，日久化热，遂生“嘈杂”，临床上多见表现烧心为主， 《丹溪心法》中说：“嘈杂是痰因火动，治痰为先。姜炒黄连入痰药，用炒山栀子、黄芩为君，南星、半夏、陈皮为佐。热多加青黛。嘈杂，此乃食郁有热，炒栀子、姜炒黄连不可无。肥人嘈杂，二陈汤少加抚芎、苍术、白术、炒山栀子。嘈杂若湿痰气郁，不喜食，三补丸加苍术，倍香附子” 。饮食不节日久则伤脾胃，导致脾失健运，脾不化湿，聚而生痰，痰凝气滞，从而加重胃气上逆。

2.2 七情失和，患者生气、抑郁、恼怒等，引起肝气郁结，肝气横逆犯胃，导致胃失和降，胃气上逆，出现反酸、烧心、反食、胸骨后疼痛，伴嗳气，胃胀等症状。 正如《寿世保元•吞酸》曰：“夫酸者肝木之味也，由火盛制金，不能平木，则肝木自甚，故为酸也”。肝气郁结日久，横逆克脾，脾失健运，导致水湿阻滞，聚而成痰。

2.3 禀赋不足，劳倦内伤，大病久病之后，导致脾胃虚弱，脾虚气滞，土壅木郁，导致肝胃不和，胃失和降，胃气上逆，导致反酸、烧心等症状。另外脾胃虚弱，水湿不化，聚而生痰，导致痰湿阻滞，气机逆乱，胃气上逆，出现反酸、烧心、嗳气、胃胀等症状。

以上三种证型，如反复发作，都可导致脾胃虚弱，脾失健运，水湿不化，聚而生痰，痰气阻滞，中焦升降失常，胃气上逆，加重反酸烧心。

综上所述，可知胃食管反流病的发生与肝、脾、胃密切相关，病机多为肝胃不和、湿热中阻、痰湿阻滞，而气机逆乱，胃失和降是其基本病机 。由于本病病程较长，病情易反复发作，故本病多为本虚标实，本虚是指脾胃虚弱，标实是指痰湿、气滞、热郁等。 如反复发作，势必会导致水湿不化，聚而成痰，最后痰气交阻，脾胃升降失司，胃气上逆，从而引起反酸烧心反复发作。顽固性胃食管反流，与脾虚痰阻有关，治疗时就应健脾化痰，和胃降逆。

3.痰邪在胃食管反流病中的临证表现及治疗

痰邪是人体因感受外邪、饮食不节、七情失和、禀赋不

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足等原因导致的病理产物。在不同的部位表现则不一样。“在肺则咳，在胃则呕，在头则眩，在心则悸，在背则冷，在胁则胀，其变不可胜穷也。”痰病的性质可分为湿痰、热痰、燥痰、寒痰、风痰等。在胃食管反流病中，在不同的部位则表现不一样，阻滞于经脉可影响气血运行和经络的生理功能，停滞于脏腑可影响脏腑的功能和气机升降。如痰停留在咽喉部，则表现为咽异物感，咽中如有物堵，吞之不下，吐之不出；停留在食管，则表现为反酸烧心、胸骨后疼痛；停留在胃部，则表现为胃胀，胃痛，纳差，恶心，呕吐，嗳气，反酸、反食等；停留在胸胁，可见胸闷憋气，胸胁胀满；停留在胸膈，则表现为胸闷，咳喘，不能平卧；停留在大小肠，则肠间沥沥有声，大便秘结或大便稀溏，黏滞不爽。

4.顽固性胃食管反流病的中医治疗

4.1 痰在咽喉：反酸，烧心，反食，咽部异物感，咽中如有物堵，吞之不下，吐之不出；或咳嗽气急，咯痰不爽，涩而难出，胸膈满闷，苔白，脉弦缓或弦滑。贝母瓜蒌散合半夏厚朴汤加减。

4.2 痰在胸膈：反酸，烧心，反食，胸痛彻背，胸闷憋气，胸胁胀满，咳嗽痰多，色白难咯，恶心呕吐，胸膈满闷，肢体困重，或头眩心悸，舌苔白滑或腻，脉滑。瓜蒌薤白半夏汤合二陈汤加减。

4.3 痰留食管：胸骨后疼痛，反酸烧心，伴心下痞满，反食，或呕吐，肠鸣下利，舌苔腻而微黄，脉滑，偏于寒热错杂者半夏泻心汤加减；伴头痛目赤，耳聋胁痛，口干口苦口粘，舌红苔黄腻，脉弦滑，偏于肝胆湿热者龙胆泻肝汤加减。

4.4 痰在胸胁：反酸，烧心，反食，胸闷憋气，胸胁胀满，心烦喜呕，不欲饮食，口苦，咽干，头晕目眩，头痛呕逆，咳嗽喘急，痰涎粘稠，舌苔厚腻，脉弦滑。导痰汤合小柴胡汤加减。

4.5 痰邪留胃：反酸，烧心，反食，心下痞闷，按之则痛，胃脘痞闷或胀满，纳差，恶心，呕吐，嗳气，反食或心胸闷痛，或咳痰粘稠，舌苔白腻，脉缓或滑。旋覆代赭汤合小陷胸汤加减 。

4.6 痰在大小肠：反酸，烧心，反食，食少难消，脘腹胀满，肠间沥沥有声，大便秘结或大便稀溏，黏滞不爽。小便短赤，舌苔白腻或黄腻，脉滑。三子养亲汤合枳实导滞丸加减。

笔者在临床实践中，还总结出了一些用药小窍门。如常用治疗反酸烧心的对药有：乌贼骨、浙贝母，瓦楞子、海浮石，黄连、吴茱萸，黄连、干姜，煅龙骨、煅牡蛎，海藻、昆布，龙胆炭、黄芩炭等，可根据具体情况临证加减。

病案举例

提要：本病例是一功能性消化不良伴有反流性食管炎、Barrett’s 食管病例，采用《伤寒论》之半夏泻心汤辛开苦降法治疗，明显缓解。

姓名：孙某 性别 男 30 岁

首诊：09-09-15

主诉：剑突下疼痛 2 个月。

现病史：剑突下疼痛，放射至周边，无明显反酸烧心，咳嗽（饭后），无痰，咽痒，纳可，二便调。

检查：09-08-05 胃镜：反流性食管炎，Barrett’s 食管（片状） 慢性浅表性胃炎伴糜烂

病理：（窦）轻度慢性炎，腺体轻度萎缩，伴粘膜及小凹上皮增生，（食道）鳞-柱状上皮粘膜慢性炎，伴鳞状上皮单纯性增生。

望诊：舌淡红苔白。

闻诊：未闻异常口气及体气。

切诊：脉弱。

辨证分析：患者脾胃不和，脾属寒，胃属热，脾胃不和，寒热错杂。脾胃为人体升降之枢纽，升降不利，气机阻滞，故出现胃脘部疼痛。脾失健运，水湿不化，痰湿内生。胃失和降，气机上逆，故咳嗽、咽痒。舌淡红苔白，脉弱，为脾气虚弱之象。综上所述，本证为寒热错杂，痰瘀互阻，胃气上逆之证。

中医诊断：胃痛（寒热错杂，痰瘀互阻）

西医诊断：反流性食管炎，Barrett’s 食管，功能性消化不良

治法：辛开苦降，健脾化痰，理气降逆

方药：泻心汤加减

清半夏 10g	黄芩 10g	黄连 6g	干姜 3g
吴茱萸 3g	浙贝母 10g	海螵蛸 30g	瓦楞子 30g
青黛 10g	百合 20g	降香 10g	三七面 3g
旋覆花 10g	生赭石 10g	白蔻 10g	白及 10g
海浮石 30g			

中药：七剂日一剂水煎服，每日两次。

中成药：康复新液 （100ml*1）X4 瓶/15ML，口服，日三次； 复方陈香胃片（0.56g*48 片）X2/4 片，口服，日三次

辅助治疗：穴贴神阙-化瘀清胃膏（本院自制）

二诊：09-9-24

剑突下仍有疼痛，空腹时明显，嗳气，口干，晨起明显，咳嗽消失，无咽痒，大便日一次，偏干，小便调，纳食可，眠安。 舌暗淡苔白，脉弦滑。

治疗：穴贴神阙-化瘀清胃膏

中药：十四剂日一剂水煎服，每日两次。

清半夏 10g	黄芩 10g	黄连 6g	瓜蒌 20g
吴茱萸 3g	浙贝母 10g	海螵蛸 30g	瓦楞子 30g
青黛 10g	百 合 30g	降香 10g	三七面 3g
旋覆花 10g	生赭石 20g	白蔻 10g	白及 10g
海浮石 30g			

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三诊：09-10-25

胸骨后隐痛，饥饿时胃痛，进食油腻则大便稀，嗳气减轻，口干，不苦，纳可，大便调。 舌淡黯苔黄腻，脉沉细。

清半夏 10g	黄 芩 10g	醋柴胡 10g	北沙参 15g
麦冬 15g	浙贝母 10g	海螵蛸 30g	瓦楞子 30g
青黛 10g	百合 30g	降香 10g	三七面 3g
旋覆花 10g	生赭石 20g	白蔹 10g	白及 10g
海浮石 30g			

中药：七剂日一剂水煎服，每日两次。

中成药：康复新液 （100ml*1）X2 瓶/10ML，口服，日三次

辅助治疗：穴贴神阙-化瘀清胃膏

四诊：09-10-22

诸症状均有减轻，偶有进食不适时有胃脘部不适，隐痛，伴有嗳气，纳可，二便调。舌红苔黄腻，脉弦滑。

清半夏 10g	黄芩 10g	醋柴胡 10g	北沙参 15g
麦冬 15g	浙贝母 10g	海螵蛸 30g	瓦楞子 30g
五灵脂 10g	蒲黄炭 10g	降香 10g	三七面 3g
旋覆花 10g	生赭石 20g	白蔹 10g	白及 10g
海浮石 30g			

中成药：七剂日一剂水煎服，每日两次。

辅助治疗：穴贴神阙-化瘀清胃膏

五诊 09-10-29

胸骨后稍有隐痛，偶有嗳气，纳可，二便调。舌红苔黄，脉沉弦。

清半夏 10g	黄 芩 10g	蒲公英 30g	北沙参 15g
麦 冬 15g	浙贝母 10g	海螵蛸 30g	瓦楞子 30g
五灵脂 10g	蒲黄炭 10g	黄连 3g	三七面 3g
旋覆花 10g	生赭石 20g	白蔹 10g	白及 10g
海浮石 30g			

中药：七剂日一剂水煎服，每日两次。

治疗：穴贴神阙-化瘀清胃膏

六诊 09-12-17

饮食不慎后胸骨后疼痛，反酸烧心，时有嗳气，无恶心呕吐，口干，无口苦，二便调，纳眠可。 舌红苔黄，脉弱。

清半夏 10g	黄 芩 10g	蒲公英 30g	北沙参 15g
麦冬 15g	浙贝母 10g	海螵蛸 30g	瓦楞子 30g
五灵脂 10g	蒲黄炭 10g	黄连 3g	三七面 3g
全蝎 3g	蜈蚣 3 条	白蔹 10g	白及 10g
海浮石 30g			

中药：七剂日一剂水煎服，每日两次。

康复新液 （100ml*1）X4 瓶/15ML，口服，日三次

治疗：穴贴神阙-化瘀清胃膏

七诊 09-12-24

胃脘部不适，无疼痛，无反酸烧心，二便调，纳眠可。 舌淡苔白，脉弦滑。

清半夏 10g	黄芩 10g	蒲公英 30g	北沙参 15g
麦冬 15g	浙贝母 10g	旋覆花 10g	生赭石 20g
五灵脂 10g	蒲黄炭 10g	黄连 3g	三七面 3g
全蝎 3g	蜈蚣 3 条	白蔹 10g	白及 10g
海浮石 30g			

中药：七剂日一剂水煎服，每日两次。

康复新液 （100ml*1）X4 瓶/15ML，口服，日三次

按语

本病例是一反流性食管炎、Barrett’s 食管伴有功能性消化不良病例。因其症状以胃痛为主要表现，故中医诊断为“胃痛”。患者脉弱，是脾虚表现；胃痛，是胃失和降，气滞血瘀所致。脾虚痰湿不化，气滞血瘀，痰瘀互阻，导致血腐肉败，故形成反流性食管炎、Barrett’s 食管。由于脾属脏，属阴；胃属腑，属阳。脾虚多为脾阳不振，中焦虚寒，痰湿内阻；胃气不降，多郁而化热。故脾病多寒，胃病多热。脾胃不和多为寒热错杂。故属于寒热错杂，脾胃不和，痰瘀互阻。用《伤寒论》之半夏泻心汤寒热并用，辛开苦降，故能起到较好疗效。用失笑散、全蝎、蜈蚣以活血通络止痛，用浙贝母、瓦楞子、海浮石等清化顽痰，用白蔹、白芨敛疮止血，治疗反流性食管炎、Barrett’s 食管之粘膜充血糜烂，可谓古方今用。本病例是一辨证与辨病相结合的典型案例。

作者简介

刘汶，医学硕士。北京中医医院主任医师，教授，硕士研究生导师，感染科主任。长期从事消化系统胃肠及肝胆疾病的临床、科研及教学。已发表学术论文 40 余篇，并参加了《实用中医消化病学》、《中医消化病诊疗指南》等书的编写，著有《刘汶脾胃病临证心悟》一书。现为北京市突发公共事件中医药应急专家委员会专业组专家，北京中西医结合学会临床营养治疗专业委员会副主任委员，北京市中西医结合消化病专业委员会秘书，北京市中医药学会肝胆病专业委员会秘书长，北京中西医结合学会第六届肝病专业委员会委员，北京中医药学会感染专业委员会委员，北京中医药学会心身医学（精神与卫生）专业委员会委员，《中华中医药杂志》、《中国实验方剂学》审稿专家，《光明中医》杂志社编委，《中国医药导报》特约专家，《中国中医药现代远程教育杂志 》特约专家，世界中联脾胃病专业委员会理事，世界中联亚健康专业委员会理事。

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桂枝加葛根汤运用心得

黄伟（Falkirk）

摘要：桂枝加葛根汤见《伤寒杂病论》第十三篇，辩太阳病脉症并治上。桂枝加葛根汤用于太阳病，头项强痛，项背强紧紧，有汗怕风的病人。太阳病，汗出恶风，是桂枝汤证。只用桂枝汤，仅能解肌祛风，调和营卫，对驱除经脉中邪气力量不够，所以加葛根就成了桂枝加葛根汤。经方应用中，剂量问题一直有诸多争论，本文觉得必须严格把握剂量。随着中医药学发展，桂枝加葛根汤的运用已经大大超过了“伤寒”的范畴，且得到了现代药理学的广泛支持。

关键词：太阳病；桂枝加葛根汤；心得；中医；现代药理

1.经文今悟

1.1原文学习

桂枝加葛根汤见于《伤寒杂病论》第十三篇，辨太阳病脉证并治上。

原文为：太阳之为病，脉浮，头项强痛而恶寒。太阳病，项背强几几，反汗出恶风者，桂枝加葛根汤主之。（几音：紧，紧固拘挛不柔和貌）方三。

葛根四两 麻黄二两（去节）芍药二两 桂枝二两（去皮） 甘草二两（炙） 生姜三两（切）大枣十二枚（擘）右七味，以水一斗，先煮麻黄、葛根减二升，去上沫，内诸药，煮取三升，去滓，温服一升，覆取微似汗，不须啜粥，余如桂枝法将息及禁忌。（仲景本论，太阳中风自汗用桂枝，伤寒无汗用麻黄，今证云汗出恶风，而方中有麻黄，恐非本意也。第三卷有葛根汤证，云无汗、恶风，正与从方同，是合用麻黄也。此云桂枝加葛根汤，恐是桂枝中但加葛根耳）[1]

1.2量效要领

正确运用经方，须把握剂量。按汉代度量衡：汉1斤＝250g；1两＝15.625g；汉1合＝20ml；1升＝200ml；1斗＝2000ml；1斛＝20000ml[2]

所以，桂枝加葛根汤方应为：葛根60g 芍药30g 桂枝30g 炙甘草30g 生姜45g（切）大枣十二枚（擘）。加水2000ml，先煮葛根，去除泡沫后待水减少至1600ml时，加入其余五味，再煎至600ml，每次温服200ml。除不以热粥助药力外，其余注意事项同桂枝汤。

身材魁梧的照此剂量，若身材娇小则取此方三分之一量，灵活掌握。

1.3膀胱经生理复习

太阳膀胱经上连风府，与督脉相通；下络腰肾，和肾相连，可借助督脉和肾的阳气主管全身表阳。又有太阳膀胱经散布于心，可影响心的功能。而且，膀胱在肾阳的温煦作用下通过气化化生阳气后，通过太阳膀胱经脉和三焦经脉向体表输布；膀胱还化生津液向全身输布并排泄水。

1.4膀胱经病理及桂枝加葛根汤的效用

风寒入侵太阳经脉会出现多种太阳病的临床症状。太阳病本身有头项强痛，头痛，后项部肌肉拘紧不柔和。太阳病寒邪入经本来是无汗的，但病人却有汗，这就提示了寒邪在经，经气不利。正因为外有风邪，风主疏泄，卫阳被伤，卫外失司，所以有汗出。外有风邪，卫阳被伤，伤得较轻，所以有恶风——当风则恶，无风则缓，是畏寒比较轻的一个症状。太阳病，汗出恶风，是桂枝汤证。但只用桂枝汤的话，仅能解肌祛风，调和营卫，对驱除经脉中的邪气力量不够，所以加一味葛根，于是就成了桂枝加葛根汤。桂枝加葛根汤可以解肌驱风，疏通经脉。葛根在此有三个作用：1.升阳发表，助桂枝汤解肌驱风，并鼓舞胃气上行。桂枝汤养营力强，发汗力弱，发汗需要喝热稀粥200ml并盖被子，而加葛根就可以助桂枝汤发汗达表，故桂枝加葛根汤不需要再喝热稀粥；2.疏通经脉，驱除经脉中的邪气；3.升津液，起阴气，滋润经脉。

2.现代药理研究拾遗

2.1葛根概览

现代药理研究证实，葛根具有显著的β受体阻滞效应。葛根降低血压，减慢心率，扩张冠状动脉，降低心肌耗氧，与心得安等β受体阻滞剂作用相似，但无明显抑制心脏作用，能使β受体兴奋引起的心电图S - T段异常,得到改善或恢复正常[3]。

研究表明葛根所含葛根素和葛根总黄酮有扩张脑血管,增加脑血流量,扩张冠状动脉,增加冠脉流量,抑制血小板聚集的作用。尚有降低外周血管阻力，降低血压的作用。

研究发现,葛根煎剂具有降低家兔血糖的作用，改善脂肪细胞的胰岛素抵抗,从而增强脂肪细胞对葡萄糖摄取利用的能力及改善Ⅱ型糖尿病患者胰岛素的抵抗和降低空腹血糖的作用。

葛根发汗解热的作用,不但可用于风寒感冒,同时也可用于风热感冒,尤对太阳表证项背强直、头痛疗效更好,同时还可治疗麻疹初起,疹出不畅之症。

葛根提取物能促进未成熟大鼠乳腺、子宫发育,使其功能正常发挥,从而使乳腺、子宫重量增加,同时又能增加血清E2、FSH、LH水平表明其对垂体—卵巢轴具有兴奋作用[4]。

葛根素能增加外周血内皮细胞(endothelial progenitor cell，EPC) 数量,且能改善EPC增殖、迁移黏附和体外血管生成能

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力。提示葛根素不但直接对内皮细胞具有保护作用，可能同时增加EPC的数量，并改善其功能从而促进内皮修复改善冠心病患者的临床症状和预后。

葛根素具有保护鼻黏膜上皮细胞免受雌激素缺乏的损害作用,葛根总黄酮对卵巢切除大鼠鼻黏膜的保护作用可能在于大豆黄酮的雌激素样作用,也可能与抗氧化等作有关[5]。

葛根素在机体缺血再灌注时通过抑制细胞内Ca2＋ 的聚集,减轻细胞损伤;葛根素上调BcL-2（B-细胞淋巴瘤基因2）蛋白的表达,下调Bax蛋白的表达,从而抑制神经细胞凋亡,发挥神经元保护作用。

葛根素可减轻缺血性大鼠脑细胞的损伤，提高其HSP70蛋白表达水平，通过诱导细胞表达HSP70,而对神经细胞的损伤产生保护[6]

高剂量葛根素对选模引起大鼠的全血过“浓”“黏”导致的全血高、中、低切黏度值异常升高,具有显著抑制作用。葛根素还可通过显著降低血液屈服应力起到改善血“凝”的作用。而其对急性血瘀症大鼠过高的细胞聚集指数和血小板最大聚集率的双重降低作用，表明葛根素具有抑制血“聚”的作用[5]。

2.2桂枝汤新解

现代药理研究表明：桂枝汤具有发汗解表，抗炎镇痛，抑制病毒，镇咳，祛痰，平喘，调节肠道、免疫功能和心脑血流等作用。

1.抗病毒、抗炎、镇静、镇痛等作用：桂枝汤煎剂灌胃能显著抑制小鼠流感病毒性肺炎的肺肿胀；经此方灌胃处理后的兔、大鼠血清在体外能显著抑制副流感等病毒致细胞病变作用。灌胃能对抗小鼠皮肤毛细血管通透性增高，抑制角叉菜胶或甲醛性足肿胀的形成和发展；能显著减少小鼠的自主活动，可与巴比妥钠协同，提高入睡率，延长睡眠时间；能降低醋酸刺激腹膜所致的扭体发生数；腹腔注射能提高小鼠对热刺激的拟疼痛阈值。煎剂灌胃能延长氨水诱致的小鼠咳嗽时间、提高气管内酚红排泌量；能延长组胺诱致豚鼠哮喘发生的潜伏期；灌胃后20分钟即能明显增加正常兔的心肌血流量，作用持续达2小时。

2.双向调节作用:桂枝汤煎剂灌胃可降低正常以及酵母所致大鼠发热，对安痛定所致的大鼠体温降低有升温作用。进一步研究发现，在体温升高的大鼠，桂枝汤煎剂灌胃可阻断发热激活物和白介素-1、干扰素、肿瘤坏死因子等内生致热源的作用，降低前列腺素E2和环核苷酸（cAMP）等中枢发热介质在下丘脑中的含量及作用，促进体温调节中枢神经递质5-羟色胺的降解灭活、抑制乙酰胆碱的作用，激活致冷神经调质蛙皮素受体的活性，从而发挥其降温作用；在低体温机体，桂枝汤可提高前列腺素E2和cAMP等中枢发热介质在下丘脑的含量，阻断发热神经递质5-羟色胺的降解灭活，提高其在体温调节中枢中的含量，拮抗致冷神经递质去甲肾上腺素作用，激活传出神经能受体，从而发挥其升温作用。

煎剂灌胃，能增加正常大鼠足跖部的汗腺分泌，能抑制安痛定所致的汗腺分泌亢进和拮抗阿托品引起的汗腺分泌减少；灌胃，能抑制因注射新斯的明引起的小鼠肠蠕动亢进和拮抗肾上腺素引起的肠蠕动抑制。桂枝汤煎剂灌胃对免疫功能已呈抑制的病毒感染小鼠，可提高其巨噬细胞吞噬功能、血清凝集素、溶血素效价和外周血中T细胞百分率，使之恢复到正常；而对免疫功能已增强的左旋咪唑处理小鼠，则降低其血清凝集素、溶血素效价和外周血中T细胞百分率，使之接近或恢复到正常水平。

上述研究表明桂枝汤在体温、汗腺分泌、肠蠕动、免疫等方面具有双向调节作用，为其调和营卫即补身救弊，调节紊乱的内涵提供了一定的现代理解。

2.3桂枝汤配伍研究拾穗

配伍研究：以抑制流感病毒性肺炎、角叉菜胶性足肿胀、碳末廓清（RES）功能为指标，利用正交设计实验，观察到全方抑制病毒性肺炎、增强RES功能的作用显著强于组成药味的各种组合，全方减去任何一种药味都会影响疗效。对于不同观察指标，方中各组成药味在全方中所起的作用不同：桂枝以抗炎为主，芍药以抑制病毒为主，而大枣以提高RES功能为主。方中各组成药味间有协同、拮抗等不同关系：桂枝伍芍药，其抗炎作用增强；桂枝伍生姜，其抗炎和RES功能增强；芍药伍甘草，其抗病毒、抗炎和提高吞噬活性等功能增强；芍药伍大枣，其抑制肺炎病变的作用增强，对RES活性的提高有拮抗作用；甘草伍大枣，其抗炎和提高RES功能增强。提示在抗病毒感染方面，桂枝汤方中诸药在配伍上具有协同增效性，方中药物在配伍上的重要性与药理作用的选择有关。

对大、小鼠的时间药理学研究表明，桂枝汤对活动期动物的解热作用强于静止期动物，提示桂枝汤对人宜白昼服用。提高环境温度并辅以药后灌服小米粥，能增强桂枝汤的抑制病毒性肺炎和单核巨噬细胞吞噬功能，说明“啜热粥温覆以助药力”的科学性。以小鼠巨噬细胞功能为指标，桂枝汤一日2剂的作用强于一日1剂，连日服的作用强于非连日服。一日总量分三次口服，每次间隔2.5小时，作用也明显强于总量一次服，证明桂枝汤宜多次分服的合理性。[7]

3.小结

因而，在临床上以此方治疗“普通感冒、流行性感冒、面神经麻痹、原发性震颤、僵人综合征、乙脑后遗症、重症肌无力、慢性多发性肌炎、高血压、脑动脉硬化、颈椎病”等有风寒入太阳，表虚的“头项强痛，项背强几几”症状者多可获良效。

4.典型病例

李某某，女，24岁，餐馆服务员。2010年4月26日诊。主诉：咳嗽，高热，头痛，颈项强痛，恶风伴疲乏十多天。十多天前患“感冒”，出现发热，咽喉痛，头痛，颈项强痛，

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身痛。服西药后出汗，咽喉痛，身痛好转，体温下降，但复又出现咳嗽少痰，高热（39℃ --39.8℃ ），头痛，颈项强痛，恶风伴全身疲乏。继续服“感冒药”“抗生素”一周多疗效不明显。经人介绍前来就诊。

刻诊：面稍赤，覆厚衣戴帽，精神差。口唇稍干。咳嗽，咯少许黄痰。头痛，颈项强痛，恶风，疲乏。无鼻塞，清涕及咽喉疼痛。查：体温39.5℃，扁桃体无充血肿大及化脓，舌微红苔薄黄稍干，脉浮稍数。诊断：1.呼吸道感染。2.流感？辨证：太阳中风证兼经气不利。

治疗：当解肌祛风，升津舒筋，辅以清热解毒。予针刺。桂枝加葛根汤：葛根20g 芍药10g 桂枝10g炙甘草10g 生姜15g（切）大枣5枚（擘），二剂。“清肺口服液”20ml/次 3次/日。

4月28日复诊，头痛已瘥，颈项强痛，恶风，疲乏及咳嗽明显好转。体温37.3℃。续用前法，再予桂枝加葛根汤三剂，生姜减量至9g。

5月1日复诊，诸证已除，予加减八珍汤五剂调养。5月3日电话告知体力睡眠已经恢复正常并开始正常工作。

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Is Acupuncture Effective in Improving Fertility in Patients with Polycystic Ovary Syndrome?

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Abstract: Polycystic ovary syndrome (PCOS) affects 5-15% of women of reproductive age and causes 50-70% of female infertility in anovulation. Many research studies showed the positive results on using acupuncture treatment PCOS. In order to further assess the effectiveness, this study reviewed the published clinical treatments results between 1995 and 2014. Data from 6 research papers was further analysed. Results showed that 5 out of 6 study results show that acupuncture treatment is effective in treating PCOS which showed significantly higher ovulation rate and pregnancy rate compared to clomiphene treatment or in a self-controlled study. Another study did not show its effect compared to sham control. In view of the absence of published research using patient sample size above 100 and less fully randomly controlled experiment and standard treatment procedure, a better RCT and standard study is needed to further confirm the effectiveness of acupuncture treatment PCOS.

Key words: Polycystic ovary syndrome; Acupuncture; Ovulation rate and pregnancy rate

1. Introduction

Polycystic ovary syndrome (PCOS) affects 5-15% of women of reproductive age and causes 50-70% of female infertility in anovulation (Broekmans, et al., 2006). Two-thirds of women with PCOS have metabolic dysfunction which increases risks of developing type 2 diabetes mellitus and cardiovascular disease (Goodarzi and Azziz, 2006). In most PCOS cases, the ovaries become enlarged and contain numerous small, immature follicles scattered along the outer edge of each ovary, this may cause failure to release eggs upon maturation.

PCOS is characterised by ovulatory dysfunction, oligo/amenorrhea, and polycystic ovaries (Hull, 1987; Jonard, 2005; Dronavalli and Ehrmann, 2007). PCOS patients often suffer from menstrual abnormalities, leading to difficulty in getting pregnant. Other common symptoms are excess hair growth on the lips and legs, facial acne, weight gain, et al (Goodarzi, 2011). In women in adolescence, infrequent or absent menstruation may signal the signs and symptoms of PCOS. In women past adolescence, difficulty becoming pregnant or unexplained weight gain may be the first sign (Dronavalli and Ehrmann, 2007).

The aetiology of PCOS is unclear. The biochemical changes of the syndrome include elevated levels of insulin and luteinizing hormone (LH), in about 70% of women with PCOS, there is lower or no effect on follicle-stimulating hormone (FSH) and this will cause the LH/FSH ratio increase to more than 2.5 (Ma et al.,

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1996). Ovarian androgen production was increased in about 50–75% of women with PCOS, which impair follicle development (Goodarzi, 2011). In the face of a high LH/FSH ratio, more androsternedione is synthesized but not aromatised, thus perpetuating a vicious cycle driving LH production and prolactin production which induces granulose cell differentiation and subsequent follicle growth (Franks, et al. 1999; Marx and Mehta, 2003). Acupuncture treatment can reverse the increased LH and decreased ratio of LH:FSH (Stener-Victorin and Manneras, 2008). Increased fat mass and central adiposity are related to hyperinsulinaemia from prepuberty to postmenarche (Hasson et al., 2003). Weight gain worsens metabolic disorders, e.g. dyslipidemia, insulin resistance and hyperandrogenism et al., and reproductive abnormalities, e.g. menstrual irregularity and infertility in obesity women with PCOS (Ciaraldi et al., 2009; Aroda et al., 2008). With 20–40% of first-degree female relatives of women with PCOS affected by the PCOS compared to the general population (prevalence 4–6%) (Vink et al., 2006)

There is no golden standard for the long-term treatment of women with PCOS. Treatment generally focuses on management of individual main concerns, as the medications may include ameliorating hyperandrogenic symptoms, inducing ovulation, regulating menstruation and preventing complications (Marx and Mehta, 2003). Treatments include oral contraceptives (Banaszewska, 2011) containing synthetic estrogen and progesteronein; insulin sensitizers (Geller et al., 2011), e.g. metformin, in order to decrease insulin levels; Clomiphene citrate, an oral anti-estrogen medication, should be taken in the first part of her menstrual cycle in order to help ovulation (Dronavalli and Ehrmann, 2007; McFarland, 2012); and lifestyle interventions, e.g. eating balanced diet with high in fibre and do regular exercise to keep an ideal weight (Carmina et al., 2003; Manneras et al., 2008).

Chinese medicine has achieved some positive effects in treatment of PCOS. According to TCM theories, PCOS is caused by the dysfunction in the Liver, Kidney and Spleen systems, especially the imbalance and regulation of the kidney (Tiangui), Chong and Ren (Hou et al., 2008). Acupuncture, an integral part of TCM, has been applied to the treatment of human diseases, e.g. pain, dating back 3000–5000 years. Acupuncture has been widely used by patients for infertility problems, although their efficacy has not yet been fully established. Acupuncture treatments decrease total testosterone and other sex steroid levels, reduce the LH/FSH ratio, and improve menstrual frequency without adverse effects. Several randomized controlled trial (RCT) have been performed to evaluate the effects of acupuncture on hyperandrogenism and oligo/amenorrhoea in women with PCOS who do not attempt to conceive (Chen et al., 2007; Pastro et al, 2011). Case-control studies suggest that acupuncture has stronger effects than physical exercise on these variables (Jedel et al., 2011). Acupuncture on Yishu (also called Weiwangxiashu, EX B3) point also showed significant improvements in ovulation rate in PCOS patients with non-insulin-resistance (Hu et al., 2009). Treatment on Yishu also showed the regulation of islet function and reducing the hyperglycimia in an animal study (Shi et al., 2001). Clinical evidence also showed the effectiveness of acupuncture in assisting the reproductive treatment either in clinical trial (Zai et al., 2003; So et al., 2009; Moy et al., 2011) or in system meta-analyses (Zheng et al., 2012;).

Some research showed the benefit of acupuncture treatment on PCOS. However, the true effectiveness hasn't been thoroughly analysed due to avoiding bias or poor design. The aim of the study was to review its effectiveness by analysis the published data.

2. Methodology

Papers published in English or Chinese with English abstract from 1995 to 30th March 2014 have been electronic searched. They were from: (1) PubMed and Medline using key words: polycystic ovary syndrome and acupuncture; 49 papers were found. 12 papers were found if further searched by using polycystic ovary syndrome, acupuncture, and clinical trial. Among them, 3 papers were related to ovulation. Among them, 1 paper was on both ovulation and pregnancy but it is written in Chinese with English abstract. (2). Electronic medical database from China National Knowledge Infrastructure (CNKI) was searched. A total of 49 published papers were found from 1995 until 30th March 2014, using key words: 多囊卵巢综合征 (PCOS), 针灸 (acupuncture) or 针刺 (needle pricking) and 临床观察 (clinical observation). Among them, 27 papers are clinical trials, and all studies with words like "randomization" or "quasi-randomization" in their abstracts, and only 4 papers meet the selective criteria (including one paper found in PubMed). Articles that were deemed to provide the greatest contributions to understanding acupuncture on the ovulation and infertility research in human clinical trial. Four papers with clomiphene (a medicine used to improve ovulation) treatment as control group were selected for statistical reanalysis. Numbers of non-pregnancy and non-ovulation in treatment and control groups were reanalysed based on previously published paper's data.

Selected criteria: randomly controlled trials that studied the efficacy of acupuncture treatment in infertile women with PCOS. In this review, reanalysis papers with 1) controlled group treated with clomiphene and 2) treatment group using acupuncture only. In other papers, using self-control or control group with sham treatment. The exclusion criteria are 1) the trial with a group size below 10; 2) diseases, e.g. congenital disease, physical defect, cancer; adrenal gland disease, thyroid disease, 3) acupuncture treatment combined with herbs or western medicine, using hormone treatment within 3 months before trial.

All papers on acupuncture treatments related to pregnancy or ovulation have been considered and the indices are: 1) For pregnancy test, the couples live together for at least 2 years and having normal sexual life without taken the contraception, and the ratio of LH to FSH is above 2-3. The volume of both ovaries is increasing under the B-ultrasonic screen, the reflective sound increasing and anovulation; 2) Pregnancy diagnosis: pregnancy should be recognised if following criteria are met: amenorrhea above 40 days, Konsuloff's

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reaction is positive and HCG concentration is above 3IU/L, and pregnant sac can be seen under obstetric ultrasonography; 3) Definition of ovulation should be based upon the following test: the basic body temperature wave is showing the biphasic pattern, the diameter of the ovarian folicle is above 18 mm in the preovulatory phase and the diameter is reduced in the postovulatory phase; 4) Diagnostic criteria of PCOS: Menstrual abnormality include menstrual intervals longer than 35 days; fewer than eight menstrual cycles a year; failure to menstruate for four months or longer; and prolonged periods that may be scanty or heavy.

Table 1 General information on depicting the selected papers

Key Words	CNKI	PubMed /Medline
Acupuncture; Polycystic ovary; Syndrome	49	49
Acupuncture; Polycystic ovary syndrome; Clinical trial	27	12
Acupuncture; Polycystic ovary syndrome; Clinical trial; Ovulation	19	3
Acupuncture (no combined treatment); Polycystic ovary syndrome; Clinical trial; Pregnancy and ovulation (Chinese paper plus clomiphene)	3	1
Selected to meet the criteria	3	3

The initial literature search identified 92 papers in total using the key word acupuncture and polycystic ovary. With the key word of clinical trial added, it narrowed the search to 39 papers and final reading and selection to meet the criteria down to 6 papers used in this study. Table 1 shows the flow of papers in the process.

Statistical difference between treatment and control groups was analysed using chi squared (X2) analysis.

3. Results

3.1 The review papers were summarised in Table 2 and 3

Four papers tested the effect of acupuncture treatment on PCOS compare with clomophene treatment. They are, Yuan L, et al., (2010); Yang Y et al., (2005); Ma R et al., (1996); Chen D et al., (2007). One paper used sham as control to observe the effects of acupuncture in treatment

Table 2 Basic information in selected papers

Experimental design	Method	Treatment group	Control group (clomiphene control)
In *Ma (1996)* Quasi-randomized controlled	Not clear	N = 50; Age: 22-39 years old History of infertility or irregular menstrual 8-13 years; Among them, wish to be pregnancy: N = 32	N = 48; Age: 24-36 years; History of infertility or irregular menstrual 0.5-13 years; Among them, wish to be pregnancy: N = 29
In *Yuan (2010)* Quasi- randomized controlled	Treatment order	N = 30; Age: 20-40 years old; All patients wish to be pregnancy, but not mention infertility history in paper	N = 30; Age: 20-40 years old; All patients wish to be pregnancy, but not mention infertility history in paper
In *Yang (2005)* Quasi- randomized controlled	Not clear	N = 66; Age: 21-35 years old Infertility history: 2-8 years	N = 60; Age: 22-36 years old Infertility history: 2-7.5 years
In *Chen (2007)* Randomized controlled	Random number	N = 61; Age: 21-38 years old Infertility history: 2-12 years	N = 60; Age: 22-39 years old Infertility history: 2-12 years
In *Pastroe (2011)* Randomized controlled	Random number	N = 40; Age: 18–43 years old; the presence of both oligomenorrhea and hyperandrogenism, at least one menses and no more than eight periods in the most recent 12 months	N = 44; Age: 18-43 years old; the presence of both oligomenorrhea and hyperandrogenism, no more than eight periods in the most recent 12 months
In *Stener-Victorin (2000)* Non-randomized controlled		N = 24; Age: 20-40 years old; amenorrhea or oligomenorrhea with no more than four spontaneous bleedings per year	self-control

Table 3 Basic information in treatment group

Acupuncture points	Treatment method & Index of observation
In *Ma (1996).* Main points: Guanyuan (R4), Zhongji (R3), Zigong, Dahe (KI12), Sanyinjiao (SP6), and	After 5 days of menstrual, daily treatment, needles remain 20 minutes, continual 20 days per cycle, take 5 day off treatment

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• If weak of Spleen and Kidney qi, add Shenshu (BL23), Zusanli (ST36), Taibai (SP3), Gongsun (SP4) with reinforcing method and moxibustion plus electronic stimulation • If liver qi stagnation, add Ganshu (BL18), Jueyinshu (BL14), Qimen (LR14), using reinforcing-reducing method plus electronic stimulation	after 20 days treatment, maximum continuous treatment for 6 cycles. **Index of observation:** Pregnancy rate; Ovulation rate; LH; FSH; LH/FSH; Testosterone
In *Yuan (2010)* Zhongwan (R12), Xiawan (R10), Qihai (R6), Guanyuan (R4), Zhongji (R3), Zhigong, above point deep puncture; Wailing midle puncture.	After 5 days menstrual (or withdrawal bleeding after progesterone treatment), daily treatment for 3 days , after 3 times treatment, every other day for 3 times, needle retention 30 minutes, 6 times treatment per cycle. Repeat the rule of the next cycle if no pregnancy, mmaximum continuous treatment for 3 cycles. **Index of observation:** Pregnancy rate; Ovulation rate; LH; FSH; LH/FSH; Testosterone
In *Yang (2005)* Selected three groups of points for alternative use: **Group I:** Yinjiao (R7), Guanyuan (R4), Diji (SP8), Shuidao (ST28); **Group II:** Guilai (ST29), Dahe (KI12), Qugu(R2), Xuehai (SP10); **Group III:** Zhongji (R3), Shuidao (ST28), Guilai (ST29), Shanyinjiao	After 10 days of the menstrual or withdrawal bleeding of progesterone intramuscular injection, patients were given treatment in turn to use 3 group points. Needle retaintion 30 minutes. Continuous acupuncture 5-10 days. **Index of observation:** Pregnancy rate; Ovulation rate
Acupuncture points	**Treatment method & Index of observation**
In *Chen (2007)* **The main point:** Paravertebral points (1.5 to 2 inch away from 7th cervical Spinous process); The sacral plexus point (posterior superior iliac spine, To about 1 to 2 Wang pointed at), 2nd lumbar beside the point (in the lumbar 2, 3, the end of the bilateral transverse process of the midpoint, and the Shenshu the same), Guilai (ST29) Submain point: Qichong (ST30) and the point beside a lumbar (at the end of the 1st and 2nd lumbar bilateral transverse process of the midpoint, and the same lever as Sanjiaoshu (BL22)).	Pricking on the 1st clean day after menstrual, every 3 to 5 days pricking, and treatment of a total of 8 to 10 times. During ovulation, every 3 to 5 days pricking. Mixmum treatment for 3 mentrual cycle. Locally anesthesia the pick points, and then using specially designed stainless steel pick-needle (National Patent number: the ZI 98,243,187.2) penetrate subcutaneous in the point, holding the needle, the needle to the rhythmic traction action with medium stimulation frequency (80 to 120 times / min), the intensity varies from person to person. Mixmium treatment for 6 mentrual cycle. **Index of observation:** Pregnancy rate; Ovulation rate; LH; FSH; LH/FSH; Testosterone
In *Pastroe (2011)* Shensu (BL23), Pangguangsu (BL28), Sanyinjiao (SP6), and Yinlinquan (SP9) use EA; Shenmen (P6), triple energizer 5 (SJ5), and Baihui (Du 20) use manual acupuncture	12 sessions of true or sham acupuncture (Park sham device) for 8 weeks. Twice each week for the first 4 weeks followed by once per week for an additional 4 weeks. **Index of observation:** Ovulation rate; LH; FSH; LH/FSH
In *Stener-Victorin (2000)* Shensu (BL23), Pangguangsu (BL28), Yinlingquan (SP9), Sanyinjiao (SP6) use EA Shenmen (P6), triple energizer 5 (SJ5), and Baihui (Du 20) use manual acupuncture by rotation	EA was given twice a week for 2 weeks and then once a week, altogether 10–14 treatments. Needles remain 30 minutes. Maximum treatment for 3 months. **Index of observation:** Ovulation

Table 4. The effect of acupuncture treatment on pregnancy rate (%)

	Treatment group			**Control group**		
	Pregnancy	Non-pregnancy	%	Pregnancy	Non pregnancy	%
Yuan (2010)	13	17	43.4	11	19	36.6
Yang (2005)	40	26	61.2**	19	41	31.7
Ma (1996)	26	8	81.3*	15	14	51.7
Chen (2007)	32	29	52.5*	23	37	38.3

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Total+	111	80	58.1**	68	111	38.0

*, **: significantly different compared to control group; * P<0.05, ** P<0.01.

+: data reanalyzed

Control group were all treated with clomiphene which used the following procedure. The control group, in 5th day of the menstrual or withdraw bleeding by progestrone intromuscluar injection. Patients begin serving daily doses of 50mg clomiphene for five consecutive days. According to the results of the B-ultrasonic monitoring of follicular development, when the follicular diameter greater than 18mm, single intramuscular injection of chorionic gonadotrophin (hCG, a hormone produced during pregnancy that is made by the developing embryo after conception) 10000U;

The sham control used Park sham device was placed on the skin at standardized points on all four extremities (Achilles tendon and lateral head of the triceps) chosen to avoid standard acupuncture meridians and acupuncture points (Stener-Victorin, et al., 2000).

3.1.1 Effect of acupuncture on pregnancy rate and ovulation rate (compared with clomiphene treatment) seen on Tables 4 and 5.

The results show that acupuncture treatments significantly increase both pregnant rate (Table 4) and ovulation rate (Table 5) in combined data of four studies. Although one individual study did not show acupuncture treatment significantly increase pregnant rate and the ovulation rate from one study even lower than control group, acupuncture treatment shows its benefit higher than clomiphene treatment in improving pregnant rate.

3.1.2. EA treatments induced regular ovulations

Stener-Victorin et al (2000) has tested whether EA could affect oligo-/anovulation in 24 women with PCOS and oligo-/amenorrhoea. They were treated by EA for 3 months, 10-14 treatments in total. Nine women (38%) had good effect of EA treatment and showed improve the ovulation and oligo/amenorrhoa by a mean of 0.66 ovulations / woman in the period during and after the EA period compared to a mean of 0.15 before the EA period.

Table 5. The effect of acupuncture treatment on ovulation rate (%)

	Treatment group			Control group		
	Ovulation	Non- ovulation	%	Ovulation	Non ovulation	%
Yuan (2010)	38	34	52.8	42	25	62.7
Yang (2005)	56	10	84.8**	19	60	24.0
Ma (1996)	49	1	98.0	44	4	91.7
Chen (2007)	51	10	83.6*	38	22	63.3
Total+	194	55	77.9**	143	111	56.3

*, **: significantly difference compared to control group; * P<0.05, ** P<0.01.

+: data reanalysed

Table 6. The change of LH and FSH lever and LH/FSH ration compared with before treatment

	Yuan (2010)		*Yuan (2005)*		*Ma (1996)*		*Pastore (2011)*	
Group:	Treatment	Control	Treatment	Control	Treatment	Control	Treatment	Sham
LH	↓*	↓	↓*	↓	↓*	↓	↓	↓
FSH	-	-	-	-	-	-	-	-
LH/FSH	↓*	↓	↓*	↓	↓*	↓	↓	↓
Testosterone	↓*	↓	↓*	↓	↓*	↓		

Note: ↓: significantly decrease compared with pre-treatment (baseline);↓*: significantly decrease compared with control group; -: no significantly change compared with before treatment (baseline)

These women also demonstrated significantly lower levels of body mass index, serum testosterone concentration, serum testosterone/sex hormone binding globulin ratio and serum basal insulin concentration compared to those women with no effect.

3.1.3. True and sham acupuncture produced similar frequency of ovulation

Pastore et al (2011) recently conducted a random control, double-blind, sham-controlled clinical trial using 12 sessions of true or sham acupuncture (Park sham device). The trial lasted 8 weeks. Eighty-four reproductive-aged women with PCOS were involved in the study. They were not involved in hormonal intervention 60 days before enrolment. Serum LH and FSH were measured at baseline, after intervention, and 3 months later. Ovulation was measured with weekly urine or blood samples. Results show that true and sham acupuncture produced similar frequency of ovulation and both groups had a similar improvement in their LH/FSH ratio.

3.1.4. Summary of the effect of acupuncture on LH, FSH and testosterone levels

In three clinical trials, the LH and testosterone level and LH/FSH ratio showed a significant decrease compared to pre-treatment and control group treated with clomiphene. One clinical trial used sham control, LH

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lever and LH/FSH ratio in both group have significantly decreased compared with pre-treatment, and also LH level has significantly decreased compared with sham group, LH/FSH ratio has declined but there was no significant difference compared with sham group.

4. DISCUSSION

Acupuncture has been used for treatment PCOS for many years, however, there is no inconclusive confirmation about its effectiveness. This study focused on a systematic review of published data on acupuncture in the treatment of PCOS, the aim is to assess whether acupuncture is effective in improving fertility in patients with PCOS. 6 papers were selected for this review.

4.1 Acupuncture treatment effectively increase ovulation rate

The data showed ovulation rates in the treatment group was higher (Yang et al, 2005; Chen 2007) than the control group treated by clomiphene, a medicine used frequently to treat anovulation; ovulation rate in treatment group was equal to the control group (Ma et al, 1996; Yuan et al, 2010) and this shows clinical effectiveness of acupuncture treatment; 38% of patients showed effect after treatment and ovulation rate has been increased in these patients by 4 times, but there is no difference between after treatment and pre-treatment if the total group was considered (Stener-Victorin et al 2000). There is no effect of acupuncture treatment compared to sham treatment (Pastore et al 2011), however, this is caused by other components of sham acupuncture and the treatment method's difference. The four studies (Ma et al, 1996; Yang et al, 2005; Chen 2007; Yuan et al, 2010) used participants from hospital patients with irregular anovulation or infertility history. There is no detailed information on the patients whether they have clomiphene resistance in the above 4 studies and in Pastore et al (2011) study. In Stener-Victorin et al (2000) study, 19 out of 24 participants are clomiphene resistant.

4.2 Acupuncture treatment effectively increase pregnancy rate

The data showed acupuncture 1) significantly increases pregnancy rate (Ma et al, 1996; Yang et al, 2005; Chen, 2007) in treatment group compared to control group treated with clomiphene; 2) pregnancy rate with acupuncture treatment, 8% higher than the control group treated with clomiphene (Yuan et al, 2010)

4.3 The strength and limitation in the studies

Published data has been searched thoroughly and there are not many well designed RCT studies. Among the 6 papers selected, 4 papers are written in Chinese and they have good case control studies: acupuncture treatment compared to clomiphene treatment. In view of the absence of published research using patient sample size no more than 80 participants - based on the power calculated by Pastore (2011) plus it not being a fully randomly controlled experiment, it shows interesting results but a better quality controlled and standard study is needed.

One study is self-controlled (Stener-Victorin et al, 2000) with small size participants. Another study (Pastore et al, 2011) is a well-designed RCT with double blinded trial. However, they selected a variety of acupuncture points in these treatments (see Table 3). Treatments in all four studies: Ma et al, 1996; Yang et al, 2005; Chen 2007; Yuan et al, 2010, selected the needle points based on their personal situation, however, the other two studies did not treat based on individual needs, and used acupuncture treatment in a consistent way to all participants in the whole treatment period, such as acupuncture points, the depth of the needle, the duration of stimulation and intensity of the stimulation were all same. These 'same method' is different from actual acupuncture practice which should be based on individual situation and symptoms to choose a variety of acupuncture points, time course et al.

The Pastore et al (2011) study used large random controlled trails, following Stener-Victorin's treatment procedure, but the whole period (2 months treatment and 3 months follow up) is less than Stener-Victorin's treatment which is a total of 8-9 months study period, thus studies showed different results. Pastore et al also couldn't collect the basic information for EA treatment on the menstrual and ovulation patterns before treatment. The good thing is that the clinical trial size met the experiment requirement.

4.4 Acupuncture treatments show effectiveness in recovering the imbalance of hypothalamus-pituitary-ovary axis in some extent

These papers also tested the LH, FSH and testosterone levels and found that after acupuncture treatment, LH significantly reduced and thus reduced the LH/FSH ratio. Acupuncture treatments also decreased testosterone and inhibited GnRH secretion and re-balanced the hypothalamus-pituitary-ovary axis.

4.5 There is no effect in the Pastore et al (2011) study: a randomized, double blind, sham-controlled clinical trial.

In this study, 84 reproductive-aged women with PCOS completed 60 day's intervention and then they were followed up for 3 months. Intervention included 12 sessions of true or sham acupuncture in the points (Table 3) for 8 weeks. Results showed acupuncture produced a similar ovulation rate compared with sham control group. These non-effective results may be caused by not having enough treatments and other factors in the sham control treatments.

5. CONCLUSION

Among 6 papers analysed, 4 papers used case-control studies which compared the acupuncture treatments to the control groups that were treated with clomiphene. 1 paper used no random self-control study and another one is a fully RCT study. 5 out of 6 study results show that acupuncture treatment is effective in treating PCOS which showed significantly higher ovulation rate and pregnancy rate compare to clomiphene treatment or in a self-controlled study. Another study did not show its effect compared to sham control. In view of the absence of published research using patient sample size above 100 and less fully randomly controlled experiment and standard treatment procedure, results show limited information. Subsequently a better RCT and standard study is needed to further confirm the effectiveness of acupuncture treatment PCOS.

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The Latest Research Review on Chinese Herbs of Anti-myocardial Ischemia

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Coronary heart disease (CHD) is the UK's biggest killer. Although western medicine has achieved a lot progress in treating CHD, it is still causing around 82,000 deaths each year. About one in five men and one in eight women die from the disease. In traditional Chinese medicine many herbal remedies have showed a good effect on treating angina. Many laboratory studies have been done to investigate the mechanism of treating myocardial ischemia (MI). I published a research review on this topic many years ago (Tang, T. 2003). Many progressive new reports have been published in the last 5 years. For a clinical practitioner these research updates will provide a helpful reference in treatment of CHD. For researchers and students it can provide a useful reference for future research projects. As for the general public, it has displayed some scientific evidence for Chinese herbs in treating ischemic heart disease.

1 Research on individual herb and plant monomer

Danshen (*Salvia miltiorrhiza*) is a very commonly used traditional Chinese herb in treating heart disease. It contains many sub fractions, which are mainly Tanshinone Ⅰ, ⅡA, ⅡB, Salvianolic acid A (SAA), and Salvianolic acid B (SAB). In an in vivo study, rat MI model was induced by permanent left anterior descending coronary artery ligation. The results showed Tanshinone IIA attenuates the MI pathological changes and improves heart function, and reduces expression of MCP-1, TGF-β1 and macrophage infiltration. It could also decrease the expression of TNF-α and activation of nuclear transcription factor-kappa B (Z.H.Ren, 2010). Researchers applied a myocardial infarct rats model. The rats were given different concentrations of SAA. Immunohistological analysis was performed to measure vascular endothelial growth factor and vascular endothelial growth factor receptor-2 expressions. The secretion of matrix metalloproteinase type X was evaluated in serum of post-ischemic rats. The result showed SAA potentiated the ischemia induced neovascularization. These findings show that SAA has potent proangiogenic properties by promoting the expression of proangiogenic factors (Yujuan Li, 2014). Another study shows SAB also can markedly and dose-dependently reduce fibrinogen and malonaldehyde levels, increase the HDL level, improve blood viscosity and plasma viscosity in MI rabbits (Qian Yang, 2010). A study applied an RT-PCR and Western blot method to detect p38 MAPK gene expression. The result suggests that Tanshinone IIA play a role in protection cardiomyocytes from ischemic and hypoxic injury. The effect is based on inhibiting miR-1 expression through p38 MAPK signal pathway (Zhang, Y. 2010).

Asperosaponin VI is a saponin from Chinese herb Xuduan (*Dipsacus asper*). A study investigated the anti-MI effects of Asperosaponin VI both in vivo and in vitro. The results suggested that it could provide significant cardioprotective effects against acute MI in rats. These mechanisms might be attributed to scavenging lipid peroxidation products and reactive oxygen species, increasing antioxidant defence enzymes and preventing mitochondrial damage (Chunmei Li, 2010).

Angelica sinensis polysaccharides are an active ingredient extracted from Danggui (*Angelica sinensis*). The cardioprotective effects were evaluated by using MI/reperfusion rats. A sinensis polysaccharides treatment significantly reduced myocardial infarction size, enhanced CT-1 and antioxidant enzymes activity, down regulated caspase-12 mRNA expression in rats (Song Zhang, 2010).

Juemingzi (*Semen Cassiae*) was proved to reduce blood lipid levels. A study investigated whether it can reduce MI and reperfusion injury. The results showed Juemingzi extract can not only significantly reduce the plasma lipid level, but it can also improve the instantaneous first derivation of left ventricle pressure and reduce infarct size (Feng Fu, 2014).

Gegen (*Lobed Kudzuvine Root*) has been widely used in the treatment of myocardial and cerebral ischemia. Puerarin is a major active ingredient extracted from Gegen. A study was designed to observe the effects of puerarin on the signalling transmission mediated by P2X3 receptor in stellate ganglia and cervical dorsal root ganglia after MI damage. The results suggested that Puerarin could reduce systolic blood pressure and heart rate, relieved pain and decreased up-regulated expression of P2X3 mRNA and protein after MI. Puerarin was shown to inhibit the up-regulated ATP-activated currents after MI. This suggested that puerarin can relieve MI through blocking the P2X3 signalling transmission (Shuangmei Liu, 2014).

Rougui (*Cinnamomum cassia*) is widely used for the treatment of ischemic heart disease. The active components, cinnamic aldehyde and cinnamic acid, can be isolated from Rougui. A study has investigated the effects of anti MI of Cinnamic aldehyde and cinnamic acid. The results showed these two extracts can decrease the ST elevation induced by acute MI, decreased serum levels of CK-MB, LDH, TNF-α and IL-6, and increased serum NO activity, increased SOD activity and decreased MDA content in myocardial tissue (Fan Song,2013).

Shanzha (*hawthorn*) is commonly used Chinese medicine. A study was designed to investigate the effects and mechanisms of hawthorn leaf flavonoids on acute MI/reperfusion in anesthetized dogs. The results indicated

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that this flavonoid can significantly decrease the degree and scope of MI, markedly inhibit the increase of myeloperoxidase activity, and IL-1 and TNF-α content induced by MI/infarction. It can also increase G protein-coupled receptor kinase 2 expression and inhibited NF-κB expression (Jianhua Fu, 2013).

Tetramethylpyrazine, sodium ferulate and puerarin are extracts from Chinese herbs Chuangxiong, Danggui and Gegen respectively. Some research has shown that these three extracts can antagonize the nociceptive or pain transmission mediated by P2X3 and/or P2X2/3 receptors in primary afferent neurons. They could therefore be considered as new methods for treating MI injury and cardiac arrhythmia (Shangdong Liang, 2010).

Dracocephalum moldavica L is an extract from Chinese herb Xiang Qing Lan. A study evaluates antioxidative and cardioprotective effects of total flavonoids extracted from Xiang Qing Lan. It showed remarkable scavenging effects against 1, 1-diphenyl-2-picrylhydrazyl, hydroxyl and superoxide anion radicals in vitro. It can improve the heart rate and coronary flow, raise left ventricular developed pressure and decrease creatine kinase, lactate dehydrogenase levels in coronary flow. It can also reduce the infarct size in ischemic area of heart. (Jiangtao Jian, 2014).

2 Research on compound formulas

Apart from individual herb and plant monomers, some studies have focused on compound formulas. Many traditional and modern formulas have been shown to be effective in treating MI.

Compound Danshen Tablets (CDT) are formulated from a compound remedy. The ingredients are Danshen, Sanqi, and Borneol. A study investigated therapeutic mechanisms of CDT by using a metabolomic approach. Plasma extracts from sham, MI model, CDT and western medicines were used in treating rats. Plasma was analyzed by ultra-performance liquid chromatography/ quadruple. The orthogonal partial least square model was built, and found that metabolites were expressed in significantly different amounts between MI and sham groups of rats. The results showed that CDT presented protective effects on MI by reversing potential biomarkers to sham levels, especially for the four metabolites in the pathway of purine metabolism. (Yonghai Lv, 2010).

Tanshinone IIA, SAB and ginsenoside Rb1 are the three major active ingredients of CDT. A report has found that the combination of these three ingredients brings nearly equal therapeutic effects on MI as CDT and it plays more stable regulated action on those 22 identified metabolites than single compound (Yonghai Lu, 2011). Another report uses an in vivo myocardial infarction model mice; endothelial nitric oxide syntheses (eNOS)/nitric oxide (NO) pathway were detected. The results showed that both Tanshinone IIA and salvianolic acid B have cardio protective function in certain levels through multiple targets related with NO production, such as eNOS phosphorylation, L-arginine uptake (Chunshui Pan, 2011).

Another study applied an ischemia-reperfusion injury rat model to examine coronary blood flow, vascular diameter, velocity of red blood cells, and albumin leakage in vivo after reperfusion. The result showed pre-treatment with CPT significantly attenuated myocardial microcirculatory disturbance, including decreased coronary blood flow and red blood cell velocity in arterioles, increased expression of CD18 on neutrophils and intercellular adhesion molecule 1 on endothelial cells, and albumin leakage from venules. It was also shown that it could significantly ameliorate the myocardial damage and apoptosis, inhibitor-κBα degradation, and expression of Bcl-2, Bax, and caspase-3 in myocardial tissues (Na Zhao, 2010). A metabonomic study was conducted to assess the effect of Danshen, Sanqi and their compound formula for myocardial infarction in rats. As a result, the compound was shown to exert synergistic therapeutic efficacies to exhibit a better effect on MI when compared to singular herbs (Xiaoping Liang, 2011).

Gualou Xiebai Tang is composed of Gualou (*fructus trichosanthis*) and Xiebai (*macrostem onion*). It was first recorded in JinGui YaoLue, and is one of the main formulae to treat chest pain, used since the Han Dynasty (A.D 206). A study aimed to investigate the effect of Gualou Xiebai Tang ethanol extract on myocardial fibrosis. The mRNA levels of Collagen I and Collagen III were detected by real-time PCR. The results showed that Gualou Xiebai Tang could significantly reduce the heart weight/body weight ratio as well as the left ventricle weight/body weight ratio. It also significantly alleviated the degree of inflammation, decreased myocardial collagen volume fraction, and markedly prevented the up-regulations of Collagen I and Collagen III, down regulated expressions of TGF-β1, TGFβRI, TGFβRII in the rats with myocardial fibrosis (Yongfang Ding, 2013).

Buyang Huanwu Tang is a commonly used formula to treat ischemic heart disease. A study investigated the potential mechanism of this formula in alleviating MI in rats. The expression of the cluster of differentiation 40 (CD40) in the mononuclear cells was measured using flow cytometry, and the expressions of CD40 and its ligand (CD40L) in myocardial tissues were determined by western blotting. The results showed that Buyang Huanwu Tang could decrease the expression of CD40 in the mononuclear cells and the CD40 and CD40L expressions in myocardial tissues (Yu Liu, 2011).

Sini Tang is has been used to treat MI for many years. A lot of research has been done in the past two decades. A recent study applied a urinary metabonomic method based on nuclear magnetic resonance and ultra high-performance liquid chromatography coupled to mass spectrometry in order to characterize MI related metabolic profiles and delineate the effect of Sini Tang on MI. Nineteen potential biomarkers in rat urine were screened out, primarily related to myocardial energy metabolism, including the glycolysis, citrate cycle, amino acid metabolism, purine metabolism and pyrimidine metabolism. The results demonstrated that Sini Tang could provide satisfactory effect on MI through partially regulating the perturbed myocardial energy metabolism (Guangguo Tan, 2012).

Guanxin II is a relatively new formula, currently used to treat coronary heart disease. It contains 5 traditional herbs. Akt is a key protein kinase in the processes of inhibition of apoptosis in cardiomyocytes. The results of a study found that Guanxin II can

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significantly activate Akt kinase, increase the Bcl-2/Bax ratio, inhibit cytochrome c release, reduced caspase-9 activation, and attenuated subsequent caspase-3 activation. These results therefore suggest that Guanxin II ensures the survival of myocardium by enhancing the Akt-mediated antiapoptosis pathway (Xi Huang, 2010).

Shen-fu injection is a modern formulation composed by Renshen (*Ginseng*) and Fuzi (*Aconite*). A study found that this formula can significantly decrease infarct size, apoptosis, caspase-3 protein expression in myocardial tissues, and increase p-Akt, p-eNOS, bcl-2 protein expression, compared to the control group (Yang Wu, 2011).

In this field a large number of reports have been published within the past 5 years. I have included some of the major ones here. From this review we can sum up a number of points. Firstly, research methods have been updated. A large number of studies have applied the latest biomedical techniques, such as metabolomics, apoptosis, cellular signal transduction etc. These new molecular biology techniques have been widely applied in the research of Chinese herbs. Secondly, Danshen and its sub fractions have become a hot point in this field. There have been approximately 4000-5000 reports conducted annually within the past 3 years. Thirdly, most reports are conducted as laboratory research, and relatively few are clinical reports. Finally, although all the papers are published on formal academic journals, there is still an unfortunate lack of papers from the core journals. As there is a lot of research in Chinese medicine still to be done, I believe there will be much progress in the future of this field.

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A Comparative Study of Traditional Chinese and Western Herb Medicine

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Herbs have been widely used to treat disease all over the world. In China, the use of herbal medicine (HM) became an important part of Traditional Chinese Medicine (TCM). In Europe and America HM gradually developed into Western Herbal Medicine (WHM). There are some commonalities and some differences between TCM and WHM. In this study we compared the history, basic theory, function and clinic application of commonly used crossover herbs in TCM and WHM. Through this comparison we hope to build a bridge between Chinese and western herbalists, to exchange ideas and clinical applications of some crossover herbs.

Method

1. History comparison

Human use of natural plants to treat illness can be traced back for thousands of years. Since the origin of humanity, our ancestors started to use herbs to relieve certain symptoms. The first classic about TCM theory is Yellow Emperor's Canon of Traditional Chinese Medicine (Huangdi Neijing). It was written during the Warring States Period (475 BC – 221 BC). Nearly at the same time, in ancient Greece Hippokrates (460 BC-370 BC) published the humoral theory which became the basis of WHM.

The first classic book about TCM herbs is Shennong's Herbal. It was written at early stage of Eastern Han Dynasty (AD25-220), 365 herbs were recorded in this book. The first classic of western herbs is De Materia Medica which was written between 50 --70 AD by Pedanius Dioscorides, a Greek origin Roman physician. About 600 plants were recorded. Both TCM and WHM have a long history, their basic philosophy was established at nearly the same time – about 2400 years ago.

2. Basic theory comparison:

Eastern and western cultural differences determined that from their inception TCM and WHM were based on different theories. TCM is based on the theory of Yin/Yang, five elements, Qi/blood, Zang Fu and meridians, and all the herbs are classified in Four Natures (Cold, heat, warm and cool) and Five Flavours (sour, bitter, sweet, pungent and salty). The hot and warming herbs belong to yang, suitable to treat cold syndromes; the cold and cooling herbs belong to yin, suitable to treat heat syndromes. The five flavours are matched to the five elements and five zang organs (liver, heart, spleen, lung and kidney). Each herb has a selective function to some part of the body. It may have strong effect on one or some meridians, but has little effect on other meridians. This is called 'channel tropism'. For example, many herbs are described as 'heat clearing', but because channel tropisms vary, Huanlian (Rhizoma Coptidis) is used to clear heart and stomach fire; Longdancao (Radix Gentianae) is used to clear liver and gallbladder fire; and Huangqin (Radix Scutellariae) is used to clear lung heat.

In TCM the 5 elements are linked with internal organs, people's emotions, seasons, weather and environment. See Table 1.

WHM is originally based on the theory of humoral medicine, four elements, Physio-medicalism and the interaction and function of the entire body as a whole terrain. A Holistic patient oriented approach.

Very similar to TCM, in WHM 4 humours and 4 elements was also matched with internal organs, emotions, seasons, weather and environment. See Table 2.

3. Crossover herb comparison

A selection of nine herbs which are widely used in both TCM and WHM. A comparison of their functions and indications, formulations and doses is presented in the tables below.

Result

The following results can be obtained from the above compare:

1) The origin and history of TCM and WHM is similar. They both have a very long history.

2) Although they are based on different theories, TCM and WHM both believe the universe is composed of some basic elements. Compare TCM's five elements and WHM's four elements: we find three elements are exactly the same.

3) TCM and WHM both believe these basic elements are connected to internal organs, and related to people's moods or emotions, the seasons, weather and environment.

Table 1 In TCM five elements links human body and nature

5 Elements	Zang Organs	Fu organs	Sense organs	Season	Qualities	Emotions
Wood	Liver	Gallbladder	Eyes	Spring	Wind	Anger
Fire	Heart	Small intestine	Tongue	Summer	Heat	Joy
Earth	Spleen	Stomach	Mouth	Later summer	Dampness	Anxiety
Metal	Lung	Larger intestine	Nose	Autumn	Dryness	Grief
Water	Kidney	Bladder	Ears	Winter	Cold	Fear

Table 2 In WHM four humours and four elements links human body and nature

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Elements	Humour	Season	Organ	Qualities	Ancient name	Ancient characteristics
Air	Blood	Spring	Liver	Warm & moist	Sanguine	courageous, hopeful, amorous
Fire	Yellow bile	Summer	Gallbladder	Warm & dry	Choleric	easily angered, bad tempered
Earth	Black bile	Autumn	Spleen	Cold & moist	Melancholic	despondent, sleepless, irritable
Water	Phlegm	Winter	Brain/ lung	Cold & dry	Phlegmatic	calm, unemotional

4) TCM and WHM both incorporate holistic concepts, they agree that the entire body functions as an organic whole.

5) TCM and WHM have many similar or exactly the same indications for some herbs. For example: Angelica (Danggui) was used as a blood nutrition agent and a menstrual regulator and female tonic; Ephedra Ephedra sinica (Mahuang) was used to treat asthma.

6) For some other herbs TCM and WHM have some different indications. For example: In TCM Mint (Bohe) is used to expel early stage measles, but in WHM it was used as a spasmolytic in some conditions; Ginger (Sheng Jiang) is used to treat nausea & vomiting in both TCM & WHM, but it is also used as an anti-platelet and antipyretic in WHM. In TCM's opinion it is a pungent & warm herb, only suitable for wind-cold syndrome, not suitable for wind-heat syndrome.

7) To explain the functions of herbs, TCM uses more traditional theory and terminology like yin/yang; cold/heat; deficiency/excess; qi and meridians; WHM uses more modern medicine terminology like anti-inflammatory, anti-allergic, anti-microbial, anti-Ulcer, etc.

Discussion

Modern medicine mainly uses chemical synthetic drugs to treat disease. A lot of side effects have been found for most pharmaceutical drugs. Many drugs works well to treat one disease but their side effects may cause new diseases. In some conditions drug addiction and drug resistance are difficult to avoid. Humans need an alternative approach to maintain their health and life. Herbal medicine is a wise choice.

Herbal medicine comes from natural plants; flowers, seeds, leaves, branches, roots and barks. Compared to chemical synthetic drugs they are much safer and cause fewer side effects. Some herbs can reduce the side effects of chemical drugs when they are combined together. The effect of herbs has been proved by countless cases through thousands of years' practice. In the east and west of the world, our ancestors leave us a great treasure – herbal medicine. It is our inheritance and our responsibility to develop this treasure and hand it down to next generation.

TCM and WHM are two main branches of natural herbal therapy. From basic theory to clinical indications they have many similar opinions. For a long time, the practitioners of these two traditions lacked with communication, they practiced separately, and did not know much about each other. We hope this crossover study between two different subjects will bring about some new ideas in both TCM and WHM.

Table 3.1.

	Chinese medicine	**Western herbal medicine**
Name	Danggui 当归	Angelica *Angelica sinensis*
Functions	Nourishing blood; Remove the blood stasis; Regulating menstruation and release pain; Moisten larger intestine	Anti-inflammatory; Uterine regulator; Anti-anaemic; Antiplatelet; Anti-arrythmic; Mild laxative; Female tonic
Indications	Blood deficiency, Dysmenorrhoea; Irregular menstruation; Amenorrhoea; Infertility; Constipation due to the blood deficiency	Dysmenorrhoea; Irregular menstruation; Amenorrhoea; ;PMS; Infertility; Menopause; CVS disorders
Formulations	Decoction; Pills; Tablets	Tincture
Doses	10-15g in decoction	As 1:3 tincture, 30-60ml / week

Table 3.2

	Chinese medicine	**Western herbal medicine**
Name	Bohe 薄荷	Peppermint *Mentha x piperita*
Functions	Expel wind heat; Cooling head and eyes; Expel measles	Carminative; Spasmolytic; Choleretic; Anti-emetic/ anti-nausea; Disinfectant
Indications	Common cold or flu due to wind- heat invade Early stage of measles; Headache, red eyes	Dyspepsia; Nausea or vomiting ; Flatulence; Biliary disorders; Essential oil topically as mild anaesthetic

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	and sore throat due to the wind-heat	for headache and injury pain; Used as vapour inhalation for colds/ catarrh etc
Formulations	Decoction; Pills; Tablets	Tincture; Infusion (tisane); Essential oil in enteric coated capsules
Doses	3-6g in decoction	As infusion: 1 teaspoon per cup boiling water, infused 5 mins, drunk t.d.s / p.r.n.; As 1:3 tincture, 10-30ml / week

Table 3.3

	Chinese medicine	**Western herbal medicine**
Name	Sheng Di Huang 生地黄	Rehmannia *Rehmannia glutinosa*
Functions	Clearing heat and promoting body fluid; Nourishing Yin & blood; Cooling blood	Adrenal restorative; Anti-inflammatory; Anti-haemorrhagic; Anti-pyretic
Indications	Asthenia heat, hot flash; Diabetes; Hematemesis, metrorrhagia, purpura due to blood heat; Prevent miscarriage; Constipation due to Yin deficiency.	Adrenal exhaustion; As support for adrenals during corticosteroid treatment; General tonic Some skin and muscular skeletal inflammations
Formulations	Decoction; Pills; Tablets	Tincture
Doses	10-15 g in decoction	As 1:2 tincture, 30-60ml/week

Table 3.4

	Chinese medicine	**Western herbs medicine**
Name	Xiao Hui Xiang 小茴香	Fennel Seed *Foeniculum vulgare*
Functions	Warming kidney and liver; Remove Qi stagnation and release pain; Benefit stomach.	Carminative; Anti-spasmodic; Stomachic/ orexigenic; Some use as anti-inflammatory; Expectorant, mild anti-asthmatic
Indications	Lower abdominal pain; Hernia pain; Testicle pain; Dysmenorrhea; Stomachache due to the cold	Colic; IBS; Flatulence; Poor appetite; Some use topically for rheumatism
Formulations	Decoction; Pills	Tincture; Infusion (tisane)
Doses	10-15g in decoction	Tincture: 1:2, 20-40ml / week As infusion: 1 teaspoon bruised/crushed seed per cup boiling water, infused 5 mins, drunk t.d.s / p.r.n.

Table 3.5

	Chinese medicine	**Western herbs medicine**
Name	Da Huang 大黄	Rhubarb *Rheum palmatum*
Functions	Purge sthenia heat; Expel damp-heat Smoothing intestine; Cooling blood Detoxication; Remove blood stasis	Laxative; Astringent; Haemostatic; Stomachic; Anti-inflammatory; Anti-microbial; Choleretic Antipyretic; Anti-uraemic; Antilipidaemic Nephroprotective; Antineoplastic
Indications	Constipation due to excess heat; Abdominal pain due to food retention; Jaundice due to damp-heat; Bleeding due to blood heat Carbuncles and boils; Red eyes, pain and swelling in the throat and gum.	Constipation; Haemorrhoids; Diarrhoea; Gastroenteritis; Gastro-intestinal Haemorrhage Acute hepatitis/ pancreatitis/ cholecystitis Hyperlipidaemia; Skin inflammation As an adjunct in kidney problems and some cancers
Formulations	Decoction; Pills; Tablets	Tincture; Powder; Decoction
Doses	5-10 g in decoction	As powder, ½ - 1 teaspoon per dose; As 1:2 tincture, 5-30ml / week

Table 3.6

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	Chinese medicine	Western herbs medicine
Name	Renshen 人参	Korean Ginseng *Panax ginseng*
Functions	Invigorating vital qi; Invigorating spleen and benefiting lung; Promoting body fluid	Adaptogen; Thymoleptic; Tonic; Stimulant/ anti-fatigue; Immunomodulator; Hypoglycaemic; Anti-inflammatory; Hepatoprotective & Cardioprotective; Anti-arrhythmic
Indications	Qi deficiency; Qi exhaustion	Stress & tiredness (short-term); Convalescence; Aging & Debility (long-term); Impotence, poor sperm motility/ count; Menopause; Substance abuse Poor immune function, as a prophylactic for cancers & a treatment of immune related conditions like HIV
Formulations	Decoction; Pills	Tincture; Capsules or Tablets (containing powdered herb or standardised extracts)
Doses	6-10 g in decoction	As tincture: 1:2, 7-40ml / week; As tablet, dose range equivalent to 300mg – 1.5g daily.

Table 3.7

	Chinese medicine	Western herbs medicine
Name	Wu Wei Zi 五味子	Schizandra *Shisandra chinensis*
Functions	Astringing lung; Benefit Qi and promoting fluid; Nourishing heart and kidney	Hepatic/ hepatoprotective; Detoxifying; Adaptogen; Nervine Tonic; Antitussive; Oxytocic (Uterotonic)
Indications	Chronic cough and asthma; Insomnia and palpitations; Nocturnal emission; Chronic diarrhea; Spontaneous sweating and night sweating; Diabetes due to internal heat	Liver damage and toxicity related to poor liver function Chronic and Acute liver disease; Nervous-system disorders
Formulations	Decoction; Pills	Tincture
Doses	6-10 g in decoction	As 1:2 tincture, 25-60ml / week

Table 3.8

	Chinese medicine	Western herbs medicine
Name	Ma Huang 麻黄	Ephedra *Ephedra sinica*
Functions	Inducing sweating to relieve superficies Dispersing lung relieving asthma Promoting urination and expelling edema	Anti-asthmatic; Bronchodilator; Central nervous system and cardiac stimulant; Sympathomimetic; Diaphoretic; Mydriatic; Diuretic; Anti-allergic; Decongestant
Indications	Common cold or flu due to wind-cold Asthma; Edema at up part of body	Asthma; Hayfever & Allergies; Whooping Cough (pertussis); Enuresis ; Some nervous system disorders including narcolepsy
Formulations	Decoction; Pills; Tablets	Tincture
Doses	6-9 g in decoction	As 1:4 tincture, legal maximum 48ml / week (Schedule III herb in the UK)

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观察关幼波益气活血化痰通络法治疗乙肝后肝硬化104例

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摘要: 目的　观察关幼波益气活血化痰通络方治疗乙肝后肝硬化疗效。方法　选取乙肝后肝硬化患者104例，随机分为治疗组和对照组，每组52例；两组均给予常规护肝治疗，同时治疗组给予关幼波益气活血化痰通络方，对照组给予复方鳖甲软肝片。比较两组治疗前后证候积分、肝功能指标、血小板计数（PLT）、透明质酸（HA）、III型前胶原肽（PCⅢ）、IV型胶原（IV－C）和层粘蛋白〔LN)、S指数及肝纤维化指数(FibroIndex)值变化并综合评价疾病疗效。结果　治疗后两组组内比较患者肝功能、PLT、肝纤维化四项、证候积分、S指数及FibroIndex值比治疗前均有明显减少（P<0.05），两组组间比较除PLT无明显统计学差异（P>0.05），其余指标治疗组与对照组相比有统计学差异（P<0.05）。结论　通过本研究发现益气活血化痰通络方能够有效助延缓肝脏纤维化进程，且有一定的保肝降酶作用。

摘要: 肝硬化；痰瘀理论；复方鳖甲软肝片

乙型病毒性肝炎是引起肝硬化的常见病因，疾病发展至失代偿期则难以逆转。近期越来越多基于病理学研究的肝硬化疗效评定研究证实，早期肝硬化可以逆转。肝硬化程度与透明质酸（HA）、III型前胶原肽（PCⅢ）、IV型胶原（IV－C）和层粘蛋白〔LN)等多项指标密切相关，且与无创肝纤维模型S指数[1]及FibroIndex[2]成正相关，我们应用以关幼波痰瘀理论为基础拟定的益气活血化痰通络方联合常规护肝药物及抗病毒治疗，在延缓肝硬化进程上起到了一定作用，现将结果报道如下。

1. 材料与方法

1.1一般资料

选择2011年10月 ～2012年10月就诊于我院肝病科门诊的乙型病毒性肝炎后肝硬化患者104例，患者其中男性50例，女性54例。年龄最大51岁，最小39岁，利用计算机伪随机数法随机分为2组，治疗组52例，男性24例，女性28例，平均年龄44.96±3.50岁，对照组52例，男性26例，女性26例，44.88±3.32岁，血清病原学检查HBV-DNA（+）病例总数23例。治疗前，两组年龄、性别、Child-Pugh分级、肝功能、肝纤维化四项指标、PLT、超声检查、S指数及FibroIndex等资料无明显差异（P>0.05），具有可比性。

1.2病例计算

按照随机对照试验设计要求，根据相关文献报导及我院临床治疗经验，复方鳖甲软肝片治疗肝硬化的有效率为59.8%。结合课题组的研究基础，估计常规中药辨证治疗肝硬化的有效率为85.5%, 以a=0.05，β=0.1.根据统计软件Epidemiological Calculator（流行病学计算器），简称EpiCalc2000 软件，按照成组设计两样本率比较样本含量估计公式（参照刘建平.循证中医药临床研究方法.人民卫生出版社），计算得出样本量每组45例，考虑15%的脱落率。确定本研究总例数为104例。

1.3诊断标准及纳入标准

1.3.1肝硬化诊断标准：符合2003年中国中西医结合学会消化系统疾病专业委员会重庆会议“肝硬化中西医结合诊治方案草案”拟定的肝硬化诊断标准 [3]。病因学诊断符合血清学检查HBsAg（+）。

*1.3.2中医证候诊断标准：*符合中药新药临床指导原则拟定的气虚痰瘀证标准，表现为乏力，腹胀，食欲下降，右胁隐痛而胀，胸闷不舒，头昏而重，口干苦粘，肢体麻木，或易健忘，舌质紫黯，或有瘀点、瘀斑，或舌下静脉曲张，苔腻，脉涩。

1.4排除标准

（1）年龄18岁以下或65岁以上；
（2）重型肝炎和/或肝衰竭；
（3）冠心病、慢性肺心病、血液系统疾病；
（4）伴有脑血管疾病、常规治疗未能控制的高血病及症状性高血压；
（5）呼吸衰竭、发热等可能影响观察结果者；
（6）食管胃底静脉曲张破裂所致的急性出血期；
（7）妊娠或哺乳期妇女；
（8）精神障碍不能配合者。

1.5治疗方法

治疗组按照关幼波益气活血化痰通络法予益气活血化痰通络汤 [4] 加减治疗。

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基础方：生黄芪30g 生赭石10g，旋覆花10g，杏仁10g，橘红10g，赤芍10g，白芍10g，丹参10g，香附10g，瓜蒌15g，小蓟10g，藕节10g，泽兰10g。

加减：食欲不振加鸡内金30g，焦三仙30g，胃胀加旋复花20g、生赭石30，乏力较重，加太子参30g、红景天30g，口干、眼干加女贞子30g、沙苑子30g。肝区疼痛加元胡10g、川楝子10g，舌下系带紫暗，瘀血严重者加王不留行10g，穿山甲5g。

服用方法：200ml/次，每日早晚2次，饭后1小时温服，疗程6个月。对照组给予复方鳖甲软肝片，4片/次，每天3次，疗程6个月。

两组均给予常规保肝治疗。HBV-DNA阳性患者同时给予常规抗病毒治疗。

1.6观察方法

1.6.1中医临床证候观测 利用症状体征量化表（依照《中药新药临床研究指导原则》拟定）[5] 记录中医临床症状，按无、轻、中、重分别记0、1、2、3分。

1.6.2理化指标检测 观察治疗前后肝生化功能检测：血清谷丙转氨酶(ALT)、血清谷草转氨酶(AST)、血清总胆红素(TBil)、γ-谷氨酰转肽酶（GGT）、血清白蛋白（Alb）；肝纤维化血清学指标：透明质酸（HA）、III型前胶原肽、IV－C（IV型胶原）和层粘蛋白（LN）；血常规：PLT；FibroIndex：10×eD/(1+eD)[D=-6.29+1.678×ln(年龄)-1.786×ln(PLT)+1.177×ln(GGT)+1.019×ln(HA)]。S指数：1000×GGT/(PLT×Alb2)。（疗效评价标准以肝脏组织细胞学检查为准，上述指标仅供参考）

1.7中医证候疗效标准 [6]

临床痊愈：症状、体征消失或基本消失，证候积分减少≥95%

显效：症状、体征明显改善，证候积分减少≥70%

有效：症状、体征均有好转，证候积分减少≥30%

无效：症状、体征无明显改善，甚或加重，证候积分减少不足30%

1.8疾病疗效标准 [7]

显效：症状消失;肝脾回复正常或回缩，无压痛及叩痛;肝功指标复常; HA、LN、IV-C、PCIII四项指标中异常的指标中有两项恢复正常。

有效：症状明显减轻或消失;肝脾肿大稳定不变，无明显压痛及叩痛;肝功能指标恢复正常或较治疗前异常值下降50%以上，HA、LN、IV-C、PCIII四项指标中异常的指标中有一项以上恢复正常。

无效：未达到上述标准。

1.9统计学方法

所有数据输入电脑，用SPSS19.0软件包建立数据库并进行分析，计数资料用X2检验、秩和检验、Mann-Whitney U检验，计量资料以均数±标准差表示，用 t 检验。P<0.05为有统计学意义。

2.结果

2.1两组中医证候积分比较

两组组内治疗后积分均较治疗前明显减少（P<0.01），治疗后的治疗组中医证候积分较对照组明显减少（P<0.01）。（见表1）。

表1 治疗组与对照组中医证候积分比较 (Mean±SD)

组别	例数	治疗前（分）	治疗 6 个月后（分）
治疗组	52	19.06±2.73	7.13±4.20△▲
对照组	52	18.31±2.39	9.55±4.63△

注：△与治疗前相比 P<0.01，▲与对照组相比 P<0.01。

2.2两组中医证候有效率比较

卡方检验结果提示治疗组中医证候治疗效果优于对照组（P<0.05）。（见表2）

表 2 治疗组与对照组中医证候有效率比较

组别	显效	有效	无效	合计	有效率(%)
治疗组	22	24	6	52	88.5
对照组	17	20	15	52	71.2

2.3两组疾病综合疗效比较

结果如表3所示，治疗6个月后，治疗组疾病综合疗效明显高于对照组（P<0.05）。

表 3 治疗组与对照组疾病疗效比较

组别	显效	有效	无效	合计	有效率(%)
治疗组	22	21	9	52	82.7
对照组	19	13	20	52	61.5

2.4治疗组与对照组肝功能、PLT及肝纤维化四项指标比较

治疗6个月后，两组组内比较，上述各项指标治疗后与治疗前比较具有统计学差异（P<0.05）。治疗组与对照组组间比较，肝功能指标、肝纤维化四项指标有统计学差异（P<0.05），两组组间PLT比较无统计学差异（P>0.05）(见表4)

2.5 两组治疗前后肝纤维化S指数与FibroIndex指数比较

结果显示两组在治疗后,治疗组S指数及FibroIndex指数比较具有统计学差异（P<0.01）。（见图1、图2）

3.讨论

关幼波益气活血化痰通络复方中，君药黄芪补益后天之气以扶正祛邪，据关老多年的行医经验，臣药瓜蒌、杏仁、

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表 4 两组肝功能、肝纤维化四项指标及 PLT 比较（Mean±SD）

	项目	例数	治疗前	治疗后	治疗前后比较 P 值
ALT（U/L）	治疗组	52	131.10±15.59	41.85±9.32★	P<0.05
	对照组	52	131.99±18.95	50.08±6.02	P<0.05
AST（U/L）	治疗组	52	52.27±13.01	35.53±6.81★	P<0.05
	对照组	52	50.80±13.63	45.35±8.82	P<0.05
GGT（U/L）	治疗组	52	184.70±21.50	154.60±17.64★	P<0.05
	对照组	52	188.32±18.87	165.24±16.31	P<0.05
TBIL(μmol/L)	治疗组	52	37.72±6.96	14.24±5.91★	P<0.05
	对照组	52	38.66±6.97	18.98±4.63	P<0.05
ALB(g/L)	治疗组	52	28.56±2.25	32.82±1.96★	P<0.05
	对照组	52	29.14±2.24	30.43±2.36	P<0.05
PLT（×109/L）	治疗组	52	91.51±13.63	102.17±7.33	P<0.05
	对照组	52	88.34±14.41	103.41±7.13	P<0.05
HA（ng/mL）	治疗组	52	426.7±59.8	196.9±36.2★	P<0.05
	对照组	52	434.5±61.9	298.0±39.7	P<0.05
LN（μg/L）	治疗组	52	141.7±44.7	95.3±9.8★	P<0.05
	对照组	52	133.0±45.9	104.6±14.8	P<0.05
PCIII（μg/L ）	治疗组	52	189.4±37.5	114.4±24.7★	P<0.05
	对照组	52	196.0±40.6	139.2±23.4	P<0.05
IV-C (ug/L)	治疗组	52	192.5±27.9	113.3±30.8★	P<0.05
	对照组	52	189.2±28.8	141.9±24.8	P<0.05

注：★与对照组相比 P<0.05。

治疗组与对照组 S 指数与 FibroIndex 比较直方图

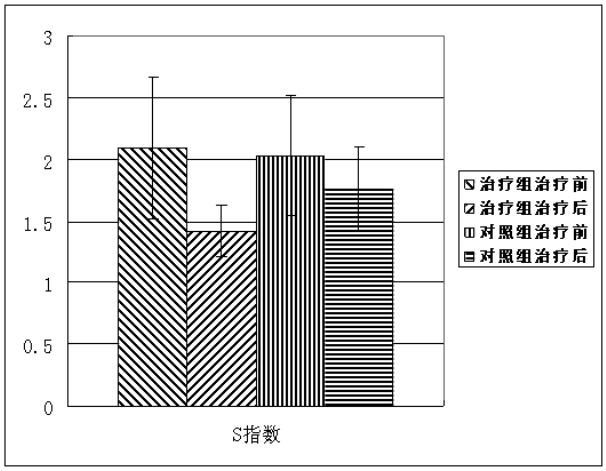

图 1

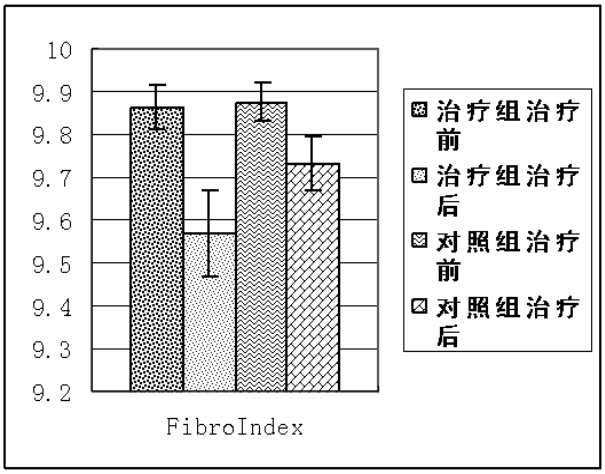

图 2

橘红相配伍后理气化痰效果甚佳，佐以旋复花、生赭石、化痰下气以除痞满治疗肝硬化之腹胀。赤芍、白芍、丹参既养血柔肝，又化瘀以止疼痛，与理气药香附相伍可以理气而不破气，活血而不伤血。因痰瘀互结，久病入络，佐以小蓟、藕节、泽兰既活血化瘀畅通络脉，缓消而散坚积，又引诸药入于肝络而治络脉之疾。食欲不振加鸡内金，焦三仙配合旋复花、生赭石消食下气除胀满；乏力较重，加太子参、红景天佐黄芪以益气养血；口干、眼干加女贞子、沙苑子滋养肝肾之阴，既能防诸化痰药物劫伤肝阴，又可治疗湿热久稽耗伤肝阴。肝区疼痛加元胡、川楝子加强活血行气。舌下系带紫暗，瘀血严重者加王不留行，穿山甲以破血通络，散结除痞。黄芪还可利水消肿，补而不滞，尤其对于肝硬化腹水者疗效显著；现代药理学研究证实：益气药物黄芪可降低慢性乙型肝炎患者HA含量,降低血清TGF-β1及提高外周血单个核细胞产生干扰素(INF)γ的活性[8]，还可以促进肝脏合成功能，提高血浆白蛋白水平；穿山甲、王不留能有效降低血

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液粘度，改善肝硬化患者微循环障碍，促进肝细胞供血，帮助肝组织再生。

肝硬化患者体内星型胶质细胞分泌大量胶原蛋白等ECM，生成大于降解，稳定的胶原纤维含量增多。由肝星状细胞分泌的HA、PCⅢ、LN、IV-C都是ECM或其代谢产物，在一定程度上反映肝硬化发展的快慢。在诊断方面，肝穿结果与模型研究证实，以乙肝病例构建的S指数[9]与肝穿刺结果纤维化程度相关系数r=0. 602，具有良好的相关性，且预测肝硬化（S4期）的AUROC在0.881水平，特异度达到93.84%，包含HA指标的 FibroIndex 值[10]与纤维化程度相关系数 r=0.718，相关度较高，灵敏度为71.3%。联合运用能够有效提高肝脏硬度诊断水平并在一定程度上代替有创肝脏穿刺病理活检。益气活血，化痰通络治疗与复方鳖甲软肝片的活血化瘀解毒治疗相比较，前者更有助于肝纤维化四项指标改善，使S指数及FiborIndex有效降低，且有一定的保肝降酶作用，在延缓肝硬化发生发展上疗效确切。本实验虽然从临床角度证实了虚、痰、瘀与肝硬化发生发展密切相关，但本方对于肝硬化发生发展干预的具体机制尚未研究充分，还有待进一步实验室基础研究讨论。

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不同取穴方法治疗腰椎间盘突出症190例观察

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目的：观察不同取穴方法治疗腰椎间盘突出症的效果，以期为临床选穴提供参考。

方法：将190例腰椎间盘突出症患者随机分为围刺取穴组（观察组1）、夹脊取穴组（观察组2）、常规取穴组（对照组）。观察组1取腰椎局部阿是点进行“围刺”(针刺前对患者进行细致检查，确定压痛或扣痛明显的腰椎节段，如有明显肌肉呈条索样改变，则以条索样改变起始点为取穴范围，对应每一腰椎节段平棘突下外围阿是点为取穴点，一侧腰痛者取同侧阿是穴与对侧L3、L4夹脊穴，双侧腰痛则按照上述方法取双侧阿是穴,以形成包围之势)，下肢麻痛者配合秩边；观察组2取阿是点及上下椎体对应夹脊穴，下肢麻痛者配秩边、环跳、承扶、阳陵泉、昆仑；对照组取膀胱经穴并循经取穴，根据不同经疼痛配肾俞、气海俞、大肠腧、关元俞、环跳、承扶、委中、承山、昆仑等。

结果：观察组1总共64例，治愈39例，显效14例，有效5例，无效6例，总有效率90.6%；观察组2总共63例，治愈34例，显效18例，有效3例，无效8例，总有效率87.3%；对照组总共20例，治愈20例，显效16例，有效6例，无效21例，总有效率66.6%。观察组1与观察组2比较无统计学差异（$p>0.05$），观察组与对照组比较有统计学差异（$p<0.05$）。

关键词：腰椎间盘突出症、围刺法、夹脊穴

1.病例资料

本实验所观察病例均明确诊断为腰椎间盘突出症，来自2009年8月至2011年8月本科室门诊病人。年龄14~71岁，病程1天~10年，男124例，女66例。按照门诊先后顺序随机分为观察组1、观察组2和对照组。观察组1病例64例，观察组2病例63例，对照组63例。三组病例患者在年龄、性别、病程、病情轻重、突出节段方面比较，差异无统计学意义，具有可比性。

2.诊断标准 [1]

（1）有腰部外伤、慢性劳损或受寒湿史。大部分患者在发病前有慢性腰痛史。

（2）常发生于青壮年。

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（3）腰痛向臀部及下肢放射，腹压增加（如咳嗽、喷嚏）时疼痛加重。

（4）脊柱侧弯，腰理理弧度消失，病变部位椎旁有压痛，并向下肢放射，腰部活动受限。

（5）下肢受累神经支配区有感觉过敏或迟钝，病程长都可出现肌内萎缩直腿抬高或加强试验阳性，膝、跟腱反射减弱或消失，拇趾背伸力减弱。

（6）X线摄片检查：脊柱侧弯，腰生理前凸消失，相邻边缘有骨赘增生。CT、MRI检查可显示椎间盘突出的部位及程度。

3.疗效评定标准 [2]

（1）治愈：腰腿痛消失，直腿抬高70°以上，能恢复原工作，能行走两公里以上。

（2）好转：腰腿痛减轻，腰部活动功能改善。

（3）未愈：症状、体征无改善。

4.实验方法

取穴方法

观察组1 根据本人多年临床经验总结的“围刺法”取穴，针刺前对患者进行细致检查，确定压痛或扣痛明显的腰椎节段，如有明显肌肉呈条索样改变，则以条索样改变起始点为取穴范围，对应每一腰椎节段平棘突下外围阿是点为取穴点，一侧腰痛者取同侧阿是穴与对侧L3、L4夹脊穴，双侧腰痛则按照上述方法取双侧阿是穴，述下肢疼痛或麻木者配同侧秩边穴。

观察组2 以腰椎压痛或扣痛点为参照点，取疼痛侧其对应夹脊穴和上下夹脊穴，述下肢麻木者配同侧秩边、环跳、承扶、阳陵泉、昆仑。

对照组 根据临床常用取穴方法，辩证取穴和循经取穴，主穴：肾俞、气海俞、大肠腧、关元俞、秩边；下肢麻痛者，循胆经疼痛者配环跳、风市、阳陵泉、丘墟穴；循膀胱经痛者配秩边、承扶、委中、承山、昆仑。

针具及仪器

针灸针为苏州医用品有限公司生产的华佗牌一次性毫针，规格30号，长短规格为1、1.5、2寸。电针仪为苏州华佗牌SDZ－Ⅱ型电子针疗仪，选用连续波，频率90～100HZ。

操作方法

穴位皮肤常规消毒，得气后通以持续电流连续波刺激30分钟。七天为一疗程，第一疗程每天针灸一次，休息两天后进行第二疗程，第二疗程隔天一次，治疗两个疗程后观察效果。

盲法

研究者、患者双盲。

5.结果

治疗效果比较见表1。“围刺法”针刺阿是穴与传统取穴比较对于腰椎间盘突出症效果更佳。针刺夹脊穴治疗腰椎间盘突出症效果优于传统取穴。

表 1 三组疗效比较

组别	例数	治愈	显效	有效	无效	有效率（%）
观察组 1	64	39	14	5	6	90.6*
观察组 2	63	34	18	3	8	87.3*
对照组	63	20	16	6	21	66.6*

*观察组 1 与观察组 2 比较差异无统计学意义（p>0.05）；

*观察组 2 与对照组比较差异有统计学意义（p<0.05）。

6.讨论

腰椎间盘突出症属中医学“腰痛”、“痹证”范畴。《素问.脉要精微论》记载：“腰者，肾之府，转摇不能，肾将惫矣”，《丹溪心法》曰：“腰痛，血滞于下”，《诸病源候论》：“劳损于肾，动伤经络，又为风冷所侵，气血击搏，故腰痛也”。其病因为外邪侵袭、体虚年衰、跌仆闪挫，基本病机为筋脉痹阻，腰府失养。是因“不通则痛，不荣则痛”，治疗上以“补肾固本，祛邪通络”为其治疗原则。针灸具有疏通经络，补肾益髓的作用，治疗腰腿痛历史悠久，《素问.刺腰痛第四十一》根据经络循行，阐述了各经络为病所出现的腰痛症状及相应的针刺方法和穴位：“足太阳脉令人腰痛，引项脊尻背如重状；刺其郄中。…少阳令人腰痛…刺少阳成骨之端出血…”，《针灸大成》：“肾虚腰痛，举动艰难，取足临泣、肾俞、脊中、委中”。

围刺法，又称围针法，是一种在病变部位周围进行包围式针刺以达到提高疗效目的的针刺法。本实验与传统的围刺法有所区别，《灵枢.经筋第十三》：“治在燔针劫刺，以知为数，以痛为腧”。本实验即以病变周围的阿是点作为围刺进针点，对病变的腰椎间盘进行围刺治疗。夹脊穴是人体常用强壮穴位，而且神经干穿出皮下大部分是在夹脊穴附近，因此刺激夹脊穴治疗腰椎间盘突出症能取得较为良好的效果。

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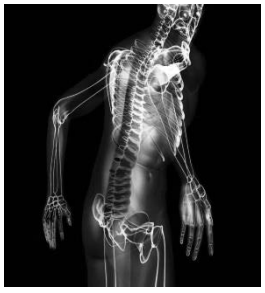

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The Treatment of Carpal Tunnel Syndrome with Acupuncture: Five Case Studies

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Abstract: In this study five cases of Carpal Tunnel Syndrome (CTS) were treated by acupuncture. In all cases there was significant improvement, and in four of the five cases patients reported that their CTS discomfort was either minor or alleviated completely. In view of the costs incurred by the NHS in treating such a common complaint, and the amount of work-days lost to employers, an effective treatment for CTS has enormous potential cost benefits for the economy, and for personal well being of the individuals affected.

Key words: Acupuncture, Carpal Tunnel Syndrome, CTS

Introduction

According to NICE U.K. (National Institute for Health and Care Excellence), Carpal Tunnel Syndrome is a peripheral nerve entrapment when there is compression of the median nerve in the carpal tunnel. It occurs more often in women than men and has no known cause, although it is related to repetitive motion, vibration and increased force in the use of the hands. It is characterized by tingling, numbness or pain in the distribution of the median nerve (the thumb, index finger and middle finger) and is often worse at night. (NICE n.d.)

Diagnosis is based upon the physical symptoms and simple tests although an electromyograph (EMG) of the wrist showing compression of the medial nerve is definitive. (Flaws and Sionneau, 2002). Treatment can be conservative; the use of a splint at night, avoidance of aggravating factors, and advice that the problem may resolve itself within six months. If there is no improvement within three months of conservative treatment, then the patient may be recommended for surgery. (ibid) Underlying conditions such as diabetes, rheumatoid arthritis and hypothyroidism must also be addressed.

There does not appear to any clear figures for the efficacy of surgery. At least one study has shown that surgical methods "are probably" better than non-surgical methods, but there were significantly more complications following surgery. The study applied only to severe cases. (Verdugo et al., 2008)

In the UK it is estimated that at least 3 out of 100 men and 5 out of 100 women will be affected by CTS at some point in their lifetime. (NHS n.d.) Up to date UK statistics are hard to find but in the US in 1994, CTS accounted for 849,000 office based visits to physicians, and involving 260,000 operations. CTS results in the highest median number of days of work lost (30 days) among all major work-related injury or illness categories, and of those cases nearly one half (47.5%) resulted in 31 days or more of loss of work. (Flaws and Sionneau, 2002)

TCM Pattern Differentiation

According to Flaws and Sionneau (2002), CTS falls into three patterns.

1) Blood Vacuity not nourishing the Sinews and Vessels.
2) Qi Stagnation and Blood Stasis
3) Wind Damp Impediment

As well as the usual treatment protocols associated with each pattern, it is also recommended that the patient stopped any activities which aggravated the condition, and that heat therapy with a TDP lamp will be helpful. Other sources (Legge, 1997) focus solely upon local stagnation.

Case Studies of treatment

Case One

Male, 38 years old, Garage Mechanic

This man had a history of injury on his hands and fingers owing to the nature of his work.. Consequently he has experienced pain in his hands and fingers for a long time, but the pain had intensified so he consulted his GP, who diagnosed CTS and advised an operation. Both hands were affected, but the right was much worse. He decided to try acupuncture before agreeing to surgery. He also suffered from diverticulitis.

Syndrome Diagnosis:

1) Liver Qi Stagnation
2) Heat in the Large Intestine
3) Kidney Yang Deficiency

Treatment Session 1

Points selected: Liver 3, Large Intestine 4, Large Intestine 11, all were retained for about forty minutes. Local Points were Pericardium 6, Large Intestine 6, and Large Intestine 5 on the right.

Session 2

After the first session, the patient reported a notable improvement in his hands and especially in his right hand. He had been on holiday, so two weeks had passed since his initial treatment.

Points Selected: as Session 1, but this time Large Intestine 5 was used bilaterally.

Session 3

The patient reports that he was free from hand pain.

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However, he had been feeling very hot and was constipated.

Points Selected: Liver 3, Large Intestine 4, Large Intestine 11 to address heat issues. Locally only Pericardium 6 was used. All were retained for about 40 minutes. At the end of the session Kidney 3 was tonified.

Result

Since the hand pain was not an issue, the patient discontinued treatment, electing not to address his other issues for whatever reason. It has been over a year since his treatment and he is still free from pain.

Case Two:

Female, 39 years old, Care Worker

This woman came to the clinic very reluctantly owing to a fear of needles. In fact her husband made the appointment for her. She had a history of CTS problems. She had surgery for CTS on her left hand which reduced the pain initially but it was returning. At the time of her visit to the clinic her right hand was very sore with a weak grip. She decided to try to avoid further surgery by trying acupuncture. She has a number of health issues including diabetes for which she injects insulin.

Syndrome Diagnosis:

1) Spleen Deficiency
2) Damp and Damp-heat
3) Liver Qi Stagnation

Treatment Session 1

Points selected: Liver 3, Large Intestine 4, Large Intestine 11, Spleen 9. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Spleen 6 was tonified.

Session 2:

After Session One, the patient reported that the pain was much less, particularly at night. It did return however the night before her next treatment. Her grip strength had improved as well.

Points selected: Liver 3, Large Intestine 4, Large Intestine 11, Spleen 6 and Spleen 9. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Kidney 7 and Spleen 3 were tonified.

Session 3:

The patient reported an overall improvement in grip strength and pain reduction. The pain, although much reduced, would return and then go away. The patient was satisfied with her progress and this was her last treatment.

Points selected: Liver 3, Large Intestine 4, Large Intestine 11. Local points: Pericardium 6, Large Intestine 6, Triple Burner 5. All were retained for about forty minutes. They were removed, and then Lung 7 and Pericardium 4 were tonified.

Result:

It has been nearly six months since her treatment, and she has had only short term occurrences of minor pain.

Case Three:

Male, 43 years old, Bus Driver and Agricultural Worker

This man came to the clinic because he has acquainted with the patient in Case 2. He had pain in both hands diagnosed by his GP as CTS. His problems started a number of years ago after a car accident, but the pain had intensified recently. He experienced a tingly sensation and then numbness in both his hands, and both were painful. His left hand was more painful than the right at night. He was quite a bit over weight.

Syndrome Diagnosis:

1) Spleen Deficiency
2) Damp-heat and Phlegm
3)) Liver Qi Stagnation

Treatment:

Session 1:

Points selected: Liver 3, Large Intestine 4, Large Intestine 11, Spleen 6, Spleen 9, Stomach 40. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Pericardium 7 was tonified, to test his Causative Factor according to Five Element theory..

Session 2:

After Session One, the patient reported excellent progress. The tingling and numbness had gone entirely, and the pain was significantly reduced.

Points Selected: (as with Session 1) Liver 3, Large Intestine 4, Large Intestine 11, Spleen 6, Spleen 9, Stomach 40. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Pericardium 7 was tonified.

Session 3:

Owing to work schedules, it was over a month until the patient returned for a follow-up treatment. He was still free of the tingling and numbness and the pain was only slight.

Points Selected: (as with Session 1, and 2) Liver 3, Large Intestine 4, Large Intestine 11, Spleen 6, Spleen 9, Stomach 40. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Pericardium 7 was tonified.

Result:

It has been nearly 3 months since his treatment, and he is free from his symptoms.

Case Four:

Male, 39 years old, Fabricator

This man had a history of CTS problems, and had undergone surgery for CTS on both wrists, which he described as partly successful. His symptoms were worse when he used a machine called a grinder which, unfortunately, was part of his usual work duties. With regard to other health issues, he is an insulin dependent diabetic.

Syndrome Diagnosis:

1) Spleen Deficiency
2) Damp Heat
3) Stomach Heat
4) Liver Qi Stagnation
5) Kidney Yang Deficiency

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Session 1:

Points Selected: Liver 3, Large Intestine 4, Large Intestine 11, Large Intestine 14. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Lung 9 was tonified.

Session 2:

The patient reported an improvement through following the initial treatment, until he was engaged in the use of the grinding machine. This machine vibrates strongly and this appears to aggravate the patient's condition.

Points Selected: Liver 3, Large Intestine 4, Large Intestine 11. Local points: Pericardium 6, Large Intestine 6. All were retained for about forty minutes. They were removed, and then Lung 6 and then Lung 7 were tonified. The tonifications however did not change the pulse condition.

Session 3:

The patient estimated a 40% improvement from his initial situation.

Points Selected: Liver 3, Large Intestine 4, Large Intestine 11, Spleen 6, Spleen 9. Local points: Pericardium 6, Lung 9, Large Intestine 6 and Large Intestine 9. All were retained for about forty minutes. During this time the patient experienced a temporary feeling of dizziness but then he was fine. The needles were removed, and then He 7 was tonified to test for his Five Element Causative Factor, which brought about an overall improvement in his pulse condition.

Result:

The patient did not return for further treatment, so the best that may be said is that there was a 40% improvement, as estimated by the patient himself.

Case Five:

Male, 53 years old, Self-employed Joiner

This patient is involved with physically demanding work, and this probably has triggered his CTS. Its onset was gradual, starting with stiffness and swelling and by the time he attended the clinic for acupuncture the pain was severe. It was especially bad at night, and he had disturbed sleep for two weeks. The pain affected is his two middle fingers and could shoot up his forearms.

His GP diagnosed CTS, and prescribed anti-inflammatory medication. The patient was also placed on a waiting list for surgery.

Syndrome Diagnosis:

1) Spleen Deficiency
2) Dampness
3) Liver Qi Stagnation
4) Kidney Yin Deficiency
5) Kidney Yang Deficiency

Session 1:

Points Selected: Liver 3, Gallbladder 34, Large Intestine 4. Local Points: Pericardium 6, Small Intestine 6, Large Intestine 6. The needles were retained and then the heart meridians were tonified to test the patient's Causative Factor., Pericardium 7, Triple Burner 4, Heart 7.

Session 2:

The patient reported daily improvement, until the day before treatment when the pain returned.

Points Selected: Liver 3, Gallbladder 34, Large Intestine 4. Local Points: Pericardium 6, Small Intestine 6, Large Intestine 6. The needles were retained and then Heart 7 and Small Intestine 4 were tonified according to Five Element practice.

Session 3:

At this session the patient said that he was experiencing no pain in his hands, but that there was some numbness in his left hand.

Points Selected: (as per Session 2) Liver 3, Gallbladder 34, Large Intestine 4. Local Points: Pericardium 6, Small Intestine 6, Large Intestine 6. The needles were retained and then Heart 7 and Small Intestine 4 were tonified according to Five Element practice.

Session 4:

The patient was still pain free, but there was still some numbness in his left hand. A small swelling was noted at the base of his left palm.

Point Selection: Left side: Large Intestine 4, Large Intestine 6, Lung 10, Pericardium 5. After retention for about forty minutes the needles were removed and Heart 7 was tonified bilaterally.

Result:

It has been ten years since treatment and the patient has been pain free and has not had a recurrence of the CTS. He did not need surgery.

Discussion

In all five cases there was an improvement, and in all four cases the length of treatment was short consisting of only three sessions and the fifth case involved four treatments. Further treatment is likely to have been helpful for cases 1 to 4. With regard to the patient in Case 4, the man's work duties aggravated his CTS. Without a significant time away from the aggravating activity it is difficult to see a way ahead towards a cure. It is also of note that when there was initial improvement followed by a return of the pain it was at about five or six days after the initial treatment. This suggests that an interval of a week is too long between treatments, particularly at the outset.

The cases presented here, admittedly a small sample, presented Syndromes somewhat different from those published. These case studies emphasized underlying Spleen Deficiency with damp as well as Qi stagnation. Patterns involving the Blood or Wind -damp impediment did not feature. As indicated in the published literature, Pericardium 6 was an important point in all the cases. The use of a TDP lamp was not tried, but it would have been a good option in cases where dampness was a concern.

The diagnostic approach involved standard TCM syndrome differentiation, as well as the use of the Five Element theory. The Five Element approach was especially important in the selection of points for tonification. In this regard, intuitive techniques in point selection were also used (Mearns, 2013).

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Overall, treatment was shown to be effective. Effective treatment for such a common complaint has the potential for enormous cost savings for the health system, and for a great reduction in the number of works days lost to employers. Effective treatment also, is a great relief to those suffering from the condition.

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Case Histories from the files of Professor Shulan Tang

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Case one

P.C., Male, 44 years old, Single, Civil Servant, Born in the UK, Currently residing in Manchester

Disease Onset 04/2001, First Consultation 20/03/2008

Presenting Complaint: Depression of almost 10 years duration

History of Presenting Complaint

Almost 10 years ago, Mr. P.C. began suffering from extremely deep depression. He felt he was in a trance-like state. His feelings/emotions are abnormal and he believes that life is passing him by. The patient is unable to communicate effectively and there was little animation in his facial expression. His sleep is poor and he has profuse nightmares. He is easily angered, his memory is deteriorating and his attention span is very low with no powers of concentration. In addition, the patient is suffering from headaches, dizziness, mental fatigue and nervousness. His facial complexion and eyes are very red, the skin on his face is dry and itchy. His stool is dry and his urine is yellow.

Tongue: Red with a yellow coating, Pulse: Soggy, fast

Other Medical History: 10 years previously, the patient had a viral infection and had a continuous low fever for a number of weeks.

Chinese Medicine Diagnosis:

Disease name: Depression

Pattern: Spleen Deficiency; Hyperactive Heart & Liver Fire; Phlegm Heat Harassing the Heart.

Treatment Principle: Strengthen the Spleen, Soothe the Liver, Clear the Heart, Transform Dampness.

Prescribed Formula

Tai Zi Shen 8g, Fu Shen10g, Dan Shen 8g, Yu Jin 8g, Bei Sha Shen 8g, Zhu Ru 6g, Chi Shao 8g, Fo Shou 8g Ban Lan Gen 10g, Dan Zhu Ye 8g, Yuan Zhi 8g, Huai Hua 8g, Jin Qian Cao 8g, Ma Chi Xian 8g, He Huan Pi 8g, Ye Jiao Teng 8g

The formula was supplied in raw herbs, to be taken for 7 days.

Further advice to the patient: Stop smoking, avoid alcohol, pungent or spicy foods, get plenty of fresh air and exercise.

Further Visits

01/04/2008 - (2nd Consultation)

The patient's memory and attention span has very obviously improved. His mouth is no longer dry and there is no feeling of body heat or sweating. Sleep and bowel movements have both improved and the patients vitality or animation has increased. The patients tongue is red with a yellow greasy coating and the pulse is soggy and rapid.

The above prescription was repeated for a further week

08/04/2008 - (3rd Consultation)

Patient continues to show improvement. Body heat has eased, but there is profuse sweating on the head. Sleep is again improved and the patient felt that it was returning to normal. The patient is now aware of normal life. Memory and concentration have further improved and emotionally, the patient is happy. Both energy and appetite have increased, defecation and urination are regular. The patients tongue is red, with a thin yellow coating and the pulse is rapid.

The above prescription was modified with the removal of Jin Qian Cao and the addition of

Sang Ye 8gms. This modified prescription was prescribed for one week.

15/04/2008 - (4th Consultation)

Patient reports continued improvement. Headaches and dizziness are gone, and the itch on the skin has completely receded.

Prescription from 08/04 was repeated for one week.

22/04/2008 - (5th Consultation)

There was continued improvement overall. The patient is smiling, his nightmares are gone, memory and concentration have further improved and he no longer experiences feelings of anxiety. He reports that both of his hands feel as if they were in water. The patients tongue is red with a thin yellow coating and his pulse is rapid.

Prescription from 08/04 was repeated for one week.

15/05/2008 - (6th Consultation)

The patient reports feeling a greater sense of relaxation. He feels as if his skin can breathe. His whole body is relaxed and there is increased energy. He is happy. The patients tongue is red with a thin white coating and the pulse is even and slightly wiry.

Prescription from 08/04 was repeated for one week.

The patient attended the clinic at weekly intervals for the first three months. After this, consultations were reduced to fortnightly and over time to monthly visits, culminating in visits at intervals of 6 to 12 months. The most recent of these visits occurred today 01/10/13.

01/10/13

The patient is in good health and spirits. Both eyes are sparking. He has recommenced work as a civil servant, working in a government department. His mood is generally good. In recent days, he noticed that the skin on his head was becoming itchy and flaky and there is slight hair loss. His lumbar back is slightly sore. His sleep is good and his appetite and defecation are regular. His tongue is red with a thin, yellow and slightly peeled coating. Pulse is wiry and rapid.

Chinese Medicine Diagnosis: Kidney Yin Deficiency with Empty Fire Harassing Upwards

Treatment Principle: Tonify the Kidneys, Support & Nourish Yin, Clear Heat, Moisten the Skin

Prescribed Formula

Sang Ye 8g, Sheng Di Xuan Shen 8g, Xia Ku Cao 8g, Fu Ling 8g, Bai Ju Hua 8g, Gou Qi Zi 8g, Di Fu Zi 8g, He Shou Wu 8g, Fo Shou 8g, Sang Shen Zi 8g, Mu Dan Pi 8g, Chi Shao 8g, Dan Shen 8g, Huai Hua 8g

Summary-Evaluation of Case Diagnosis and Treatment

This patient had, for a long period of time, been consuming alcohol and spicy foods with very little exercise or fresh air. This led to Spleen deficiency with exuberance of Heart and Liver Fire and Phlegm Heat harassing the Heart. The Western Medicine treatment was to prescribe sleeping tablets and anti-depressants to treat the outward signs.

Chinese Medicine treatment focused on the root of the problem. Treatment strengthened the Spleen, dispersed the Liver, cleared the Heart and transformed Phlegm which allowed the root of the condition to be eliminated over time. The patients health, mentally, physiologically and energetically all reached an overall balance and he is now able to function again in a demanding work environment.

Case two

Nancy, Female, 35yrs old, Married Housewife, English, Currently residing in Manchester

Disease Onset: 1993, First Consultation 11/01/2000

Presenting Complaint: Depression and nervous tension for the last 7 to 8 years

History of Presenting Complaint

Nancy has 3 sons under the age of 18. Her husband works away from home and has very little to do with Nancy and their children. It has reached the point where they are not getting on very well. Nancy constantly feels emotionally unstable and she cries easily. When she is suffering from a severe attack, both her hands are tremble and shake. She has no appetite and finds it difficult to sleep at night. She has palpitations, headaches, severe empty heat (baking heat) and acne.

Tongue: Red with little coating; Pulse: Wiry and rapid

Other Medical History: None

Chinese Medicine Diagnosis:

Disease name: Depression

Pattern: Liver Fire harassing the Heart

Treatment Principle: Disperse the Liver, Regulate Qi, Clear the Heart, Lower Fire

Acupuncture: Qu Chi (LI 11), He Gu (LI 4), Lie Que (Lu 7), Nei Guan (P 6), Shen Men (Ht 7), San Yin Jiao (Sp 6), Tai Chong (Liv 3)

Prescribed Formula:

Jia Wei Xiao Yao Wan 2 bottles

Zhi Bai Di Huang Wan 2 bottles

Dosage of each formula - 8 tablets three times daily

Further Visits

25/01/2008 - (2nd Consultation)

It is two weeks since the patient's first visit. Her mood has improved and the nervous tension has eased. The trembling in both hands has stopped. The patients sleep and appetite have both improved and she is only smoking 10 to 15 cigarettes a day. She would like to stop smoking.

Acupuncture: Qu Chi (LI 11),He Gu (LI 4), Lie Que (Lu 7), Nei Guan (P 6); Shen Men (Ht 7), San Yin Jiao (Sp 6), Tai Chong (Liv 3)

28/01/2008 - (3rd Consultation)

The patient has not smoked since the last visit. Due to the fact that her husband is abroad, emotionally she is feeling low. She feels like sighing and crying. She is agitated and unsettled and at times feels nauseous. Her food intake is poor. The patients tongue is red with a greasy white coating and her pulse is wiry and slippery.

Chinese Medicine Diagnosis: Liver Stagnation overwhelming the Spleen, Liver and Stomach not harmonised

Treatment Principle: Disperse the Liver, Strengthen the Spleen, Regulate Qi, Harmonise the Stomach

Acupuncture: Shen Men (Ht 7), Nei Guan (P 6),

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San Yin Jiao (Sp 6), Tai Chong (Liv 3), Zu San Li (St 36), Tian Shu (St 25)

Prescribed Formula

Ban Xia 8g, Chen Pi 8g, Bai Zhu 10g, Zhen Zhu Mu 12g, Fu Ling 10g, Shen Qu 8g, Chai Hu 6g, Bai Shao 8g, Dang Gui Wei 8g, Bo He 6g, He Huan Pi 8g, Dan Shen 8g

Above formula was made up in concentrate granules 100 gms, 2 level teaspoons to be taken three times daily.

10/02/2000 - The patient phoned the clinic and postponed her next appointment due to family commitments and the necessity of having to travel 2 hours to the clinic.

Summary-Evaluation of Case Diagnosis and Treatment

Nervous tension and depression are commonly seen in women in the Western world. Apart from an individual's circumstance and temperament, the origin of these conditions is principally due to home and/or work life pressures and conflicts. This illness often has its root in the emotional aspect of a female's relationship with their partner or husband. Apart from accurate pattern discrimination and treatment using acupuncture and Chinese Herbal Medicine, I personally believe that the exchange between the patient and doctor is paramount. People are generally sociable animals. The doctor must use their Heart to perceive the condition and must often listen attentively to and communicate with the patient from the Heart. The doctor must comprehend the patient's life and environment, and from this understanding of the patient's lifestyle, eating habits and pressures from home or work, accurate treatment can be effected and the imbalances within the patient can be regulated.

中医药辨病辨证结合治疗痤疮及兼症体会

袁炳胜 （BingSheng Yuan, Doncaster）

摘要：各科临床病、证，常常相兼出现。医学教材，分别病、证，盖为易于讲述、示范其例而设。临床之际，单一之病、单一之证，十无其一。新病旧病、表病里疾，虚实、寒热之证，同时并见于一人一时之案例，则十有其九。此初涉临床者所以茫茫然、疑难顽杂病证之所以无从下手、危急重症之所以易致失误者也。本文以痤疮二案为例，说明病、证同辨，不仅根据病、同时根据证的情况，来进行治疗选药，而为寒温补泻之治的临床运用。病证同辨，一则可以提高临床疗效，二则同时有利于充分发挥每一味药物各方面的的性味功能，从而减少治疗所用药物的不良反应。

关键词：痤疮 中医药治疗 / 病证同辨 兼症治疗 / 临床疗效 副作用控制。

案一，痤疮兼湿疹

D.V 女士, 26岁，立陶宛裔。2012年9月27日初诊。

主诉：面部痤疮4-5年，双手腕部湿疹3年。现病史：面部痤疮，4-5年前始发。头面部之额、颊、鼻旁等部痤疮密集分布，新发者色红，表面或有白色脓点，陈旧者暗红，突起于皮肤表面，大小不一。久久为之苦恼，医与抗生素及外用药膏治疗无效。并患双手腕及前臂内侧部湿疹3年，皮肤因痒甚搔抓而破烂，有渗出。夜间多汗，抑郁紧张。眠纳可，便调，经调。

中医检查：舌暗红，苔白略腻、脉沉略弦。

中医诊断：痤疮、湿疹。肝郁脾虚、湿热内蕴，郁积肺胃二经、血气失和，外现于皮肤。

治法：健脾除湿、疏肝理气，清热和血。

处方：丹参3克，连翘4克，桔梗3克，枳壳3克，薄荷3克，黄柏3克，苍术3克，柴胡3克，紫草6克，地肤子10克，紫花地丁6克，苦参2克，生甘草3克，白茅根6克，7剂。二煎三服，一日一剂。

10月6日，复诊。经服前方7剂尽，面部痤疮大为好转，大部分疮疹已经消褪，原有之旧疮疹亦进一步缩减或消散；原腕部湿疹皮损已愈，仅见有皮损愈后之脱皮，完全不痒。非常高兴。舌淡红偏暗，苔白薄，脉沉略弦缓。

继用上方，加南沙参、薏苡仁6克，再服7剂巩固。

10月20日，前症尽愈，皮肤除有轻微原皮损遗留印痕外，余与正常无异，因购物路过，特以相告。

小结：

本例痤疮多年，久经其原籍（立陶宛）及英国医生诊治，服用多种抗生素等疗效不佳。并不是所用抗生素不好，盖因此病，虽有炎症之表现，但细菌和炎症并非致病之最重要原因。本病虽也有成年后仍长期不愈者，但多始发于青春期前后、生长发育旺盛之青少年。《内经.素问.上古天真论篇第一》说：女子“二七天癸至，任脉通，太冲脉盛，月事以时下, 故有子；三七肾气平均（张志聪注曰：肾气者，肾藏所藏之气也。气生于精，故先天癸至，而后肾气平），是故真牙生而长（音掌）极，四七筋骨坚，发长极，身体盛壮”；男子“二八，肾气盛，天癸至，精气溢泻，阴阳和，故能有子；三八肾气平均，筋骨劲强，故真牙生而长极”。本病的发生，是和青春期肾气、天癸、冲任气血、阴阳的变化密切相关的,所以单从局部病理变化的角度,对病论治,效果不佳；即使暂时获效,也极易反复。

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根据本例患者的舌脉症，局部表现，体质情况，认为系肝郁（舌暗，脉弦，抑郁、紧张）、脾虚（脉沉苔腻）、湿热内蕴（舌红苔腻，湿疹痤疮）、血气失和（湿疹痒甚），外现于皮肤，痤疮与湿疹并见。

故治疗以健脾（甘草苍术）、疏肝理气（柴胡枳壳），清热除湿（紫草地丁、连翘、苦参、薄荷、黄柏、地肤子等）、和血（丹参白茅根）。不仅清除湿热致病之标，且健脾除湿，疏肝解郁，和血利气，以调理脏腑功能及气血阴阳，使标本内外同治而获痊愈。

疮疡为有形之病症，然有形生于无形。西医认为系有形病原微生物所致，故皆主以抗菌抗病原微生物为治。然如此例痤疮一类病症，抗菌抗病原微生物往往难以见到根本的效果，盖因于此也。中医辨病的同时，结合辨证，考虑到气血的失调，阴阳的失和，导致湿热、邪毒产生的内在因素，使用一系列不仅对应病、亦且对应证的治疗措施，所以取得了较单一的对病治疗更好、更快捷、也更彻底、同时几乎没有见到明显治疗的副反应，同时全身健康情况还得到改善的疗效。

案二，痤疮兼风疹、花粉症，月经不调。

曹女士，20岁。2013年3月25日初诊（电话及网络诊治，其母及本人叙述病史，舌脉未诊）。

主诉：面部痤疮一年半。现症：面部痤疮，额、腮、下颌为甚，经期前后加重。疮疹色红，顶部有白色脓点，便不畅，口臭、纳差。经期延后4-5天，有时延后半月。经行次日腹痛，每6-7天而净。有时头痛、手足凉。

诊断：1.痤疮；2.月经不调。脾虚肝郁，内生湿热，蕴郁肺胃，熏蒸于面部，伴冲任失调。

因前此曾于国内就诊于某名中医，与处方：桑叶9克，菊花9克，枇杷叶9克，桑白皮9克，黄芩6克，银花9克，蒲公英9克，连翘9克，薏苡仁12克，泽泻9克，车前子9克，因商于余。据其症每于经期加重，经迟、痛经、便秘诸证，加丹参4，知母9克，稍佐之以活血清热，调经通便，诸味以浓缩药粉与之，每次2-3克，1日3次，开水冲服。

4月11日，电话复诊。服上方一周，痤疮稍好转；近3-4天不慎受凉，清涕、鼻塞、伴身起红色小痒疹。询知来英后因气候不同而患花粉症，亦一年半左右，每遇气候变化或受凉则发清涕喷嚏，甚为不舒。

兼感风寒，外郁于表，肺气不利；引动内郁之湿热，营卫不和，故身痒出疹。嘱前方暂停，宜宣通肺卫，清热利湿，兼和其营分。另为拟方：

苍耳子6克，甘草3克，紫草10克，薄荷6克，桑叶6克，桔梗4克，地肤子10克，枳壳6克，柴胡6克，白芍10克，当归6克，苍术6克，茯苓6克，神曲6克，服用法同前。

4月22日，诉服用前方后，现面部痤疮已全部消失，身上的痒疹亦全部消除；且服药1-2日即明显生效。现在面部仅遗留原痤疮留下的瘢痕。嘱继续服完11日方巩固，并宜清淡饮食，适当进食蔬果，少熬夜。

30日，服完11日方，除面部遗留痤疮瘢痕外，仅偶遇凉轻微鼻塞。3月25日方尚余一半，予斯方加苍耳子4克，荆芥4克，牛蒡子4克，继续服完。

6月10日，诉经前治疗，面部痤疮消除。未再有新发。仍有瘢痕。近日经前服食辛辣食物，致面部有一二枚红疹出现，担心痤疮复发，希继续调治根除。继与疏肝宣肺，疏风清热除湿，兼佐活血调经治之。

柴胡6克，白芍6克，枳壳4克，甘草3克，黄芩6克，生地6克，川芎3克，荆芥6克，牛蒡子6克，苍耳子4克，连翘6克，桔梗4克，桑白皮6克，桑叶6克，薏苡仁10克，薄荷4克，香附3克，益母草6克，浓缩粉剂，摇匀为散，每次3克，一日3次。

3月余后随访，痤疮愈，经调、经行不痛，头痛数月来亦未觉。

小结

本例痤疮，兼有月经失调，且经期加重。又兼花粉症，遇凉则清涕喷嚏立作。痤疮与花粉症，均为1年半前来英后发生。是脾虚肺郁，风寒湿热，滞郁于内外表里、皮腠官窍之间；又肾虚肝郁，气血不和、冲任失调，月经迟至。经期前后血气动荡，故痤疮加重。受风冷则肺卫之表郁更甚，则涕、嚏顿发。总为虚实夹杂之证，宜乎补其所虚，祛其邪实，唯因缓急而消息用药。

前医治法，侧重于疏风清热解毒祛邪，以治痤疮之标，是一般治疗痤疮的通常习用之法，用药亦然。然此患者痤疮表现，多因月经将至而加重，故加丹参活血调经，疏其血气；肺与大肠互为表里，其人便微秘，肠道热郁，熏蒸于上；若得知母之清疏宣导其下，则热郁于上之痤疮易治，前医诸药，更易建功矣。

后因兼花粉症、身起红疹作痒，是有风寒湿热同时为患，肺卫气分营分同病，则不可仅治其热，不见其寒；仅治其实，不见其虚；仅见其卫、气，不见其营、血。故疏风散寒、清热除湿、清宣表里营卫气血以祛其实（柴胡、桑叶、薄荷、苍耳子、紫草、地肤子），健脾和中（苍术、茯苓、神曲、甘草）、疏肝理肺（柴胡、白芍、甘草、枳壳、桔梗）以安其里、再佐理气和血（枳壳、当归、白芍、紫草）疏其壅遏，有是证用是药，又嘱清淡饮食、适寒温以杜绝风寒湿热之源、充分休息以助营卫气血之安定、助脏腑功能、体力正气之回复，故获良效。

体会

各科临床病、证，常常相兼。医学教材，盖为分别讲述、示范其例而设。临床之际，单一之病、单一之证，十无其一。新病旧病、表疾里疾，虚实、寒热，同时相兼见于一人一时之案例，比比皆是；而疑难顽杂之疾犹然。此初涉临床者所以茫茫然，久事临床者，遇多方诊治，难以获效之疑难顽杂病证，所以无从下手者。

此两案例，皆以痤疮为患者来就诊的主要问题。医者常因患者之求治心切，欲求对症之治而不暇顾及其余之症，然则往往欲速则不达。案一者，西医以痤疮之局部疮疡表现，用抗生素及外用药膏对病治疗无效，但以中医辨病与辨证，病、证兼顾治疗而获佳效；案二前医以面部痤疮，而从疮疡之治，用清热解毒，而未能兼顾患者其他情况。尤其痤疮常因月经将来而加重，并伴便秘，认为在治疗中必须考虑这两个与痤疮有高度相关性的问题，故于其方中加丹参、知母，

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服药7天而稍觉好转；但因受凉而并发花粉症，遇冷则涕、嚏并作、风疹身痒，遂转而更进一步辨病与辨证结合，整体治疗而迅速获效（1-2天）。可见，病辨与不辨、单纯辨病与辨病辨证结合论治，其临床效果是不可同日而语的。

如此二案，案一痤疮兼湿疹，案二痤疮兼风疹、更兼内科或耳鼻喉科之花粉症（本患平常以过敏性鼻炎表现为主，中医谓之鼻鼽）、妇科之月经不调；此仅其例也，临床类似者屡见不鲜。是故要求医者需望、闻、问、切，明辨病、证，了知虚、实所在、病、证所因，标本主次，因果关系，舌脉从舍、治证取舍；又需熟悉药物性能、寒温补泻、主治脏腑经络、升降浮沉燥润散敛之宜，尽可能有效利用药物的功能作用，合理用之，人、病同治，才能既能迅速缓解病情，又尽可能将治疗的不良反应尽可能下降甚至于零，而利于病人整体的健康。

中药复方治疗痛经验案一则

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摘要：痛经，是妇女正值经期或经行前后出现周期性小腹疼痛或痛引腰骶，甚至剧痛晕厥者，称为痛经。笔者跟随曲凡医生出诊，现整理曲凡医生应用中药复方治疗痛经验案一则。

关键词：痛经；验案

痛经，是妇女正值经期或经行前后出现周期性小腹疼痛或痛引腰骶，甚至剧痛晕厥者，称为痛经。笔者跟随曲凡医生出诊，收获良多。曲凡医生是医学博士，妇产科学博士后，副研究员，博士研究生导师，也是首届江浙沪中西医结合优秀青年人才奖获得者。现整理曲凡医生应用中药复方治疗痛经验案一则，报道如下：

患者，女，薛某某，37 岁，2013 年 3 月 29 日就诊。患者有 10 年痛经病史，经多方求治无效。平素月经规则，15 7/25 2014 年 3 月 5 日，量中，色暗红，质稠月经第 1-2 天小腹疼痛，痛连腰骶，难忍，影响正常工作及生活。平素白带量多，色略偏黄。胃纳可，睡眠安，二便正常。舌红苔黄腻，脉滑数。妇科检查：外阴已婚式；阴道畅；宫颈光，激光术后改变；宫体前位，常大，无压痛，双附件未及。白带检查正常。证属湿热蕴结，治以补肾健脾，清热除湿。金银花 30g 茵陈 30 g 焦山栀 15 g 桑叶 25 g 青蒿 10 g 淡竹叶 15 g 太子参 25 g 北沙参 20 g 芡实 12 g 苏梗 10 g 炙甘草 12 g 黄精 12 g 黄芩 25 g 女贞子 20 g 覆盆子 15 g,7 剂。

4 月 12 日，二诊，末次月经 2014 年 3 月 31 日，性量无明显改变，痛经较前略缓解。7 天经净。白带量减少，色白。胃纳可，睡眠安，二便正常。舌红苔黄腻，脉滑数。治以健脾清热利湿。金银花 30g 茵陈 30 g 焦山栀 15 g 桑叶 25 g 青蒿 10 g 淡竹叶 15 g 太子参 25 g 砂仁 3 g（后下） 芡实 12 g 苏梗 10 g 炙甘草 12 g 黄精 12 g 黄芩 25 g 垂盆草 10 g 竹茹 10 g 柴胡 20g 泽泻 12g 猪苓 15g，7 剂。

4 月 18 日，三诊，患者服药后无明显不适，白带正常。舌红苔黄腻，脉滑数。治以清热利湿，化瘀止痛。金银花 30g 茵陈 30 g 焦山栀 15 g 桑叶 25 g 青蒿 10 g 淡竹叶 15 g 太子参 25 g 砂仁 3 g（后下） 芡实 12 g 苏梗 10 g 炙甘草 12 g 黄精 12 g 黄芩 25 g 垂盆草 10 g 竹茹 10 g 柴胡 20g 泽泻 12g 猪苓 15g 元胡 10 g 益母草 30 g 皂角刺 10 g 乌梢蛇 10 g，14 剂。

4 月 26 日，四诊，患者服药后无明显不适，白带正常。舌红苔薄黄，脉滑。治以清热利湿，化瘀止痛。金银花 25g 茵陈 20 g 焦山栀 15 g 桑叶 25 g 青蒿 10 g 淡竹叶 15 g 炒白术 20 g 白扁豆 10g 芡实 12 g 苏梗 10 g 炙甘草 12 g 黄精 12 g 竹茹 10 g 柴胡 20g 泽泻 12g 猪苓 10g 元胡 10 g 益母草 30 g 皂角刺 10 g 乌梢蛇 10 g，14 剂。

5 月 2 日，五诊，末次月经 2014 年 4 月 28 日，色暗红，量、质中等，痛经缓解。7 天经净。胃纳可，睡眠安，二便正常。舌红苔薄白，脉滑。患者服药后无明显不适，白带正常。治以健脾清热利湿。金银花 25g 焦山栀 15 g 桑叶 25 g 青蒿 10 g 炒白术 20 g 白扁豆 10g 芡实 12 g 苏梗 10 g 炙甘草 12 g 黄精 12 g 竹茹 10 g 柴胡 20g 7 剂。

体会：本例患者，为湿热蕴结型痛经。湿热之邪，盘踞冲任子宫，气血失畅，湿热与血互结壅滞不通，故腹痛，痛连腰骶；湿热扰血，故经色暗红质稠；累及任带，则带下异常。舌红、苔黄腻、脉滑数均为湿热蕴结之候。初诊，以金银花、焦山栀、桑叶、黄芩、青蒿清热；茵陈、淡竹叶利湿；太子参、芡实、苏梗、炙甘草、黄精、苏梗健脾利湿；月经

即将来潮，不忘同时以北沙参、女贞子护阴，覆盆子补肾填精。二诊，患者白带转为正常，但舌红苔黄腻，脉滑数，湿热仍较重，以垂盆草、泽泻、猪苓利尿通淋；砂仁、竹茹清中焦之湿热；柴胡和解表里，加强清热利湿之功效。三诊，患者白带虽正常，但舌红苔黄腻，脉滑数。湿热仍重，继续原治疗，月经后期，前方之上加益母草活血化瘀，元胡、皂角刺、乌梢蛇行气活血止痛。四诊，患者舌红苔薄黄，脉滑。湿热去之大半，前方金银花、茵陈减量；去垂盆草、黄芩；去人参、砂仁改为白扁豆，减少清热利湿之功。五诊，月经第 5 天，患者因湿热得利，淤血得痛，痛经缓解，去淡竹叶、泽泻、猪苓、元胡 10 g、益母草、皂角刺、乌梢蛇 10 g，继续清热化湿巩固治疗。

征稿启事

《英国中医针灸杂志》为中英文双语学术期刊，每年三月和九月发行两期，并可在学会网上阅览。本会刊宗旨着重在于为大家提供一个平台和论坛，借此互相沟通学习，不断提高学术水平和质量，从而推动中医针灸的发扬光大。欢迎诸位会员，中医同仁及各界读者慷慨赐稿，与大家共同分享你们的临床经验，典型病例分析，行医心得，理论探讨，中医教育和发展，文献综述和研究报告。并建议大家推荐本刊给病人及其周围之人阅读，让更多英国民众看到并亲身体验到中医之奇妙果效，从而提高中医之声誉，扩大中医之影响。

来稿中文或英文均可，中英双语更受欢迎。字数中文 5000 字以内，英文 4000 字以内，并附 200 字以内摘要。文章必须符合以下格式：标题，作者，摘要，关键词，概要，文章内容，综述/讨论或结论，以及参考文献。每篇文章也可附带一份单独的作者简介。

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下期来稿截至日期为 2014 年 8 月 10 日。若来稿于此日期之后收到，我们会考虑在以后之期刊发表。

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Papers should be in Chinese or English, but preferably bilingual, with up to 5000 words in Chinese or 4000 words in English. An abstract of 150-200 words should also be attached. The article must comply with the following format: Title, Author, Abstract, Key Words, Introduction, Text, Summary/Discussion or Conclusion and References. Each article may also be accompanied by a short biography on a separate page.

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Deadline of submission for next Issue (Volume 22 Issue 1) is **10th March 2015**.

Papers received after the deadline may still be considered for publication, but in the later issue.

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Guideline of English standard for authors

(1) Please run a spell check on your computer before submitting.
(2) Only use sentences (NOT fragments) containing a subject, verb and object.
(3) Avoid long and confusing sentences with commas and semicolons.
(4) Double check that you use the proper tense. We would recommendto write case histories in past tense.eg, the patient had... (NOT is...)
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(6) Avoid phrases that are difficult to express or translate in another language, or explain them properly.
(7) Use standard and unified measures, eg, minutes (NOT mins), hours (NOT hrs) etc.
(8) All herbal names should have their proper Pin Yin and Latin name, and the measures of dosage must be followed, eg, Shan Yao 10g (NOT 10).
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