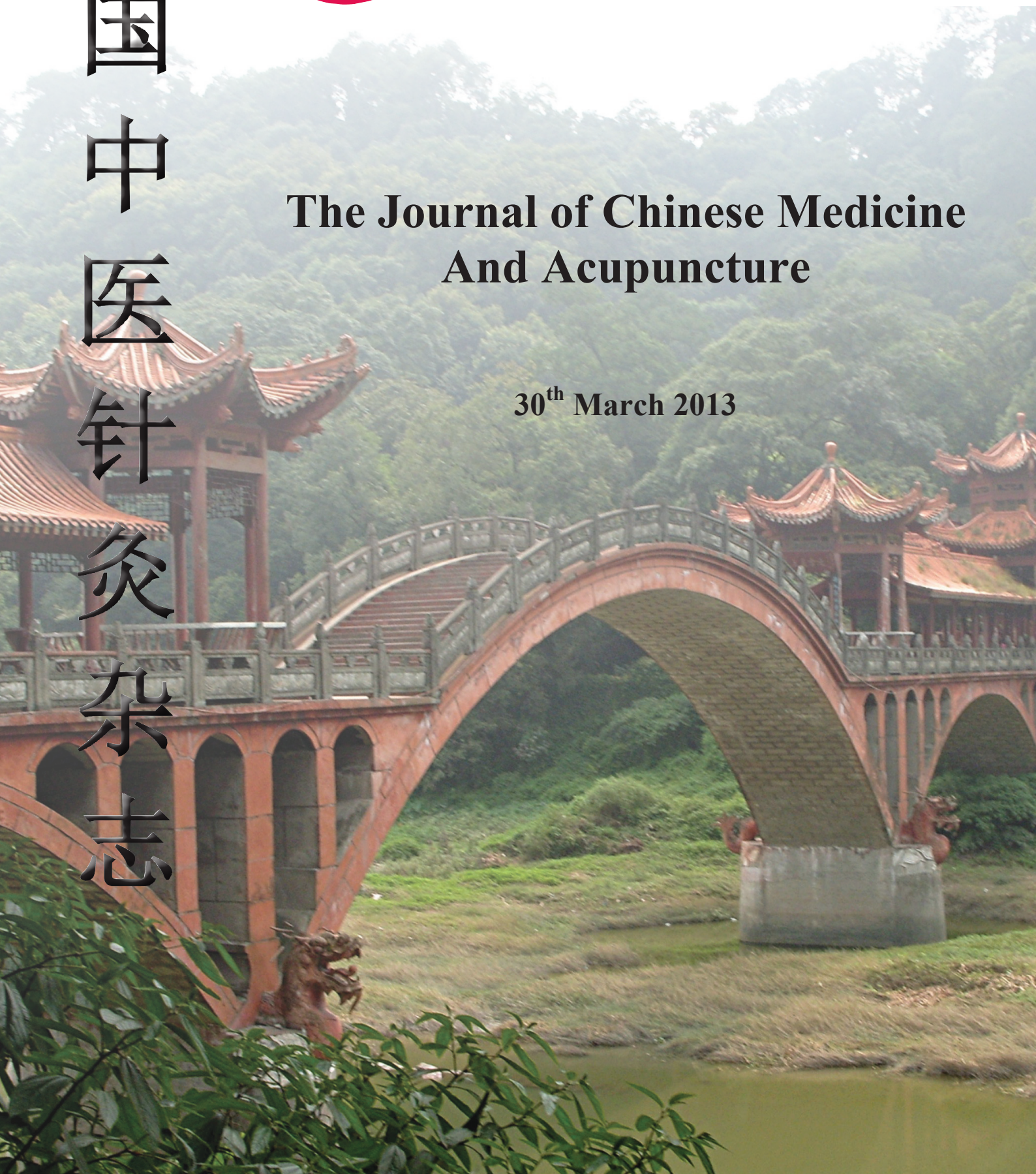
ISSN: 1745-6843
Volume 20 Issue 1
第 20 卷 第 1 期

英国中医针灸杂志

The Journal of Chinese Medicine And Acupuncture



30th March 2013

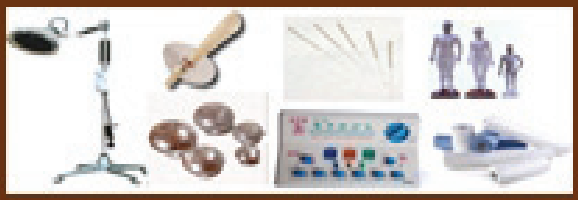
传承中华文明　弘扬中医文化

地道中药饮片
NaturalHerbs

热情服务　价格优惠　品质保证

高品质中药浓缩粉
HerbalPowder

中医针灸器材系列
Acupuncture Needles and Accessories



秦朝批发

更多产品欢迎来电咨询

02085316888

Qin Dynasty Ltd　Tel: 0208 531 6888　Fax: 0208 523 3688
Unit 5, Walthamstow Business Centre, Clifford Road, London
E17 4SX　Email: qindynastyltd@yahoo.co.uk

秦朝

目录 Contents

Editorial –

Welcome to the Journal of Chinese Medicine and Acupuncture (JCMA)

The Journal of the Association of Traditional Chinese Medicine (JATCM) was started soon after the establishment of the Association of Traditional Chinese Medicine and Acupuncture UK (ATCM) in 1994. We intended to create a platform for our ATCM members, stimulate debate and development of acupuncture and Chinese medicine in the UK. It has been improved dramatically since it was established, including the quality of papers published on the journal and the editorial work. However, JATCM has always wished to be recognised worldwide by attracting more practioners and readers from other organisations of TCM, Chinese herbal medicine and acupuncture professionals.

On this special 1st issue of Volume 20, we are very delighted to announce that we were finally able to register the new name 'The Journal of Chinese Medicine and Acupuncture (JCMA)' in November 2012, and from this issue, we start to use the new name – The Journal of Chinese Medicine and Acupuncture (JCMA). We would like to invite you to participate in the development of JCMA, including contributing papers, research reports and book reviews, or suggesting interesting topics and forums. Our editorial committee will continue to work hard, striving to improve it constantly.

JCMA Editorial Committee

刊首语 –

英国中医针灸杂志（JCMA）欢迎您!

<英国中医药学会会刊>（JATCM）杂志是在英国中医药学会（ATCM）于 1994 年成立之后不久即创办的。我们起初旨在为 ATCM 的会员们建立一个学术交流的平台，激发和探讨中医药和针灸在英国的发展。自从创刊以来，杂志已经有了明显的改善，包括发表的论文质量和杂志的编辑工作。然而，JATCM 一直希望得到世界各国中医业界的广泛认同，吸引更多的中医从业人员和其他中医团体的中草药和针灸专业人士和读者。

在这特殊的第二十卷第一期，我们非常高兴地宣布，我们终于得以在 2012 年 11 月注册了新的杂志名称<英国中医针灸杂志>（JCMA），从本期我们开始使用这一新的名称。我们真诚希望和邀请您来参与 JCMA 的发展，贡献您的论文，研究报告和书评等，或建议有趣的话题和论坛。我们的编辑委员会将继续努力工作，争取不断地完善我们自己的杂志。

JCMA 编辑委员会

Xiong Bi (胸痹) and Xin Tong (心痛) Syndrome in Jin Kui Yao Lue

Engin CAN 张恩勤 [1], Ming Zhao CHENG 程铭钊 [2]

[1]Everwell Chinese Medical Centre, London; [2]Middlesex University, London

Xiong Bi (胸痹 in Chinese), literally meaning Chest Blockage, has been termed as 'chest impediment' in English, as in the book 'International Standard Chinese–English Basic Nomenclature of Chinese Medicine' published in 2008 by the World Federation of Chinese Medicine Societies[1]. Xin Tong (心痛 in Chinese), literally meaning Heart Pain, is the main equivalent of Angina dominated by pain in the chest.

Xiong Bi and Xin Tong are closely linked to each other. Xiong Bi is a syndrome marked by chest distension and choking pain, and in severe cases left chest gripping pain (angina) with radiating pain to the back and the upper arm, breathlessness and dyspnoea. Xin Tong is episodes of Angina which can be on an off.

This syndrome was first discussed in detail in Chapter 9 'On Pulse Syndrome Complex and Treatment of Xiong Bi (Chest Impediment), Xin Tong (Heart Pain) and Duan Qi (Short Breath)' of Jin Kui Yao Lue 金匮要略 (Synopsis of the Golden Chamber), which is a part of Shang Han Za Bing Lun 伤寒杂病论 (Treatise on Cold Damage and Miscellaneous Diseases) by Dr Zhang Zhong-jing in the East Han Dynasty (3rd Century CE, about 200-219 CE).

In the first clause of this chapter, Zhang Zhong-jing gives the description about the pulse and cause of Xiong Bi syndrome. It states: 'when feeling a patient's pulse, the doctor should find whether there is excess or deficiency in the patient's pathogenic condition. In the cases of Xiong Bi, a feeble pulse at Yang (meaning at the Cun 寸 position) and taut pulse at Yin (meaning at the Chi 尺 position) indicates a Xiong Bi syndrome marked by chest pain. The reason for this is that there is extreme Yang deficiency. This Yang deficiency is in the upper-jiao hence feeble pulse at the Cun position. Xiong Bi and Xin Tong (Heart Pain) with taut pulse at the Chi position indicate yin and cold". In summary, this clause clearly tells us that Xiong Bi and Xin Tong are due to Yang Deficiency with Cold in the chest.

Further to the first clause, Zhang Zhong-jing continues by stating in the second clause that "the patient normally does not have heat or cold, but he suffers breathlessness and dyspnoea. This is because there is an excess (that blocks the Chest Qi)".

Based on this pathology, to treat Xiong Bi and Xin Tong syndome, one must strengthen the Yang Qi in the chest. In the meantime, one must also clear away the Cold in the chest or other pathological products such as phlegm in the chest.

Following his pathological conjecture on Xiong Bi and Xin Tong, Zhang Zhong-jing designed the following 10 formulae in Chapter 9 of Jin Kui Yao Lue to treat Xiong Bi and Xin Tong.

1. Gualou Xiebai Baijiu Tang (Decoction of Trichaosanthes, Chinese Chive and White Liquor 瓜蒌薤白白酒汤)

Ingredients:

Gualou (Fructus Trichosanthis) 1 pc/15g
Xiebai (Bulbus Allii Macrostemi) Half Sheng /15g
Baijiu (White Liquor) 7 Sheng /1,400ml

Original preparation and administration:
Boil the above 3 ingredients together until 2 sheng (400ml) remains. The decoction is divided into 2 portions. Take one portion warmed each time, 2 times a day.

Actions:

Activating chest-yang to dissipate nodulation, promoting the flow of qi to dispel phlegm.

Indications:

Xiong Bi syndrome, manifested as pain and fullness in the chest, or chest pain radiating to the back, cough with phlegm, shortness of breath, white greasy tongue coating, and deep wire or tense pulse.

Original text (Clause 3):

"Xiong Bi syndrome has the following symptoms and signs, such as panting, cough, spitting, pain in the chest and back shortness of breath. The pulse is deep and slow in Cun position and small, tense and rapid in Guan position. This should be treated with Guanlou Xiebai Baijiu Tang".

This is the basic formula for Xiong Bi and Xin Tong. All the formulae that follow are based on this. In this formula, Gualou widens the chest to smooth chest qi and untie the phlegm nodules. Xiebai makes the yang qi move in the chest, while Baijiu, which is pungent and warm, enhances the power of the other two herbs. All working together the formula will remove blockages, move chest qi and resolve phlegm; hence the chest pain will go. This formula is a typical prescription for treating xiong bi syndrome. Though it formula consists of just 3 ingredients, the function is certainly effective.

Current applications:

Today, we still often use this formula plus Taoren (Semen Persicae), Honghua (Flos Carthami), Danshen (Radix Salviae Miltiorrhizae) to treat coronary heart diseases marked chest pain and short breath. We may not use as much Baijiu as originally designed. Li[2] introduced this formula for treating angina pectoris, non-suppurative costochondritis, and intercostals neuralgia due to obstruction of chest-yang and phlegm in the interior.

2. Gualou Xiebai Banxia Tang (Decoction

of Trichaosanthes, Chinese Chive and Pinellia 瓜蒌薤白半夏汤)

Ingredients:
Gualou (Fructus Trichosanthis) 1 pc/15g
Xiebai (Bulbus Allii Macrostemi) 3 Liang/ 9 g
Ban Xia (Rhizoma Pinelliae) half Jin/9g
Baijiu (White Liquor) 1 Dou/2000ml

Original preparation and administration:
Boil the 4 ingredients together until 4 sheng (800ml) remains. The decoction is divided into 2 portions. Take one sheng (200ml) warmed each time, 3 times a day.

Actions:
Activating chest-yang to dissipate nodulation, removing phlegm and promoting the flow of qi to relieve chest pain.

Indications:
Xiong Bi syndrome which is so painful that the patient can not lie flat, and the pain radiating to the back, white greasy tongue coating, and deep taut or tense pulse.

Original text (Clause 4):
"Xiong bi syndrome is so painful that the patient could not lie flat, and pain in the chest radiates to the back. This should be treated with Gualou Xiebai Banxia Tang".

This formula is based on Gualou Xiebai Baijiu Tang, adding Banxia to clear away phlegm and rheum in the chest.

Today this formula is regarded as the basic formula for treating coronary heart disease marked by chest pain and fullness in the chest. We also use this formula to cases of pleurisy, bronchitis, intercostal neuralgia and pericarditis manifested as distension and pain in the chest and short breath. Ling Gui Zhu Gan Tang and Taoren Honghua Dansheng can be added to enhance yang qi and blood movement. Wang[3] reported to use this formula for a female patient with hyperplasia of right lobular mammary gland for 2 years. After taking 40 doses of the modified formula, the hyperplasia disappeared.

3. Zhishi Xiebai Guizhi Tang（Decoction of Immature Orange Fruit, Chinese Chive and Cinnamon Twig 枳实薤白桂枝汤） and Renshen Tang (Ginseng Decoction 人参汤)

These two formulae, which appear in the same clause, give a good example on treating the same disease with different formulae. Original text (Clause 5) states: "Xiong Bi syndrome manifests as fullness and pain in the chest due to the stagnation of qi in the chest and ribs, accompanied with a sensation of flushing qi from the hypochondria to the heart. This should be treated with Zhishi Xiebai Guizhi Tang or Renshen Tang".

The formulae

A. Zhishi Xiebai Guizhi Tang:

Ingredients:
Zhishi (Fructus Aurantii Immaturus) 4 pcs/12g
Houpu (Cortex Magnoliae Officinalis) 4 Liang /12g
Xiebai (Bulbus Allii Macrostemonis) half Jin /15g
Guizhi (Ramulus Cinnamomi) 1 Liang /3g
Gualoushi (Fructus Trichosanthis) 1 pc /15g

Original preparation and administration:
Boil the first two ingredients in 5 sheng (1,000ml) of water until 2 sheng (400 ml) remains. Discard the dregs, add the remaining herbs, and boil for a while longer. The decoction is divided into 3 portions and taken warmed, 3 times a day.

Actions:
Activating chest-yang and promoting the flow of qi to relieve fullness and pain in the chest.

Indications: Xiong bi syndrome marked by fullness and pain in the chest due to stagnation of qi in the chest and ribs , and flushing qi from hypochondria to the heart, white tongue coating, and deep wire pulse.

This formula should be applied to patients with coronary heart disease marked by fullness and pain in the chest due to stagnation of qi in the chest and ribs. It can also be used for cases of chronic gastritis manifested as fullness and pain in the stomach with a sensation of flushing qi from hypochondria to the heart.

B. Renshen Tang (Ginseng Decoction 人参汤)

Ingredients:
Renshen (Radix Ginseng) 3 Liang /9g
Gancao (Radix Glycyrrhizae) 3 Liang /9g
Ganjiang (Rhizoma Zingiberis) 3 Liang /9g
Baizhu (Rhizoma Atractylodis Macrocephalae) 3 Liang /9g

Original preparation and administration:
Boil the above 4 ingredients in 8 sheng (1,600ml) of water until 3 sheng (600 ml) remains. Take 1 sheng (200ml) warmed, 3 times a day.

Actions:
Tonifying qi and activating chest-yang to relieve fullness and pain in the chest.

Indications:
Xiong Bi syndrome due to deficiency of middle-qi, marked by fullness and pain in the chest, or accompanied by a sensation of flushing qi from hypochondria to the heart, a pale tongue with white coating, and weak pulse.

This formula should be applied to patients with coronary heart disease marked by the qi deficiency in the spleen and stomach. Tao Hong Si Wu Tang should be added to it for long term coronary heart disease marked by deficiency of middle-qi and blood stasis. It can also be used for patients with chronic colitis, or frequently spitting saliva and spittle due to deficiency-cold in the spleen and stomach, or profuse menstrual bleeding or dysfunctional uterine bleeding of deficiency -cold of spleen and stomach[4].

The differences

Both Zhishi Xiebai Guizhi Tang and Renshen Tang are used in Xoing Bi in this clause, but Xiong Bi can be excessive or deficient syndromes. For Zhishi Xiebai

Guizhi Tang and Renshen Tang, the patient should have excessive phlegm and rheum, which needs purging – when there is an excess, use purging method. In contrast, for Rensheng Tang, there is chest and middle jiao yang deficiency (which causes the blockage is the chest and chest pain). In this situation, warming and tonifying method should be used.

4. Fuling Xingren Gancao Tang (Decoction of Poria, Apricot Seed and Liquorice Root 茯苓杏仁甘草汤) and Ju Zhi Jiang Tang (Decoction of Tangerine Peel, Immature Orange Fruit and Fresh Ginger 橘枳姜汤)

Again, these 2 formulae, appearing in the same clause, give another good example on treating the same disease with different formulae. Original text (Clause 6) states: "A patient with Xiong Bi syndrome manifests as a feeling of obstruction in the chest, accompanied with short breath. This should be treated with Fuling Xingren Gancao Tang or Ju Zhi Jiang Tang".

The formulae

A. Fuling Xingren Gancao Tang

Ingredients:

Fuling (Poria) 3 Liang /9 g
Xingren (Semen Armeniacare Amarum) 5 pcs/9g
Gancao (Radix Glycyrrhizae) 1 Liang /3g

Original preparation and administration:

Boil the above 3 ingredients in 1 Dou (2,000ml) of water until 5 sheng (1,000 ml) remains. Take 1 sheng (200ml) warmed, 3 times a day. A second dose is required if the first dose is not effective.

Actions:

Tonifying the spleen and removing phlegm and water, and activating chest-yang to relieve obstruction of qi in the chest.

Indications:

Mild Xiong Bi syndrome due to deficiency of spleen and obstruction of phlegm and water in the chest, marked by an obstruction sensation in the chest, accompanied by short breath, white slippery tongue coating, and taut and slippery pulse.

This formula is usually applied to patient with mild coronary heart disease marked by deficiency in the spleen and obstruction of qi and phlegm rheum in the chest.

This formula can be used for the treatment of pulmonary oedema caused by heart failure in rheumatic heart disease, pulmonary heart disease and coronary heart disease. Li[5] reported that this formula were effective cough and asthma.

B. Ju Zhi Jiang Tang

Ingredients:

Jupi (Pericarpium Citri Reticulatae) 1 Jin /12g
Zhishi (Fructus Aurantii Immaturus) 3 Liang /9g
Shengjiang (Rhizoma Zingiberis Recens) half Jin/15g

Original preparation and administration:

Boil the above 3 ingredients in 5 sheng (1,000ml) of water until 2 sheng (400 ml) remains. Take 1 sheng (200 ml) warmed, 2 times a day.

Actions:

Removing the stagnation of qi and phlegm to treat the obstruction of qi and phlegm in the chest.

Indications:

Mild Xiong Bi syndrome due to the stagnation of qi and phlegm in the chest, marked by a sensation of obstruction in the chest, accompanied by short breath, white tongue coating and taut and slippery pulse.

This formula can be applied to patients with mild chest pain marked by the stagnation of qi and phlegm in the chest.

This formula can be used to patients with pulmonary emphysema manifested as obstruction feeling in chest due to stagnation of qi and phlegm. It can also be used for patients with chronic bronchitis and asthma marked by stagnation of qi and phlegm in the chest and lung.

The differences

These 2 formulae are used for mild blockages in the chest. Fuling Xingren Gancao Tang is for mild Xiong Bi caused by blockage of Phlegm and Rheum (Tan Yin - more watery blockage), whereas Ju Zhi Jiang Tang is for mild Xiong Bi caused by Qi Stagnation. They can also be combined together if the patient has both Qi Stagnation and Tan Yin.

5. Yiyi Fuzi San (Powder of Coix Seed and Aconite 薏苡附子散)

Ingredients:

Yiyiren (Semen Coicis) 15 Liang /15g
Fuzi (Radix Aconiti Lateralis Preparata) 10 pcs /9g

Original preparation and administration:

Pound the above 2 ingredients into powder. 1 Fangcunbi (3g) of powder is taken orally, 3 times a day.

Actions:

Removing the obstruction of cold and dampness in the chest.

Indications:

Xiong Bi syndrome which aches mildly with occasionally episodes of severe aching due to cold and dampness in the chest, white slippery tongue coating and a tense and taut and slippery pulse.

Original text (Clause 7):

"Acute Xiong bi syndrome which needs to be calmed down urgently, Yiyi Fuzi San should be used".

This formula has 2 ingredients. Fu Zi is used raw so its yang tonic action is quick. Yi Yi Ren is to remove dampness. As the formula is used is for an acute and emergency situation, it is made into a powdered form. Currently, this formula cannot be used in the UK because Fuzi is not allowed to be taken orally according to the UK regulation.

In China, as well as Xiong Bi, this formula can be used for patients with rheumatic arthritis.

6. Guizhi Shengjiang Zhishi Tang (Decoction of Cinnamon Twig, Fresh Ginger and Immature Orange Fruit 桂枝生姜枳实汤)

Ingredients:

Guizhi (Rumulus Cinamomi) 3 Liang /9g
Shengjiang (Rhizoma Zingiberis Recens) 3Liang /9g
Zhishi (Fructus Aurantii Immaturus) 5 pcs /15 g

Original preparation and administration:

Boil the above 3 ingredients in 6 sheng (1,200ml) of water until 3 sheng (600 ml) remains. Take 1 sheng (200ml) warmed, 3 times a day.

Actions:

Activating chest-yang, dispelling cold and descending reverse qi.

Indications:

Xiong Bi syndrome manifested as a fullness feeling in the chest, accompanied with hypochondrial adverse flushing qi causing heart pain, white tongue coating, and taut pulse.

Original text (Clause 8):

"Xiong Bi syndrome manifests as an obstruction feeling in the chest, accompanied with adverse qi causing heart pain, Guizhi Shengjiang Zhishi Tang should be used".

This is one of the 2 formulae Zhang Zhong-jing Designed for Xin Tong (heart Pain).

Guizhi Shengjiang Zhishi Tang is designed for cold rheum blocking the heart and the chest. The patient feels heart pain with adverse qi symptoms. Gui Zhi will activate yang qi, Sheng Jiang is used to clear Rheum, and Zhi Shi to clear fullness and obstruction. Therefore, this formula is usually applied to patient with chest fullness marked by cold and qi obstruction in the chest.

Apart from Xin Tong, this formula can be used to treat hysteria with heart pain due to obstruction of cold and qi, manifested as an obstruction feeling in the chest with hypochondriac adverse flushing qi. It can also be used for gastric dilatation marked by fullness in the chest and stomach.

7. Wutou Chishizhi Wan (Aconite and Red Halloysite Pill 乌头赤石脂丸)

Ingredients:

Shujiao (Fructus Zanthoxyli) 1 Liang/3g
Wutou (A parent root of Radix Aconiti) 1 Fen/0.3g
Fuzi (tuberous root of Radix Aconiti Laterralis Preparata) 1 Fen /0.3g
Ganjiang (Rhizoma Zingiberis) 1 Liang /3g
Chishizhi (Halloysitum Rubrum) 1 Liang /3g

Original preparation and administration:

Pulverize the above ingredients, knead with honey, and make into pills as large as a parasol seed. Take 1 pill before meals, 3 times a day. If not effective, slightly increase the dosage.

Actions:

Activating chest-yang, dispelling yin cold and removing cold obstructing in the heart.

Indications:

Heart pain piercing to the back, or back pain piercing to the heart, due to yang deficiency and yin cold obstructing in the vessels of the heart.

Original text (Clause 9):

"Heart pain piercing to the back, or back pain piercing to the heart, apply Wutou Chishizhi Wan".

This is a powerful formula for Heart Pain. It is made into pills so that it can be used in an emergency. In the formula, Wu Tou and Fu Zi are used together, forming a heart strong yang tonic. Combined with Shu Jiao and Gan Jiang, they give the heart a quick boost of Yang qi and expel the cold pathogen at the same time. As they are very pungent that can disperse the precious yang qi, Chi Zhi Zhi is added to help astringe Yang.

Liu[6] reported that it is effective for patients with angina of coronary heart disease, sciatica and urticaria, while Li[7] reported that this formula was effective for patient with pyloric obstruction and gastric ulcer.

The problem now is that Wu Tou, Fu Zi and Chi Shi Zhi are banned in the UK. We are unable to apply this formula until proper regulation is established.

8. Appendix: Jiu Tong Wan (Pill for 9 Kinds of Heart Pain 九痛丸)

Ingredients:

Fuzi (tuberous root of Radix Aconiti Laterralis Preparata) 3 Liang/9g
Sheng Langya (Potentilla Recens) 1 Liang /3g
Badou (Fructus Crotonis) 1 Liang /3g
Renshen (Radix Ginseng) 1 Liang /3g
Ganjiang (Rhizoma Zingiberis) 1 Liang/3g
Wuzhuyu (Fructus Evodiae) 1 Liang /3g

Original preparation and administration:

Pulverize the ingredients; knead with honey to make pills in the size of a parasol seed. For strong patients, take 3 pills at first time, 3 times a day; for weak patients, 2 pills each time only.

Actions:

Activating chest-yang, dispelling yin-cold obstructing in the heart.

Indications:

For all kinds of heart pain (hence Jiu Tong – nine pain), stroke, fullness and pain in the abdomen ,aphasia, chronic cold accumulation causing pain in the chest and heart, flushing up of chill-qi, injuries from falls from a horse or cart; and blood diseases .Ordinary eating taboos to herbal administration apply to this formula.

Comments:

This formula was introduced in an appendix of Chapter 9. Most of scholars believe that is not the original formula created by Zhang Zhong-jing. Fu Zi, Sheng Lang Ya and Ba Dou are all toxic and banned. Therefore, the use of this formula is not recommended.

Summery

In this article, the symptoms, pulse and cause of xiong bi syndrome described in Jin Kui Yao Yue were discussed. 10 formulae for treating Xiong Bi, Xin Tong and short breath have been introduced, namely: Guanlou Xiebai Baijiu Tang (Decoction of Trichaosanthes , Chinese Chive and White Liquor 瓜蒌薤白白酒汤), Guanlou Xiebai Ban-xia Tang (Decoction of Trichaosanthes , Chinese Chive and Pinellia 瓜蒌薤白半夏汤), Zhishi Xiebai Guizhi Tang（Decoction of Immature Orange Fruit, Chinese Chive and Cinnamon Twig 枳实薤白桂枝汤）, Renshen Tang (Ginseng Decoction 人参汤), Fuling Xingren Gancao Tang (Decoction of Poria ,Apricot Seed and Liquorice Root 茯苓杏仁甘草汤), Ju Zhi Jiang Tang (Decoction of Tangerine Peel, Immature Orange Fruit and Fresh Ginger 橘枳姜汤), Yiyi Fuzi San (Powder of Coix Seed and Aconite 薏苡附子散）, Guizhi Shengjiang Zhishi Tang (Decoction of Cinnamon Twig ,Fresh Ginger and Immature Orange Fruit 桂枝生姜枳实汤), Wutou Chishizhi Wan (Aconite and Red Halloysite Pill 乌头赤石脂丸) and Jiu Tong Wan (Pill for 9 Kinds of Heart Pain 九痛丸).

The main symptoms of Xiong Bi are chest and upper back pain, breathing difficulty, dyspnoea and short of breath. The main symptoms of Xin Tong are pain in the heart area, chest pain piercing to the back or back pain piercing to the heart. These 2 can sometimes happen simultaneously.

The general pathological mechanism of Xiong Bi and Xin Tong is Yang deficiency and cold in the upper jiao, affecting the normal function of the heart. It is Ben Xu (root deficient) and Biao Shi (branch excessive). Therefore, in treatment, it is essential to have a balanced approach – Tonify yang qi and clear away pathological agents (cold, phlegm, rheum and damp). That is why Zhang Zhong-jing has designed so many different formulae for Xiong Bi and Xin Tong.

The first 5 formulae are still commonly applicable in TCM practice.

References

[1] World Federation of Chinese Medicine Societies 2008 International Standard Chinese–English Basic Nomenclature of Chinese Medicine. People's Medical Publishing House page 388.

[2] Li J et al 2006 Formulas of TCM, High Education Press, Beijing, p 532.

[3] Wang X Y et al 1988 Fujian Journal of TCM 1:41.

[4] Li W R 2005Modification and Applications of Classical Formulas. Xueyuan Press, Beijing China p 369-370.

[5] Li W R 2005 Modification and Applications of Classical Formulas. Xueyuan Press, Beijing China p 372.

[6] Liu J S 1987 Application of Wutou Chishizhi Wan, Beijing Journal of TCM 4:28.

[7] Li W R 2005 Modification and Applications of Classical Formulas. Xueyuan Press, Beijing China p 376.

《伤寒杂病论》与“三元论”

王以胜

北京同仁堂（英国伦敦）

摘要：以胜将“一分为三看世界”方法论提高到“三元论”的层面，认为“三元论”是古今中外人类文化的精髓、真谛。它可以涵盖“一元论”、“二元论”、“多元论”，它还是沟通“二元论”和“多元论”的思想武器，是人类全面认识世界的方法论。按照“三元论”思维，以胜给“中医学”新的定义为：中医学是以中国文化为母体而构建的、以“阴阳”和“五行”学说为说理工具的、以“天人合一”和“辨证论治”为特色的中国医学。而《伤寒杂病论》是把“三元论”哲学理论具体运用到临床的经典之作，是“理论思维、辨证论治、临床实践”的“三位一体”紧密结合的经典之作。张仲景倡导的“六经辨证”的方法论，其实质就是“一分为三看世界”方法论，即“三元论”。本文仅是选自近年来以胜研究“三元论”理论和中医药关系二百多篇“小文章”其中三篇，作为引玉之砖。

关键词：“一分为三”方法论，“三元论”，中医学，六经辨证，方证。

（一）六经辨证方法论

自从“阴阳学说”引入医学之后就有辨证之说，《黄帝内经》奠定了中医药学辨证思想基础。从《伤寒杂病论•序》所说“乃勤求古训，博采众方，撰用素问、九卷、八十一难、阴阳大论、胎胪药录、并平脉辨证、为伤寒杂病论十六卷”，可以知道汉代之前已经有中医“辨证”专著。

正如《黄帝内经•素问》“阴阳应象大论篇第五”所说“阴阳者，天地之道也。万物之纲纪，变化之父母，生杀之本始，神明之府也，治病必求于本。”，这个“本”就是“阴阳”。又说“善诊者，察色按脉，先别阴阳”。所以《伤寒杂病论》的“六经辨证”，以及后世的“八纲辨证”，都是以“阴阳”为辨证大纲。

以胜理解“六经辨证”是在“一分为二”方法论即“阴阳”（二元论）指导下，其实际操作是按照“一分为三”方法论（三元论）进行的。

经高人指点，以胜将“一分为三看世界”提高到“三元论”的层面，认为“三元论”是古今中外人类文化的精髓、真谛。它可以涵盖“一元论”、“二元论”、“多元论”，它还是沟通“二元论”和“多元论”的思想武器，是人类全面认识世界的方法论。

张仲景《伤寒杂病论》继承了《黄帝内经》的阴阳学说（二元论），综合汉代之前的医学成果，创造性地发展为“六经辨证”。首先解决“病发于阴，还是发于阳”。“阴、阳”确定，就是“治病求本”之道。然后按照“一分为三看世界”方法论（三元论），进一步探讨“病位之所在，病情之所属，病势之进退”；进而确定“表、里；寒、热；虚、实”情况，这就是“八纲辨证”。

如果只会辨证到“八纲”为止，还不能解决临床治疗问题。因为这些还没有把具体的脏腑经络病理变化结合起来，就如找人只找到街道，没有找到住户；还不能确切而深刻地阐明各种复杂的病理变化，进一步指导临床治疗。而“六经辨证”把“八纲辨证”的内容落实到“脏腑经络”上，使“八纲辨证”和“脏腑辨证”有机地结合起来，正好解决“八纲辨证”之不足。由于“六经辨证”贯穿“八纲”而联系“脏腑经络”，是以脏腑经络的生理、病理变化为物质基础，使“辨证”言之有物，言之有据。

探讨“六经”之“经”字，可知“经者，径也。”根据“经”则知道邪气的来去之路径；“经者，界也。”根据“经”则知道病有范围界限，彼此不会混淆。有了“经”就会在辨证时一目了然。如见“头项强痛”，可知是太阳经受邪；见面赤、额痛、鼻干，可知阳明经受邪；见耳聋、胸胁苦满，可知是少阳经受邪；见腹满时痛，可知是太阴经受邪；见咽痛，可知是少阴经受邪；见巅顶痛、干呕吐涎沫，可知是厥阴经受邪。因为经络内联脏腑，外通肌肤，网络机体上下内外、四肢九窍、皮肉筋脉等成为一个有机的统一体，六经辨证特别注意脏腑经络病变的表里互相影响。如发热、恶寒而脉浮者，是太阳经邪在表；如果脉不浮反而沉，则为太阳表邪又内累少阴。太阳与少阴为表里关系，当少阴阳气不足而外感风寒时，会形成两经同时受邪，形成太阳与少阴“两感”证。脾与胃互为表里，发生病变也会互相影响，故有“实则阳明，虚则太阴”的说法。

例如六经病中的太阳病，有“发热恶寒，头痛项强，脉浮”等证，八纲辨证属“表证”，仅仅如此辨证还不能指导治疗，必须再根据“有汗、无汗”来辨证，有汗为“表虚”，无汗为“表实”；进而可以指导“论治”：太阳表实证，要“开泄腠理，发汗散寒”，用“麻黄汤”。太阳表虚证，要“调和营卫，解肌祛风”，用桂枝汤。

再如少阴病有“脉微细，但欲寐”等证，八纲辨证为里证、虚证；还需要进一步了解阴阳盛衰，如果“无热恶寒，四肢厥逆，脉沉微细”则为少阴寒化证；如果“心烦不寐，咽干或疼痛，脉细数”等阴虚内热脉证，则为少阴热化证。分别运用“扶阳抑阴”之法，方用“四逆汤之类”；或用“育阴清热”之法，方用“黄连阿胶汤之类”。

由此可知，六经辨证的方法论，就是“一分为三看世界”方法论，即“三元论”。

（二）六经病证的治则

按照“一分为三看世界”方法论，我们来探讨《伤寒杂病论》的“六经病证的治则”：一是当邪气重、正气不太虚时，以攻为主的“驱邪”；二是当邪气与正气相当时的“攻补兼施”；三是虽然有邪气但是正气比较虚弱时的“扶正”；这就是《伤寒杂病论》的治则。

但是历来人们看到的则是“驱邪”和“扶正”两方面，国家教科书也是这么写，即“阴阳学说”、“矛盾论”的“二元论”表述方法。以胜提倡的是“一分为三看世界”方法论即“三元论”表述方法，不仅仅是“驱邪”和“扶正”，还应当注意中间状态的“攻补兼施”适当调养。这就是“一分为三”和“函三归一”的“三元论”哲学思想。其意是在机体“阴阳气血平衡”被破坏、即健康状态下的“一”发生变化、发生疾病后，会产生三种状态和治疗原则：邪气重、正气不太虚时的“攻邪”；邪正相当时的“攻补兼施”；正虚邪实时的“扶正”。而后达到恢复“阴平阳秘、阴阳气血相对平衡状态”即“函三归一”的健康状态。养生和治疗的目的就是为了“函三归一”，这就是“知道一，万事毕”。

《伤寒杂病论》字里行间、始终贯穿和表达了“一分为三”方法论，即“扶阳气、保胃气”、“存阴液、存津液”、“阴阳自和”三种治疗原则，基本精神都是为了达到“阴平阳秘，生命乃治”的目的。

在临床上，我们必须明确：按照“一分为三”方法论，人类所进行的所有“医事”活动，高度概括起来，就是把握和处理好“人、病、药”三者的辩证关系。

所有的“药”（包括手术、针灸、心理疗法等所有治疗手段都可以归入一个“药”字），所有的治疗手段，都是为了治疗这个“病”字，千万记住，“人”是三者之中最重要的，这是因为“治病用药”，无非为的就是“人”，所以，无论用什么手段治病，都不能“伤人”，否则，会导致“阴阳离决，生命乃绝”的不良后果。

以胜认为，由于中、西医学的哲学理念不同，而有不同的“诊断、治疗”方法。最大的不最大的不同就是西医学是“二元论”，只注意“病、药”，以消灭疾病为主的“对抗性”思维，把“疾病”消灭了，“人”也不行了，最典型的表现在治疗肿瘤的三大手段上。中医学是“三元论”，注意“人、病、药”，是“整体论”以人为主的“调和性”思维，全部诊断治疗就是为了恢复和保持人的“阴阳气血平衡”健康状态。

《伤寒论》在治疗原则和方法上，已经包含有八法：汗、吐、下、和、温、清、补、消。

三阳病，以驱邪为主。太阳病在表，一般用“解表发汗”剂，不可用吐，下法。如桂枝汤、麻黄汤、葛根汤等都属于太阳病的发汗剂。由于病情不同，太阳病又分太阳“经证”和太阳“腑证”。

“太阳病经证”分二个证型：一是“太阳伤寒（表实）证”，治疗应“发汗散寒”，方用“麻黄汤”。二是“太阳中风（表虚）证”，治疗应“调和营卫，解肌祛风”，方用“桂枝汤”。

太阳病“腑证”分二个证型：一是“蓄水证”，治疗应“化气行水”，方用“五苓散”。二是“蓄血证”，治疗应“活血逐瘀”，方用“桃核承气汤”等。

阳明病是里、热、实证，热结于里而“胃家实”应当用“下法”；但是“热而不实者”，宜清法。即阳明病也分二个证型：一是“阳明经证”，治疗应当用“清法”，方用“白虎汤”。二是“阳明腑证”，治疗应当用“下法”，方用“承气汤”类。

少阳病为枢机不利，是“半表半里证”，治疗应当用“和解少阳”的“和法”，方用“小柴胡汤”。

三阴病多属里、虚、寒证，治法以扶正为主。

太阴病为“脾虚寒湿证”，治疗应当“温中、散寒、燥湿”，方用“四逆理中”之类。不可用“汗、下、吐”。

少阴病为“心肾虚衰、气血不足”，少阴寒化证，治疗应当“扶阳抑阴”，方用“四逆汤”类。少阴热化证，治疗应当“清热育阴”，方用“黄连阿胶汤”类。

厥阴病，证候错综复杂，热者宜清法，如“白头翁汤”；寒者宜温补，如“四逆汤”类；寒热错杂应当寒温并用，如“乌梅丸”。

（三）六经病证之“方证”

以胜认为《伤寒杂病论》是医圣张仲景把秦汉之前的医学成果融会贯通，将《黄帝内经》等中医学经典著作奠定的基本理论，以及许多临床医生的诊断治疗经验进行“系统总结、分别疏理、高度概括”，形成了“理法方药”一以贯之的“辨证论治”理论体系，具体就是《伤寒杂病论》的“六经辨证”，这是把“三元论”哲学理论具体运用到临床的经典之作，是“理论思维、辨证论治、临床实践”的“三位一体”紧密结合的经典之作。

《黄帝内经》是一部中医学基本理论和养生经典，告诉后人有关中医学的基本理论和大原则，具体诊断治疗疾病方法也只是明确大的方向，对于临床具有指导意义。读好《黄帝内经》就能够掌握基本养生理论，但是如果想诊断治疗疾病，还必须认真学习《伤寒杂病论》（后人分为《伤寒论》和《金匮要略》二书）。这本书是中医药学从基础理论到具体临床实践的桥梁、工具、金钥匙，是中医师必读之书。因此，以胜经常说：学医不读“伤寒论”，行医肯定“瞎胡混”。

学习《伤寒杂病论》，首先要知道有一个特有的名词，叫做“方证”。通常中医师所说“理、法、方、药”，就是先把发病“机理”搞清楚，而后确定治疗原则和“方法”，后面就是用哪个“药方”，具体都是那些“药物”。各个有关的“方药”的适应证，简称为“方证”。

我们讨论过“八纲辨证”和“六经辨证”，在此基础上，可以确定治疗大原则、治疗大法。但是在临床上仅仅到这一步还是不够的。例如，我们知道太阳病提纲所说的“太阳之为病，脉浮，头项强痛而恶寒（1）”，知道这是太阳病，除了太阳病一般特征“脉浮、头项强痛、恶寒”之外，还需要再研究病人的其它情况，例如还有“发热、汗出、恶风，脉缓者”，这里可能是“脉浮缓”，适用于“桂枝汤”。如果没有汗出，而有身体疼痛，脉紧而喘者，适用于“麻黄汤”。如果有项背强几几，无汗，恶风者，则宜给予“葛根汤”。如果脉浮紧，发热恶寒，身疼痛，不汗出而烦躁者，则宜应用“大青龙汤”。以上虽然都是太阳病的“发汗”方剂，但是各有其治疗的固定的适应症。某方的适应证，就叫“某方证”，如“桂枝汤证”、“麻黄汤证”、“葛根汤证”、“大青龙汤证”、“小青龙汤证”、“小柴胡汤证”等等。

由于病情不同，太阳病又分太阳“经证”和太阳“腑证”。六经病中的太阳病，有“发热恶寒，头痛项强，脉浮”等证，八纲辨证属“表证”，仅仅如此辨证还不能指导治疗，必须再根据“有汗、无汗”来辨证，有汗为“表虚”，无汗为“表实”；进而可以指导“论治”：太阳表实证，要“开泄腠理，发汗散寒”，用“麻黄汤”，这个“方证”就是“麻黄汤证”。太阳表虚证，要“调和营卫，解肌祛风”，用桂枝汤，这个方证就是“桂枝汤证”。

现代中医名家、原北京中医学院内科教授、伤寒临床大家胡希恕先生，在1915年师从清末国子监培养出来的进士、太医徒弟王祥徵，二年学完《伤寒论》。胡希恕先生后来于1919年参加当地国民政府举办的中医考试，考取中医士证书。后来成为著名“经方大师”，他临床治疗效果非常好，靠的就是《伤寒论》原方、原剂量用于临床而取效。他会诊、或带学生，经常说“这个哮喘病人是大柴胡汤合桂枝茯苓丸证，这个肝炎患者是柴胡桂枝干姜汤证，------”，都是用原方、原量，很少加减，治疗效果却很好。《伤寒论》大师刘渡周教授高度赞扬胡教授：“群贤会诊，高手如云，惟先生能独排众议，立方遣药，效果非凡！”

高手临床诊断治疗，就是“拿捏”好这个病人“当时”是属于什么“方证”，而后应用《伤寒杂病论》的“经方”。例如六经之中，“太阳病”的“方证”最多。现代病中，少阳病的“小柴胡汤证”也不少，甚至有的中医师一辈子就是用“小柴胡汤”加加减减可以治疗所有的病人。

所以说，“方证”是“辨证”的继续，是“辨证”的尖端，中医治病疗效关键就在于“方证”是否“辨证”正确，以胜理解，所谓“辨证论治”就是“辨方证”而“施治”。

论中医学之痹证

张恩勤 康泰诊所

摘要：本文首先以《内经》为据，论证“痹证”的发生是因风、寒、湿三邪乘虚侵入人体经脉，不通则痛所致。接着介绍了“痹证”的辨治方法，分为风痹、寒痹、湿痹、瘀血痹和心痹；所选方药，既有传统的中医方剂，也有作者多年来积累的有效验方。最后，根据中医“上工治未病”思想，提出“痹证”的预防和护理方法。

痹，在中文有“闭塞不通”之意。中医学所称的“痹证”，乃指因风、寒、湿三邪合之，侵入人体，导致经脉不通的病理状况，主要表现为关节、肢体疼痛等。

由于关节痛是“痹证”主症，故西方学者常把“痹证”翻译成‘Arthralgia Syndrome’【1】。 ‘Arth’表示关节；ralgia 表示疼痛。

中医之“痹证”，概括了西医所讲的风湿性关节炎、类风湿性关节炎、骨性关节炎、肌纤维炎、坐骨神经痛、狼疮、痛风、神经痛，以及布氏杆菌病、血栓闭塞性脉管炎、硬皮病、结节性脉管炎等多种疾病。然而，中医临床处方是以“辨证施治”为依据，西医的诊断仅供参考。

《黄帝内经》对痹证的病因、证候分类以及转归与预后等，早有明确阐述。后世医家对痹证论述颇多，在治疗上也积累了丰富的临床经验。如汉唐时期，积累了大量治疗痹证的有效方剂；明清时期对痹证的病机、辨证、治则以及方药的选择、配伍等均有发展。近代国内外专家，多采用辨病与辨证相结合及实验室验证的研究方法。

中医治疗“痹证”主要使用针灸、推拿和中药。目前由于英国在实行欧盟中草药新法，禁止中成药进口，造成市场中成药供应短缺，中医诊所只能靠草药饮片和中药浓缩粉来维持。

病因病理

根据传统的中医理论，痹证主要由以下因素所致：

1. 外界因素：风、寒、湿侵入人体的肌肉、关节和经脉，气血痹阻不通。

《素问.痹论第四十三》云：“风寒湿三气杂至，合而为痹也。其风气胜者为行痹，寒气胜者为痛痹，湿气胜者为著痹也”【2】。明确指出痹证是因风，寒，湿一起侵入人体所造成的。其中，如风邪尤甚，表现为关节痛呈游走性，就称为“行痹”、“风痹”；寒邪尤甚，表现为关节冷痛、痛处固定的，称为“痛痹”、“寒痹”；而以湿邪为主，表现为关节肿痛、沉重感，称为“著痹”、“湿痹”。痹证的这一分类方法，至今仍在中医界延用。

风、寒、湿，本为自然界的正常气候变化。但如发生过于突然，超过了超越了人体的适应和调节能力，就会变成风寒湿病邪，转成致病因素，引起多种疾病，包括痹证。从临床角度看，风湿病、类风湿性关节炎等具有“痹证”症状的患者，多在遭遇寒冷、潮湿的气候时发病；也常因气候变化而加重或缓解。

此外，久居高寒、潮湿地区，或长期在低温、水中、潮湿、寒冷、野外的环境中作业，更易患痹证。起居不慎，如睡眠时不盖被褥，夜间单衣外出，病后及劳后居处檐下，或直吹风扇；或汗出入水，或冒雨涉水等，均与痹证发病有关。

2. 内在因素：正气不足，卫气虚弱，对风寒湿抵抗能力低下，是引起痹证的内在因素。

中医学认为，“正气存内，邪不可干，邪之所凑，其气必虚”。在正气不足、卫气虚弱的情况下，外界的风寒湿病邪，更易突破人体的体表防线，侵入人体而引起痹证。临床上常见到这样的情况，人们同居一个生活环境，有的人患痹证，有的则健康无恙。究其原因，就是因为正气强弱不同。

导致正气不足、卫气虚弱的因素很多，如素秉虚弱，先天不足，即类似现代医学讲的遗传因素；或劳逸过度，或大病、久病或产后，或饮食失调，或外伤等，都导致正气损伤。

中医认为，“通则不痛，痛则不通”。当以上诸种因素导致经脉闭塞、气血运行不畅时，就会“不通则痛“，出现关节、肢体疼痛等“痹证”的症状。

此外，患痹证后，如果患者阳气偏盛或素有内热，风寒湿痹可转化为热痹。痹证久治不愈，还发展为淤血痹、痰湿痹。

根据痹证的发病季节，《素问-痹论篇第四十三》曾将痹证再分成五类，即“以冬遇此者为骨痹，以春遇此者为筋痹，以夏遇此者为脉痹，以至阴（季夏）遇此者为肌痹，以秋遇此者为皮痹“。以上分类方法，与“五行理论”有关。

《内经》认为，痹证病久不愈，还可进一步累及内脏。即所谓“骨痹不已，复感于邪，内舍于肾；筋痹不已，复感于邪，内舍于肝；脉痹不已，复感于邪，内舍于心；肌痹不已，复感于邪，内舍于脾；皮痹不已，复感于邪，内舍于肺”。而“内舍”的原因，是因“各以其时重感于风寒湿之气也”。本人认为，西医讲的风湿病反复发作可造成心脏瓣膜损害，符合《内经》“脉痹不已，复感于邪，内舍于心”的描述。

辨证要点

1) 风痹：关节、肢体疼痛，呈游走性，或伴有恶风，舌苔白或腻，脉浮。
2) 寒痹：关节、肢体冷痛，遇温则减，遇寒加重，舌苔白，脉紧。
3) 湿痹：关节、肢体肿胀、酸痛，阴雨天加重，舌苔腻，脉软濡。
4) 热痹: 关节、肢体红肿热痛，或伴有发热、多汗，口渴，舌苔黄腻，脉滑数。

5) 瘀血痹：病程较长，关节、肢体刺痛，或伴有关节变形，屈伸不利，舌质有瘀斑，苔白或腻，脉细涩。
6) 心痹：心悸，胸部窒息感或刺痛，短气，颧部紫红，舌暗苔少，脉弱或结代。西医检查发现有风湿性二尖瓣狭窄或关闭不全。

常见疾病

西医的多种疾病，表现为中医的“痹证”。

1. 风湿病：西医的“风湿病”与中医的“风寒湿痹”，二者概念并不相同。风湿病是指由于溶血性链球菌感染后所引起的一种变态反应性疾病。患者病前1-4周常有溶血链球菌感染史，如咽炎、扁桃体炎等。主要累及人体的结缔组织，如心脏、关节、皮肤、血管等。常发生于20-30岁青壮年。急性期表现为心脏炎、多发性，游走性关节炎、环形红斑、皮下结节、发热、舞蹈病等。急性期可有关节局部红、肿、热、痛。这与中医学“风痹”、“热痹”符合。如有二尖瓣狭窄或关闭不全心脏瓣膜损害，则类似中医的“心痹”症情。

2. 类风湿关节炎：其发病机理至今尚未明确，一般认为与自身免疫、遗传、感染等有关。表现为对称性、多发性关节炎，以手指、足趾、腕、踝等小关节最易受累。早期或急性期，有关节红、肿、热、痛和运动障碍，晚期则表现为关节强直或畸形。血沉增快，类风湿因子阳性。一般无心瓣膜损害。本病之全身关节肿痛，昼轻夜重，其痛彻骨，状如虎咬，符合《金匮要路》之“历节”病。

3. 骨性关节炎：又名增生性骨关节炎。其发生率随年龄的增高而增多。主要改变是关节软骨面的退行性变和继发性的骨质增生，表现为关节疼痛、肿胀和活动不灵活。常累及手、足、颈椎、腰椎、髋、膝等。X线表现关节间隙变窄，软骨下骨质致密，骨小梁断裂，有硬化和囊性变。关节边缘有唇样增生。本病属中医学“骨痹”范畴。

4. 肌纤维织炎: 发病原因不明。以局部肌肉僵硬和压痛为主要症状。常伴有心烦、睡眠不深、疲劳、焦虑、抑郁、大便或干或稀。似乎属中医“肌痹”范畴。

中医治疗

1. 针灸疗法

主穴：大椎，合谷，曲池，肩禺，外关，腕骨，环跳，悬钟，夹脊，风市，阳陵泉，犊鼻，昆仑。

注：选穴应根据痹证的发病部位和临床类型而定。

辅助穴：风痹，加风门、血海；寒痹，加委阳、关元；湿痹，加丰隆、阴陵泉；热痹，加曲池、二间；瘀血痹，加血海、膈腧；心痹，加通里、心腧。

针法：每次选穴6-12个，风痹、热痹、瘀血痹，用泻法；寒痹、湿痹，用补法，留针30分钟，并加灸法。

2. 中药疗法

处方的基本原则是：祛风，散寒，除湿。

（1）痹证的基本方—蠲痹汤加减。

方源：《医学心悟》， 程国彭，1732。

成分：羌活 10克，独活 10克， 桂枝10克，秦艽12克，当归10克，川芎10克，海风藤 30克，鸡血藤30克，桑枝30克。

加减：风痹，加威灵仙12克、 防风10克；寒痹，加白芷 12克、延胡索 9克；

湿痹，加薏苡仁30克、 苍术 12克。热痹，加忍冬藤30克、黄柏 10g。血瘀痹，加乳香10克、没药10克。心痹，加玉竹21克、 葶苈子 9克、 黄芪30克、 党参 15克。

用法：用冷水泡药2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎10分钟，取汁。两次取汁，合在一起。早上服一半，晚上服一半，饭后服。

作者经验：本方通用于各型痹证。

（2）风痹—羌活胜湿汤加减。

方源：《内外伤辨惑论》,李杲，1247.

成分：羌活9克， 独活9g，藁本10g，防风10g,炙甘草6g，川芎10g， 蔓荆子10g。

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎10分钟，取汁。合在一起。早上服一半，晚上服一半，饭后1小时服用。10天为一疗程

作者经验：本方可用于风湿性关节炎症见“风痹”者；也可用于风湿性偏头痛、紧张性头痛、感冒等证属“风湿外袭”的情况。

（3）寒痹或痹证日久体虚- 独活寄生汤加减。

方源： 《千金要方》，孙思邈，652。

成分：独活9克， 细辛3克，防风6克，秦艽6克，桑寄生6克，杜仲6克，白芷10克，肉桂6克， 当归 6克，川芎6克，茯苓 6克，炙甘草6克。

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎煮10分钟，取汁。合在一起，早上服一半，晚上服一半，饭后1小时服用。10天为一疗程。

作者经验：主要用于慢性风湿性关节炎、类风湿关节炎、骨性关节炎、腰椎病、坐骨神经痛和多发性神经炎等表现为“寒痹”者；或痹证日久，兼有肝肾气血虚损者。本当用乌头汤，但英国禁用乌头、附子，故以此方代之。

（4）湿痹方—薏苡仁汤加减。

方源：《类证治裁》，林佩琴，1851.

成分：麻黄6克（在英国，可改用木瓜10克代之）， 当归9克， 苍术9克，薏苡仁 24 克，桂枝6克，白术10克，白芍6克，甘草3克。

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎煮10分钟，取汁。合在一起，早上服一半，晚上服一半，饭后1小时服用。10天为一疗程。

作者经验：主要用于风湿性关节炎、类风湿性关节炎、狼疮等证见“湿痹”者。

（5）热痹—宣痹汤。

方源：《瘟病条辨》，吴鞠通,1798.

成分：广防己15克（在英国可改用忍冬藤 15克），杏仁15克，薏苡仁15克，蚕沙9克，半夏9克，连翘9克，栀子9克，滑石15克， 赤小豆9克。

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎煮10分钟，取汁。合在一起，早上服一半，晚上服一半，饭后1小时服用。10天为一疗程。

作者经验：用于急性风湿性关节炎、感染性关节炎，属“热痹”者。

（6）血瘀痹—疏风活血汤加减。

方源： 《东医宝鉴》，许浚（朝鲜），1613。

成分：当归2.5克， 川芎2.5克， 威灵仙2.5克，白芷2.5克，汉防己2.5克(在英国可改用牛膝) ， 黄柏 2.5克， 胆南星2.5克，苍术2.5克， 羌活2.5克， 桂枝2.5克，红花1克，干姜1克。

注：此方源于朝鲜医师，剂量是根据日本汉方习惯。作者建议，以上各药剂量均改用6-10克为宜。

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎煮10分钟， 取汁。合在一起，早上服一半，晚上服一半，饭后1小时服用。10天为一疗程。

作者经验：用于骨性关节炎、类风湿性关节炎证属“血瘀”者。

（7）心痹—心痹汤。

方源：作者本人。

组成：当归15g，川芎10g， 赤芍10g，乳香9g, 路路通10g,羌活9g, 桑寄生15g, 威灵仙9g, 玉竹21g, 葶苈子6g,鹿含草10g.

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎煮10分钟， 取汁。合在一起，早上服一半，晚上服一半，饭后1小时服用。10天为一疗程。

作者经验：自1985年以来，用此方治疗10余例“风湿性心脏病”证属“心痹”者，表现为心悸,胸部窒息感或胸痛，气短，口唇紫暗，手足冷，舌质暗红少苔，脉涩或结代，能明显缓解症状。

（8）颈椎舒—颈椎病

方源：《伤寒论研习指导》，作者本人，2006.

成分：葛根15克，当归10克，川芎10克，赤芍10克，桃仁10克，红花10，路路通10克，刘寄奴10克，白芷10克，胆南星6克，白芥子10克，桑枝15克，羌活10克。

用法：冷水泡2-3小时，然后水煎25-30分钟，取汁；再加水少量，煎煮10分钟，取汁。合在一起，早上服一半，晚上服一半，饭后1小时服用。35服为一疗程。

作者经验：在导师吕同杰教授指导下，用此方共治疗700例颈椎病患者，表现为颈部僵硬、疼痛，牵及肩臂，手指麻木，或伴头晕、抑郁。35剂为一疗程。治疗结果：75%患者获临床治愈，20%获症状改善，5%无效。此外，本方还有改善勃起的功能【3】。

中成药—小活络丹

来源：《中国名优中成药》，作者本人，1990.

成分： 制川乌，制草乌 ，地龙 ，制天南星 ，乳香，没药。

用法：蜜丸，每次1丸，每日2-3次；小水丸，每次8粒，每日2-3次。如用汤剂，川乌、草乌，均需提前煎煮2小时，然后再加入其他药物，再煎25-30分钟，分3次温服。

作者经验：可用于风湿性关节炎、类风湿性关节炎证属“寒痹”者。本人还用此方治疗寒湿型女子不育3例，均获成功。

注：英国药政局规定，乌头、附子，均禁止内服。乌头和附子含有乌头碱等，对神经和心脏有毒付作用。中毒后温、痛触、压觉消失是由于乌头直接或间接作用于无髓鞘的和较纤细的神经纤维，阻止了冲动的发生和传导所致。其次是兴奋一麻痹胆碱能神经和呼吸中枢，出现一系列胆碱能神经M样症状和N 样症状，最后引起呼吸麻痹和中枢抑制而致死。乌头碱能强烈兴奋迷走神经，使节后纤维释放大量的乙酰胆碱，从而降低窦房结的自律性和传导性，延长其绝对和相对不应期，使心肌（心房和心室）内异位节律点兴奋性增强，产生各种心律失常。其对心肌的直接毒害作用，使心肌各部份兴奋、传导和不应期不一致，复极不同步而易形成折返，从而发生严重定性心律失常（包括扭转型室性心动过速），甚至导致心室纤颤而死亡。 鉴于乌头、附子有如此严重的毒副作用，所以作者认为，英国官方严禁乌头、附子内服，是有道理的。根据作者经验，如在煎煮中药时，先煎乌头或附子1-2小时，将其“乌头碱”将转化为“乌头次碱”，毒性可减少到原毒性的1-2%，且药效不变。然而，作者仍建议英国同仁，以不用这两味药为上策。如病人确需用乌头或附子，可改用桂枝、黄芪代之。另外，关于乌头、附子中毒的抢救方法，我在新书《伤寒论研习指导》（英文版）中，已做详细介绍，即用阿托品和支持疗法等。这里不再赘述。

3. 推拿和复位

在英国，推拿疗法最受欢迎。尤其对颈椎病，如用推拿复位，有立竿见影之效。但必须由经验丰富的中医骨科师做“手法复位”。如手法有误，轻者头晕、恶心，重者截瘫。

预防与护理

1) 日常起居应注意防寒、防潮，避免风寒湿之邪侵入人体。汗出勿当风，劳动或运动后不可立即带汗入水洗浴。如在潮湿环境作业，应采取严格的保护措施。
2) 平时注意劳逸结合，避免过度劳累和精神压力。及时治疗感冒、咽痛等，以防病邪入里致成痹证等。
3) 痹证的急性期，应卧床休息，并及时治疗。慢性期，宜注意个体调摄，如房事有节、饮食有常、劳逸结合、作息规律等。适当做些体育锻炼，以提高机体自身的康复能力

参考文献

[1] 李振吉等《中医基本名词术语》，北京，人民卫生出版社，2008，14-322.

[2] 吴连胜等《汉英对照黄帝内经》，北京，中国科学技术出版社，1997，208.

[3] 张恩勤.《伤寒论研习指导》英文版：北京,人民卫生出版社，2012，11.

子宫内膜异位症的综合治疗

赵丽琴[1] 刘倍玉[2] 李天照[2]

[1] 英国仲景医圣堂（Zhong Jing TCM, Sheffield, UK）

[2] Department of Reproductive Medicine and Surgery, Royal Hallamshire Hospital, Sheffield, UK

摘要：子宫内膜异位症多发于育龄妇女，为全球妇女之常见疾病，是引起妇女严重盆腔疼痛及不孕症之重要因素之一，严重影响了妇女的生活质量。中医是治疗子宫内膜异位症的自然而有效的方法，而西医则可以通过手术切除异位之子宫内膜，快速缓解腹痛，中西医结合将会更有利于子宫内膜异位症的全面治疗。本文作者将分析和讨论子宫内膜异位症的中西医病因病理，介绍独特的中医综合治疗方案和最先进的西医治疗方法，并通过典型病例来进一步证实其临床使用价值和效果。

关键词：子宫内膜异位症；不孕症；中医；西医；中医辩证治疗；宫腔镜。

子宫内膜异位症是一种雌激素依赖性炎症，其特征是子宫内膜样的结缔组织生长于子宫腔外。最常见的部位是盆腔腹膜、卵巢、子宫峡部、子宫骶骨韧带和直肠子宫陷窝，个别病例也可见于腹壁、膀胱、膈膜和胸膜。

据统计大约有15%的30岁至40岁育龄妇女患有子宫内膜异位症，也有个别女孩始发于青春期 【1，3】。研究表明50%不孕妇女患有此病【2】 。子宫内膜异位症不仅是引起盆腔疼痛的主要原因，而且有近27%的患者同时患有排卵障碍或黄体功能不全 ，但也有大约40%的病人除不孕之外并无其它症状【3】。临床上根据病情轻重可将其分为轻度，中度和重度。

临床症状和体征

临床表现常不同，其主要症状为反复发作且呈周期性、渐进性的严重小腹部疼痛。其它症状包括痛经，性交痛，功能性子宫出血，大肠功能紊乱，腰酸痛，小腹下坠和不孕。部分患者因痛甚致疲惫不堪，精神抑郁和紧张焦虑。

西医病因病理

具体发病原因尚不明确，可能是由多种原因致月经逆流而形成本病【4】。常因宫颈狭窄或闭锁，或子宫后倾、后屈时经血外流受阻，使子宫内膜碎片随月经倒流，经输卵管而种植于伞端、卵巢或盆腔其它部位，导致盆腔子宫内膜异位症。

主要病理是异位之子宫内膜随卵巢蓄体激素的变化而发生周期性出血，血液分泌物及组织碎片聚集在组织间隙内，种植于腹膜表面，诱发病灶周围产生炎性样反应，纤维组织增生、粘连形成疤痕【2】。但逆经并不是唯一的因素，许多患有逆经妇女并无子宫内膜异位症，故一定另有其它因素。自身免疫功能异常常会影响疤痕组织的消除，而子宫内膜细胞的质量和数量以及血管生成也与子宫内膜异位症的发生有关，也许是因为淋巴或血源性的扩散或组织转移，子宫内膜碎屑偶然进入淋巴或血管，播散在诸如腹膜后淋巴结、输卵管、肺和鼻粘膜等部位。统计资料表明，有子宫内膜异位症家族史者发病率高于一般妇女的七倍，因而推测可能有遗传基因存在【5】。

检查和诊断

目前宫腔镜是检查和诊断此病的最佳方法，可以直接地肉眼观察子宫内膜损害程度，探查其严重性。美国生殖学协会根据宫腔镜检查结果作为评判标准而将其分期，此分期系统可用来评估疾病的轻重和治疗方案的选择。非手术性的诊断方法如阴道超声泼检查，核磁共振造影可以很准确可靠地查出卵巢子宫内膜炎，但对检查浅表腹膜和卵巢植入以及粘连却有其局限性。尽管阴道超声波检查法因其费用低而成为被推荐的诊断方法，但核磁共振被越来越多地用作腹膜下沉淀物和子宫内膜异位症的鉴别诊断。

西医治疗方法的选择

假孕或假绝经疗法可以减轻子宫内膜异位症的发展，但却无法治愈。因此，西医治疗本病的主要目的是控制其发展，提供止痛方法，保持患者生育能力。

1. 药物疗法

药物治疗是手术前后常用的止痛方法。治疗选择包括有避孕药、孕激素、雄激素（睾丸素）和促性腺激素释放激素之类。此类药物试图通过不同的机理来止痛，包括抑制卵巢功能，减少雌激素的分泌，限制雌激素的作用，减轻炎症。

（1）非激素类消炎药（NSAIDs）

此类药物是拒绝使用激素疗法患者的常用止痛药，比如妇女欲怀孕或对激素类药物副作用反应强烈者。对少女尚未明确诊断者，此类药物为首选止痛药。

（2）激素类药物

避孕药：是常用首选止痛药，可以一个月或三个月的周期性用药。患者需于月经后连续服三包（三周）避孕药直至月经前一周，用药一月后应有暂时性闭经，疗程结束后应有

撤退性出血，如此可减少频繁的痛经。病情严重者医生常给长期服避孕药，直至欲怀孕前停止。

孕激素：可周期性或连续运用。安宫黄体酮（甲孕酮）是一种与避孕药同样有效且安全易接受的止痛药，但仍有副作用，如月经紊乱，体重增加，情绪波动和经前综合征之类症状。对病情严重者，可以连续用药3-12个月，但此类药物对肝脏有损害，服药期间要定期复查肝功【6】。

促性腺激素释放激素拮抗剂： 此药可抑制促性腺激素的分泌，从而抑制卵巢功能和排卵，使体内雌激素分泌减少，致闭经或子宫内疤痕组织退化。其副作用是诱发类似更年期样症状，长期应用会影响骨质密度致骨质疏松，一般最长可用六个月。但如果配用雌激素类药物可以预防此副作用，延长用药时间至两年。“雌激素限量假设”提出控制雌二醇水平在30-45pg/ml可以保持骨质正常密度且不会刺激子宫内膜疤痕组织【7】。

丹那唑：是一种具有雄激素样作用的化合物，具有抑制促性腺激素分泌的作用，使体内雌激素和孕激素水平降低，抑制排卵，亦可直接作用于子宫内膜，使之萎缩，造成类似绝经的表现，故称“假绝经疗法”。数年前被用于治疗子宫内膜异位症，但因其雄激素样副作用可致皮肤痤疮、体重增加和声音变粗等，故现已很少使用。

抗孕激素：少数研究显示 米菲司酮可以减轻疼痛，但缺乏大量抽样试验数据证明。

左炔诺孕酮宫内缓释系统和曼月乐等也可以替代全身激素类药物疗法，使子宫内膜萎缩而止痛，控制症状五年以上。一般用于手术后，作用类似于促性腺激素释放激素拮抗剂。适合于暂时不愿怀孕者。

芳香化酶抑制剂: 此类药物对子宫内膜异位症也有治疗作用，它可以选择性地抑制雌激素的分泌以减轻疼痛，而不影响卵巢之功能。但尚需更多的证据来证实其效果。

2. 手术治疗

若患者对以上药物治疗反应不良或无效，则需手术治疗。除此之外，因激素类药物常抑制排卵功能而影响生育，对欲怀孕之妇女建议选择手术治疗。近年来，子宫内膜异位症手术常在宫腔镜下进行，不需剖腹术（常遗留下粘连而需子宫内膜纤维组织切除术或分离术）。

3. 不孕症的处理

对伴有不孕的患者，药物难以改善其生育能力，而手术可以提高其受孕机率。手术适用于中度或重度患者。根据欧洲生殖学和胚胎学协会的建议，凡子宫内膜瘤大于4厘米者应做手术切除。如果单纯手术后仍不能受孕者，则需体外授精（IVF）之类助孕疗法。研究证实，在IVF治疗前使用三个月的促性腺激素释放激素拮抗剂来抑制卵巢功能，可能有助于提高成功受孕率【8】。

4. 复发性子宫内膜异位症的治疗

复发性痛经是子宫内膜异位症的常见现象，大约有50%的病人在停止药物治疗12-24个月后症状复发。宫腔镜术后五年累计复发率为近20%，术后无药物治疗者复发率甚至更高。中西医结合可以有效地减少子宫内膜异位症的复发。

中医观点

中医可以有效地治疗子宫内膜异位症及其所致之不孕症。根据病人的症状和体征可将其归属于几种不同的中医疾病范畴，最常见的有“痛经”、“癥瘕”和“不孕”【1】。其基本病机是血瘀【1，2，3，6】，血瘀常为情志郁结、久病不愈、寒湿外侵、手术损伤或生殖器感染等所致，职业妇女长期而过度的工作紧张和压力也与子宫内膜异位症的发生有关。

1. 中医辩证治疗

因其主要病理产物是血瘀，故主治原则是活血化瘀。除血瘀之外，常合并有肾虚、肝郁、寒湿或痰热的症型。可根据临床表现的不同而辨证分型，同时也要考虑发病时间、部位、性质和疼痛程度。常见的有以下六种分型。

（1）肾虚血瘀，阻滞胞宫

病因病理：素体肾阳不足，经行感受风寒，或经期同房，或手术后，均可致血瘀，胞宫受阻，血溢于胞宫之外，逆流入输卵管、卵巢和直肠阴道陷窝，致发本病。

临床症状：经行不畅，月经量少或点滴出血，夹有小瘀血块；或经量多夹大瘀血块，经期或经后小腹胀痛，月经不调，不孕或滑胎，腰腿酸痛，畏寒肢冷，头晕，舌暗淡边有瘀斑，苔薄白，脉沉细涩或细弦。

方药：桂枝茯苓汤合金匮肾气汤加减

针灸：关元，气海，子宫，脾俞，肾俞，命门，次髎，足三里，三阴交，照海，复溜；可加艾灸或神灯照射关元，气海，子宫，肾俞和命门。

（2）气滞血瘀 ，胞脉不通

病因病理：职业妇女工作紧张忙碌，生活压力大，久之情志内伤，肝气郁结，血行不畅，阻滞于冲任胞宫而致发本病。

临床症状：小腹痛甚，经前和经期尤重，疼痛拒按，经血量少或经行不畅，质粘稠有瘀血块，经后痛减，烦躁不安，经前乳房胀痛，胁肋部疼痛，舌暗红有瘀点或瘀斑，苔薄白，脉弦涩。

方药：膈下逐瘀汤或血府逐瘀汤配加味逍遥散加减。

针灸：印堂，合谷，神门，内关，天枢，归来，血海，地机，三阴交，外关，足临泣，太冲。

（3）寒凝血瘀，积聚胞宫

病因病理：经期、产后或盆腔术后，阴寒之邪乘虚而入，或过食生冷，致寒凝血瘀，积聚胞宫而发病。

临床症状： 经行小腹剧烈绞痛或冷痛，喜热畏寒，拒按，经色暗红，质稀，瘀块多，经后痛减，舌紫暗有瘀斑，苔白，脉沉细弦或沉紧。

方药：温经汤或少腹逐瘀汤加减。

针灸：中极，关元，气海，京门，大赫，肾俞，命门，大肠俞，血海，三阴交，交信。可加艾灸神阙穴及腹部穴位，或加神灯照射小腹部30分钟。

（4）气虚血瘀，宫失所养

病因病理：素体虚弱，或久病、产后、流产后，或久患子宫内膜异位症，正气被伤，气虚下陷，瘀结于小腹，胞宫失养而发病。

临床症状：月经量或多或少，色淡红，质稀薄如水样，经期或经后小腹隐痛，或有空坠感，喜按喜暖，易疲倦，面色萎黄，大便稀软，舌淡体胖大，边有齿痕，苔薄白，脉细弱。

方药：补阳还五汤合失笑散加减。

针灸：百会，关元，气海，子宫，足三里，血海，三阴交，脾俞，次髎，外丘。温灸关元，子宫，足三里。

（5）湿热血瘀，蕴结胞宫

病因病理：妇女患有生殖器炎症，如衣原体病，盆腔炎，真菌性阴道炎等，致湿热内蕴，流注冲任；或经期、产后适感湿热之邪，稽留冲任，蕴结胞宫，瘀热胶结，阻滞气血运行，发为癥瘕。

临床症状：经前或经期小腹痛甚，拒按，经血量多，质粘稠有瘀块，色暗红，带下黄稠，低热起伏，口苦咽干，烦躁不安，性交痛，小便短黄，大便秘结，舌红，舌尖有瘀点或瘀斑，苔黄腻，脉弦数。

方药：清热化瘀汤（自拟方）

夏枯草，海藻，昆布，黄柏，连翘，桃仁，丹参，赤芍，丹皮，蒲黄，五灵脂，制香附，元胡，皂刺。

针灸：曲池，合谷，外关，膈俞，血海，三阴交，天枢，中极，地机，蠡沟。

（6）痰瘀互结，积聚胞宫

病因病理：素体肥胖，脾虚肾阳不足，健运失常，水湿不化，聚湿生痰，痰湿阻滞胞宫，与瘀血互结，积聚而成癥瘕。

临床症状：月经不调，经行腹痛剧烈，经血量少色暗，带下量多粘稠，头晕心慌，舌暗淡，苔白腻，脉细滑涩。

方药：苍附导痰汤合血府逐瘀汤加减。

针灸：合谷，天枢，关元，气海，归来，足三里，丰隆，血海，阴陵泉，三阴交，脾俞，肾俞。

2. 中药调周疗法

在运用中医辨证治疗子宫内膜异位症病因的同时，结合月经周期的四个不同阶段进行调治，可以更有效地治疗本病及其所致之不孕症，建议病人从月经周期的第四天或第五天开始治疗。本人根据临床经验总结出如下治疗方案：

（1）经后期（卵泡期）

补肾阴，养精血为主，兼化瘀消癥。常用药：当归，白芍，熟地黄，山药，女贞子，枸杞子，菟丝子，续断，淫羊藿，五灵脂，蒲黄，从月经周期第四天始，服七天至经期第十一天。

（2）经间期（排卵期）

补肾调肝，活血促排卵。常用药：桃仁，红花，丹参，赤芍，川芎，茺蔚子，香附，菟丝子，紫石英，柴胡，益母草，从月经周期第12天起，服三到四天。

（3）经前期（黄体期）

健脾补肾，温经促孕。常用药：熟地黄，白术，仙茅，仙灵脾，菟丝子，肉苁蓉，续断，山药，当归，香附，元胡，从月经周期第15天服至第25天。

（4）行经期

活血化瘀以除旧血，消癥止痛，并促新血再生。常用药：当归尾，赤芍，川芎，香附，益母草，元胡，五灵脂，三棱，莪术，山楂，从月经周期第26天服至下周期之第三天。

典型病例

病例一：子宫内膜异位症合并卵巢囊肿、子宫肌瘤、输卵管堵塞和不孕症

病史：Lindsay，32岁，自17岁初潮即患痛经，经量多夹瘀血块，性交痛。曾服避孕药十年以止痛及减少月经量，2000年停服避孕药，之后月经紊乱，试孕五年未效。2002年做宫腔镜检查诊为子宫内膜异位症合并卵巢囊肿、子宫肌瘤和输卵管堵塞，并手术切除和剥离了异位之子宫内膜和囊肿。之后两年内又做三次宫腔镜手术，但均在术后两三个月又复发。曾做两次人工授精（IUI）、两次体外授精-胚胎移植（IVF）和一次冷冻胚胎移植（FET）均失败。2005年最后一次IVF失败后，又做宫腔镜检查发现子宫内膜纤维组织已与膀胱和直肠粘连，再次行剥离术。之后欲再试IVF，同时求诊于我以图中医协助。

主症：月经紊乱，周期为35-49天，经血量多有瘀块，小腹痛甚，性交痛且时有出血，畏寒肢冷，腰酸痛，尿频，疲倦乏力，忧郁不乐，焦虑不安，失眠，痤疮。舌暗红边有瘀斑，苔白腻，脉沉细。

治疗方案：针药并用以温补脾肾，化瘀消癥，调经助孕。

中药：经期第4天至14天，服八珍益母丸合桂枝茯苓丸；经期第15天至25天，服助孕丸合肉苁蓉丸，或暖宫孕子丸合桂枝茯苓丸；经期第26天至下次月经第3天，服调经补血丸、温经汤丸或痛经丸合逍遥丸。

针灸：百会，内关，天枢，关元，子宫，归来，血海，足三里，三阴交，太冲，脾俞，肾俞，命门，加艾灸或神灯

照射腹部和腰骶部穴位。治疗期间根据病人月经周期及整体状况随时调理穴位。

结果：针药并治两周后月经来潮，35天周期，腹痛轻，量仍多，瘀血块减少；再治一月，二次行经，量正常，腹微痛；又治两周，觉小腹两侧有排卵痛，接治三周后（经期第38天）当其准备开始IVF药物时，惊喜地发现已怀孕，并于2006年夏天足月产一健康男婴。

分析：Lindsay 可能自17岁初潮时即患子宫内膜异位症，只是医生未做任何检查而未能及时确诊。尽管避孕药缓解了痛经和经量多之症，但并未治其本，故子宫内膜异位症持续发展并逐渐加重。加之多次IUI/IVF治疗，大量性激素类药物的应用，长期而持续地刺激卵巢和子宫，进一步加重了病情，严重影响了生殖器官的正常功能和子宫内环境。宫腔镜手术清除了异位之子宫内膜、结缔组织和粘连，缩短了治疗时间；而中药针灸促使疤痕组织的软化，加速子宫和卵巢内血供，改善了子宫自我修复功能，调整了激素水平，创造了一个适合于卵子受精并着床的良好子宫内环境，最终成功受孕并足月生产。

病例二：子宫内膜异位症合并严重痤疮及不孕

病史：Fiona, 37岁，曾服避孕药15年。自青春期即患痤疮，18个月前停服避孕药后痤疮逐渐加重，尤以近三月为甚，需服抗生素控制，伴月经紊乱及不孕。超声波检查发现有一子宫肌瘤，四年前查宫颈有癌变前细胞并已清除。曾有抽烟史16年，六月前戒烟。

主症：不孕，严重痤疮，月经量少，夹有瘀血块，小腹微痛，性欲低，时大便后阴道出血，精神紧张，忧郁不乐，时盗汗，唇干口渴，舌红苔白腻，脉濡细。

治疗方案：针灸每周一次，中药浓缩粉每日两次。先调治痤疮和月经，并建议做宫腔镜检查；随后针药并用促孕。

进展及结果：经治两月，经期调至27-31天，便后阴道出血症状消失，痤疮也渐好转。但医院皮肤科医生给服Spironolactone, 并要求停服中药。此周期便后阴道出血又作，经期缩短为25天，经量减少。服此西药三周，痤疮未见好转反有加重，病人决定停服。在等待宫腔镜检查期间继续中医治疗，两月后经检查诊为子宫内膜异位症合并子宫肌瘤，随做子宫内膜剥离术。术后继续针灸，经期调至29天，量较前增多，行经四天，瘀血少。再治一月而自然怀孕，孕早期偶有点滴出血，嘱其再服中药以滋养气血，固肾安胎。孕13周后未再出血，现已孕38周。

分析：Fiona 最初因严重痤疮和不孕而求诊于我，之前曾多次看家庭医生和皮肤科专家，但并未被推荐做宫腔镜检查。经本人诊断后疑有子宫内膜异位症，拟中医健脾祛湿，逐瘀化痰，理气调经，并建议做宫腔镜检查以明确诊断。术后以针灸加速子宫自我修复，为受孕做准备。待瘀血清，气血调，阴阳平而自然受孕。

总结

1) 子宫内膜异位症是一种雌激素依赖性妇科常见病，可能与神经-免疫系统有关。针灸可以改善自身免疫功能，增强经络气血流通，刺激神经系统促使大脑释放内啡呔和其它激素，具有很好的止痛效果，是治疗本病强而有效之法。

2) 中西医常可互补，两者结合是治疗子宫内膜异位症之最佳选择。宫腔镜可以明确诊断并可查出疾病之轻重，中医针灸可以加速子宫修复，增强西药效果之同时尚可减轻其副作用。

3) 尽管中医针灸可以减轻痛经等症状，预防其反复发作，但对病情严重者，有必要使用宫腔镜手术切除异位之子宫内膜，以改善生育功能。

4) 中医强调治本，不主张长期服避孕药。因避孕药只能暂时减轻疼痛，对疾病本身并无治疗作用，且有可能影响内分泌功能，导致激素水平紊乱。

5) 对欲怀孕者，应先用中医调理2-3个月后再试孕。

参考文献

[1] 夏桂成（2003），《中医妇科理论与实践》，中国北京人民卫生出版社。

[2] 曾庆琪（2003年10月），《不孕不育症中医治疗》，中国江苏科学技术出版社。

[3] Lewis R (2004), The Infertility Cure. London: Little, Brown and Company.

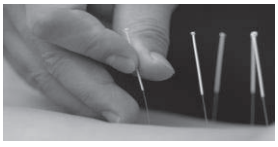
[4] Bulun SE. Endometriosis. N Engl J Med. 2009; 360:268-79.

[5] Montgomery GW, Nyholt DR, Zhao ZZ, Treloar SA, Painter JN, Missmer SA, Kennedy SH, Zondervan KT. The search for genes contributing to endometriosis risk. Hum Reprod Update. 2008; 14:447-57.

[6] 沈观印，黄克铭（1999年8月），《不孕不育症》，中国北京，科学技术文献出版社。

[7] Barbieri RL. Hormone treatment of endometriosis: The oestrogen threshold hypothesis. Am J Obstet Gynecol. 1992; 166:740-5.

[8] De Ziegler D, Borghese B, Chapron C. Endometriosis and infertility: Pathophysiology and management. Lancet. 2010; 376:730-8.



Acupuncture for Alopecia Areata (Bantu)—Case Studies

Yongzhi Li

Acupuncturist, Imperial College Healthcare NHS Trust

Abstract: Alopecia Areata (AA) is a condition characterised by partial or complete hair loss from the scalp or other parts of the body. In western medical theory this is an unpredictable disease where the immune system attacks hair follicles and the reason is not clear. However, it is thought to be an auto-immune disease and that it could be triggered by emotional factors like stress and depression. According to TCM theory, the main reasons are Liver Qi stagnation, blood stasis and Kidney essence deficiency causing disruption of support to the hair.

The author has treated many cases of Alopecia Areata using acupuncture with seven star needles or cupping, together with general health advice, including psychological measures. Satisfactory outcomes have been achieved in a number of cases and the purpose of this paper is to share this successful experience with peers and colleagues by describing two case studies.

Key Words: Acupuncture; Alopecia areata; Surround needling technique; Cupping; Life style advice.

Case one

Patient A, male, 30 years old, bank staff.

Chief Complaint: Has suffered Alopecia areata for 2 years. There were two patches (3cm x 2cm and 2cm x 2cm) on scalp, very itchy and red, one patch of 4cm x 2cm on beard right side, felt itchy. There was no any patch on both legs, but general hair loss was evident.
Other symptoms: anxiety, irritability, restlessness, stress due to over work; insomnia and depression.
Tongue: red tip with yellow coating.
Pulse: wiry and rapid.
The condition was diagnosed by his GP and a skin specialist. He had been treated by steroid creams, but did not show any improvement. He had tried acupuncture several months ago, but didn't feel any difference at that time. Subsequently he was treated by the author as outlined below.
Chinese medicine syndrome pattern differentiation: Liver Qi stagnation, with Blood stasis.
Acupuncture treatment plan:
Body Acupoints:

BL17 Geshu	BL18 Ganshu	BL23 Shenshu
LIV3 Taichong	GV20 Baihui	ST8 Touwei
HT7 Shenmen	GB34 Yanglingquan	

Needling with even method for 30 minutes.
Surround needling: 3-5 needles inserted shallowly around the patches.
Cupping: along the back shu points of Urinary Bladder meridian.
Advice given: Relaxation skills were discussed; and more gentle and regular exercise was recommended.
After the 1st treatment session, his response was positive, felt very relaxed and really look forward to continuing the treatment.
Four more sessions were carried out following the same treatment. At that point, it was noticed that very fine hair was coming from his scalp. After two more weekly sessions, similar fine hair appeared on his chin and legs.

Case two

Patient B, female, 30 years old, Interior Designer.

Chief Complaint: She has suffered Alopecia Areata for 6 months. There was a patch of 3cm x 3cm near the apex of the head, feeling itchy and dry, skin colour was normal.
Other symptoms: mental fatigue, insomnia, headache, irregular period, lower back pain, anxiety and stress due to work.
Tongue: pale colour with teeth marks.
Pulse: wiry and thread.
Chinese medicine diagnosis:
Liver and Kidney blood deficiency
Acupuncture Treatment:
Body Acupoints: Two groups of acupuncture points were used alternatively between sessions.
Group A: BL17 Geshu, BL18 Ganshu, BL23 Shenshu, GV20, tonifying technique for 40 minutes;
Group B: ST8 Touwei, ST36 Zusanli, CV4 Guanyuan, SP6 Sanyinjiao, GV20 Baihui, tonifying technique for 40 minutes.
Surrounding needling: 3-5 needles were inserted shallowly around the patches.
After 1st session, she reported that she felt more energetic and relaxed. The treatment was then continued for the rest of the treatment course. From the 4th session to 8th session, tiny fine hairs were clearly observed on the patch on her scalp. She stopped treatment after 8 sessions due to financial reasons. After a three month break she returned to me for another condition, and I noticed that the patch of missing hair had completely disappeared.

Discussion:

Western medical perspective

AA is the loss of hair in a limited local area. It is one of the common conditions going under the name of Alopecia, which include Alopecia Totalise (total loss of hair on scalp) and Alopecia Universalise (total loss of hair all over the body) (Habif TP, et al, 2009). The condition is quite simple to diagnose as the main clinical

manifestation is the loss of hair, leaving the skin smooth. New patches might develop, or existing patches expand. Most cases last more than 6 months, but treatment can reduce this.

AA can cause distress and damage self image of those affected (Patient UK, 2012). The pathology of the condition is unclear so far. The most commonly accepted hypothesis is the autoimmune theory which explains the loss of hair as the result of attack by the patient's own immune system. In clinical observation, many of the skin patches show signs of inflammation, with red or pink colour. Biopsy examination reveals white blood cells accumulated around the hair follicles, which is a sign of immune response. When immune attack persists, the hair roots (follicles) are destroyed and the hair then drops out. New hair may grow from the same hair root.

AA can also be associated with some diseases and life events such as hypothyroidism, childbirth, and chemotherapy. It is common among patients with Vitiligo.

Based on this idea, the treatment for AA is mainly immune-suppressant. Steroids are used locally by injection under the skin or by applying topically (rubbing on the skin). The overall rate of improvement is not satisfactory, many patients therefore choose to use wigs to hide the patches or choose implantation over the affected area.

Chinese medicine perspective:

In term of Chinese medicine, the hair is considered to be the product of blood and kidney essence. The hair over the scalp is mainly produced by kidney essence through the bone marrow. When kidney is rich in essence it can overflow into the bone and produce marrow. When bones are full with marrow, then marrow flows into the sea of marrow, the spine and brain. The extra marrow then supports the growth of hair. That is why the hair over the head and in the private area is closely linked with body development. The fine hair covering the rest of body is governed by Lung as an affiliated part of the skin. Hair growth consumes blood, and its maintenance requires sweat to moisten it, and the defensive Qi to keep it in. (Liu, Y, 1996)

The hair becomes thick and dark when the body is fully developed, and becomes fragile and fades with age. It is considered to be an index of the level of the kidney essence.

However, the sudden loss of hair, no matter whether in patches or generally, is considered to be the result of the deprivation of nutrition to the hair. The deprivation of either blood or kidney essence could lead to the loss of hair. Common patterns associated with damage can be summarised as Kidney essence deficiency, heat in Blood, Qi and/or Blood stagnation (Wu, X, 2002). Among other patterns causing hair loss are wind-heat attack, damp-heat attack, Kidney yang deficiency, and Liver Qi stagnation.

Commonly treatments include atopic Chinese herbal tincture (typically '101' hair liquids), internal Chinese herbal medicine (Shou Wu is the best known one), and skin needling. The treatment results are very satisfactory. They were widely available in the past decades, but are restricted to be used in the UK nowadays due to the legal situation.

The tinctures are banned as they are manufactured, and tablets are in the same position. Skin needling has the disadvantage that the needles are quite expensive for single use, which is the safest way of meeting the requirements for sterility.

Reflection

The author started treating AA 20 years ago in China, and has accumulated experience in many cases. More than half of the cases treated had a satisfactory outcome. Due to the difficulties mentioned earlier, in the past two years, a simpler acupuncture treatment protocol has been tried instead of using herbal liquids and tablets. The two cases quoted earlier followed this protocol.

According to personal observation and my review of the literature referenced, patients treated in the UK have a high level of stress caused by work or social and family pressure, and tend to be in their middle ages. Most of them were treated with steroids before acupuncture and the results were not satisfactory. Also, many of them had suffered AA for more than six month. The condition is chronic, stressful, and western medicine fails to help. It also complicates diagnosis and treatment using traditional Chinese medicine and assessment of its effectiveness.

In clinical practice, syndrome differentiation tends to include liver Qi stagnation and kidney deficiency. This is slightly different to what is described in text books which do not include liver Qi stagnation.

Liver stagnation is not the direct cause of AA in my personal opinion. However, it could easily make the situation worse, as it disrupts the Qi and blood flow, which can cause deprivation of blood to the hair. It is also a possible source of heat in blood, which is a main pattern in the text books. This is due to stagnated Qi can produce heat, the heat has no way to escape, and then turn to internal heat.

Blood stasis is another factor to consider. Due to the long term damage in the locality, and the application of medicine in the locality, inflammation is not often observed in the local skin. Shiny skin or rough skin with pale colour is common. Although this does not present any sign of blood stasis, such as blue colour or lumps, the persisting Qi stagnation, the limited local damage with clear boundary, and the constant local rubbing warrant a consideration of local stasis. Removing the local stasis to allow fresh blood flow in to support the hair should always be considered.

Life style advice is another important way to help achieve the best possible outcomes. Patients with AA should avoid alcohol, hot spicy and oily food. They all have a tendency to produce heat and cause flare ups. In Chinese medicine dietary theory they are amongst those FaWu (flaming materials) that can make skin conditions worse quickly. This has been proved by many patients. It is also important to suggest patients learning how to forget the existence of the patch, not to check it often. Relaxation skills are also very important.

It is important to keep up the patient's **confidence** in Chinese medicine treatment. Acupuncture can achieve very good effect. It is essential to work together with the patient to make a long treatment plan with at least 8-10 treatment sessions. It is unrealistic to expect hair to grow overnight. No miracle should be expected.

Regarding the acupuncture treatment plan, a combination

of **Root and Branch** is necessary. The root is always in the essence and blood, which is mostly reflected in kidney deficiency or liver deficiency. The kidney essence deficiency could present in the form of kidney yin deficiency or kidney and liver yin deficiency, or in less common cases, kidney yang deficiency.

Surround needling is not a new technique and is commonly used for reducing pain in a fixed area. It is not the first choice for treating AA. Skin needles (seven star needles, or plum-blossom needles) are still first choice in text books. However, the practice requires single use needles, and is obviously not very economic to continue using the skin needles. Surround needling is the author's personal choice as the alternative to skin needles. It is not difficult for practitioners as it only requires inserting needles surround the patch shallowly to achieve a local stimulation, which can help to eliminate the blood stasis in the local collaterals.

To help to stimulate the hair grow, rubbing a slice of ginger or garlic is a traditional way of treating AA. However, patients in the UK may not like the smell of fresh garlic on the body, therefore they may not necessarily follow the advice we've given.

Overall, the treatment of AA with acupuncture alone has a very promising future. A clinical trail might be the best way to verify the clinical effect.

References:

[1] Habif TP, et al (2009), Clinical Dermatology, 5th edition. Philadelphia: Mosby Elsevier, Page 932-934.

[2] Liu, Y (1996), Basic Theory of Chinese Medicine. Shanghai: Shanghai Science and Technology Publishing Company.

[3] Patient UK (2012), Alopecia Areata. http://www.patient. co.uk/health/Alopecia-Areata.htm , visited on 5th July 2012.

[4] Vorvick, L (2010), Alopecia Areata. In Pubmed (2010), Medical Encyclopaedia. http://www.ncbi.nlm.nih.gov/ pubmedhealth/PMH0002421/ visited on 5th July 2012.

[5] Wu, X (2002), Dermatology of Chinese Medicine, Beijing: Publishing House of Chinese Medicine.

针灸治疗意外所伤医案三则

袁炳胜（28 Effingham Street, Rotherham, S65 1AJ)

1. 无名毒虫咬伤肿痛

Jenna, 23岁。2012年8月28日上午10：40时（巳交午时）初诊。1周前在花园工作时不经意间被毒虫叮咬，旋即觉左足背剧痛，发现痛处有一小红点，很快足背红肿，数小时后踝及足趾皆肿，灼痛且痒，难以忍受，行走不便。遂急往医院求治，医与外用药物涂敷、并内服止痛药片，效果不显。因奇痛难忍，其父母嘱求治于余。诊得舌淡红，苔薄白，脉弦偏滑数。查左足背冲阳陷谷之间有一豆大创痕，周围皮肤漫肿，色泽暗红，其红肿上至踝部下至足趾，疼痛拒按，足趾端麻木，行走困难，昼夜疼痛，影响睡眠。

辨证：毒虫咬伤，虫毒损伤经络气血，走窜上下，阻滞气机，正邪交争。宜当散泄毒邪，疏通经络，宣畅气机，以促进恢复。俾气血安宁，则肿消痛止而愈。

针灸：先取足三里（双侧，留针30分钟），一则应其时之开穴，先取之可以振奋正气，激发机体自我调节抗病之机能；二则其伤损处当足阳明一经所过部位是以先取阳明为宜；再取阿是、陷谷、冲阳，于最初创痕旁高肿处直刺一，再从四围向其高肿之根底处围针透刺不留针；再取患侧八风、临泣、丘墟，皆轻刺不留针；针后旋即加罐，拔出淡黄色浓稠粘液如黄豆大数枚和暗红色血液(顿觉疼痛大减，其肿亦消减)，再取然谷、合谷、三阴交、中渚，留针20分钟。然后起去下肢针，稍捻转合谷、中渚，嘱行走放松活动患足数分钟，步履如常，灼痛痒麻感若失。2日后特来相告，并示其患足，经前治疗，已完全康复如常，唯皮色尚稍暗而已。

按语：毒虫咬伤，邪毒内侵，随经络流窜，正邪交争，遂至肿胀灼痛；虽经内服外用诸药，然邪毒未祛，经络阻滞，故以仍然痛甚不安、既痒且麻，数日难愈。必当泄散其邪，强通其滞，再调其血气，疏通经脉血络，则邪去正安，渐自平复。中医针灸临床之妙处，可见一斑。

2. 蜂蜇后面目俱肿案

罗X，男，28岁。2000年3月29日15:50（申）诊。其时当春暖花开，患者于就诊前1小时，被过往运送蜜蜂车箱内溢出的蜜蜂蜇伤左面颊部，迅即出现左侧整个面颊及上下睑漫肿红热、疼痛甚剧。急求诊于余。诊得脉弦大，舌淡尖红，苔薄白。

辨证：蜂毒入络，随经络走窜，正邪交争。治宜泄毒散邪，活血消肿，通络止痛。

治疗：先取临泣、合谷、光明，捻转提插泻法，并嘱深呼吸，以呼为主，反复捻转提插3-5分钟，自觉面部灼痛感减轻；继取太阳、攒竹、迎香透四白，行小幅度捻转泻法数回；再针三间、丰隆，提插泻法，诸穴留针30分钟。针后面部肿、痛、灼热感即大为消减。

次日特来电话告余，经昨日治疗后，肿痛大消；晨间起来，已无所苦矣。

按语：蜂毒所伤，邪毒入络，随经络走窜；正气与毒邪相交争，遂至肿痛灼热不安。因及时求治，予以疏通经络，宣散其邪，邻近与远道、循经与辨证选穴、局部与整体治疗相结合，宣疏邪气，振奋正气，经络之滞郁立解，故尔能够速愈。

3. 创伤性角膜炎

苏XX，男，36岁。2000年3月3日8点30（辰时）诊。四天前切割铝材时，不料飞沫爆溅入左目，致剧痛难忍，流泪不止，不能睁眼视物；遂往某眼病专科医院作异物清除处理包扎，并服西药散利痛等治疗四天，然其痛不减，仍不能睁眼视物，苦不堪言；伴口干、心烦、纳差厌食、睡眠不得。诊得其脉弦大、舌暗红，苔白薄。

辨证：金属飞沫，飞溅入目；损伤角膜筋膜，气血郁滞、气机紊乱。

治则：当疏通经筋络脉，舒肝利胆，解郁除滞、活血止痛，调理气机。局部与远道取穴相结合，取面部邻近及肝胆及手阳明少阳诸经穴。

针灸：合谷、太冲（双侧，留针30分钟），攒竹、太阳（患健双侧，针入得气，行捻转泻法，不留针），嘱试睁眼，即觉其痛大减，渐可睁眼视物；再嘱尝试视上下左右，转动眼球，同时捻转合谷、太冲穴针，已不觉痛楚；复取支沟、光明（患侧），留针30分钟。留针中自我适当运动眼球。起针后，眼睛睁闭、视物均已无碍。

中药：应患者要求，再与中药巩固，遂与：

葛根15，赤芍30，川芎10，山楂30，牛膝30，栀子12，青皮12，连翘20，蒲公英20，野菊花10，龙胆草6，生甘草6，菟蔚子15，决明子20（克），水煎三次，分6次服，2日1剂。

一周后应约诊视其因外伤截瘫卧床数年之妻，知其眼伤经治，痛楚俱失；服中药方3剂，再无任何不适。

按语：目者肝之筋脉所系，十二经脉气血之所注，其敏锐于感应，不容微尘。今者金属飞沫，飞溅入目；暴然受病，损伤角膜筋膜，遂至气血郁滞、气机紊乱；今虽清除异物，然其受损之经筋脉络，阻滞之气血、紊乱之气机并未得到调整，故而不惟疼痛如故，且兼见肝胆经络功能失调、气机不畅如口干心烦、纳差厌食、失眠、脉弦舌暗等舌脉症。虽伤在局部，然影响到整体之气机的条畅；故该案之治，邻近（太阳、攒竹）与循经远取（支沟、光明）相结合，局部与整体（合谷、太冲理气活血、疏肝解郁）同调，疏通血气、调理气机，筋舒络畅，而自然恢复。

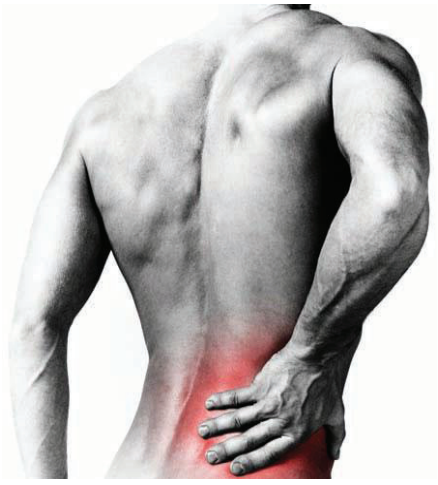
体会

中国传统医药学在其数千年发生发展过程中，历代临床家为解决临床问题，“近取诸身远取诸物”，充分认识和应用自然与自身生命规律于临床实践，建立起了中医药的理论与临床体系，积累了极为丰富的经验。针灸疗法便是应用这种规律，调节生理机能，充分调动自我康复能力、促进康复、治疗疾病极为有效的手段，如运用得当，常有意想不到之效。

意外损伤之疾，或伤于皮肉、或伤于筋骨、脏腑；然一切外伤之疾，无论是否皮肉筋骨破损，局部乃至全身，或轻或重之气血受损、气血郁滞、气机阻滞，最为常见。可以说但凡外伤，无有不伤及气血，或血出气损、或血瘀气滞；而暴受之损伤，则气机郁滞甚或气机淆乱、阴阳乖桀、昏迷厥逆，或血出气脱，亦常见之患也。临床者，尤其现代医学，只见其有形之伤，不省其无形之损、无形之滞、气机之淆乱，故而有效有不效者。中国传统医药学，则认为治疗伤损，必先调其血气，行气活血；即使出血之症，亦当于止血之时，预知其血出必瘀，故当于止血之时要考虑止血不留瘀，与“见肝之病，知当传脾，当先实其脾气”同义。而中医临床治疗，通过几千年实践形成了丰富而行之有效的治疗方法和有效药物，故在治疗此类病证时有很多的优势。

临床急症，针灸尤宜。其治疗之要，在于谨守病机，各施其宜。现代名中医姜春华先生对急症治疗独有心得，强调所谓截断扭转。所以截断扭转者，明查病机所在，予以针对性的及时有效的调整性治疗也。急症之病机所在，多为经络之淤滞、气机升降、开阖、出入之功能逆乱，阴阳之乖桀。若能明确其因、理、性质、部位，及时予以相对应有效的针、灸、药物治疗，所谓“立竿见影”、“效如桴鼓”是可以做到的。

笔者二十年来的临床实践中，尤其1990至2007年间，与所在医院门诊急救及住院医生合作，广泛应用针灸疗法于急性病症救治之中，常常获得满意效果。笔者体会，如多种原因引起的急性腹痛如肝胆结石、尿路结石、胃肠梗阻痉挛、急慢性胃肠炎、痛经、心律失常、心绞痛、重症哮喘、鼻出血、痔疮出血、美尼尔氏综合症眩晕、各部运动创伤或急性扭挫伤所致软组织损伤、以及多种意外受伤疼痛、炎性肿痛、重症咽喉肿痛，如能以中医辨病辨证，酌情合理运用局部、循经、辨证、辨病选穴或与辨时选穴法相结合；或以整体为主、或以局部为主、或局部与整体治疗调节相结合，应用针灸疗法往往可以迅速缓解症状，甚至转危为安。



Systematic Review of the Effectiveness of Acupuncture in the Treatment of Bipolar Disorder

Victoria May Heasman [1], Fanyi Meng [2]
[1]University of Lincoln; [2] Lincoln College, Lincoln

Abstract: Bipolar disorder is a common illness affecting a large proportion of population, which in the past was not well understood and often been wrongly diagnosed as depression or schizophrenia. Manic depression was the name attached to it before it was recently established as Bipolar Disorder. It could be further divided into different subtypes, with the possibility of more variations on the condition still being discovered. The effectiveness of acupuncture in the treatment of depression has been greatly explored, with many clinical outcomes proving it be an effective treatment. Clinical trials on the subject are new, and evolving. Results are promising and suggest that acupuncture may play a role in the management of bipolar disorder. However, there are very few studies on the use of acupuncture in the treatment of bipolar disorder. With the growing interest in nonpharmacologic treatments for mood disorders, the purpose of this research was to assess the effectiveness and validity of acupuncture as a treatment for bipolar disorder.

Introduction

Bipolar disorder is a severe and chronic mood disorder affecting around one in every 100 people, making it a relatively common illness (Dennehy, et al, 2009, p.897 & NHS, 2012). The severity is similar to schizophrenic disorders, causing disability to the sufferers. However, the treatment results in western medicine are not satisfactory.

There has been much research to date examining the application of acupuncture for unipolar depression. This report covers the results of 5 available clinical trials with various methodologies explored. One single-blind study researched the use of acupuncture treatment designed specifically to treat depression on patients who were not currently on medication. Results were measured the Hospital Anxiety and Depression Scale before and after treatment. A significant reduction in both anxiety and depression was observed. The scores for anxiety and depression had decreased to a normal level after the treatment period (Tao, 1993, p.327-329).

The Purpose of this Study

To review a number of clinical trials of acupuncture in the treatment of bipolar disorder and assess the effectiveness of treatment.

- Propose a research protocol for the treatment of acupuncture in patients with bipolar disorder.
- Critically discuss the difficulties and limitations in performing this research in designing appropriate control conditions and agreed upon treatments procedures.

Biomedical background of bipolar disorder

Clinical Presentation

Bipolar disorder is characterised by recurrent episodes of hypomania and depression. The illness is generally cyclical in nature. The condition is further divided into bipolar I and bipolar II disorder, according to the duration and severity of symptoms. The understanding of bipolar disorder has expanded such, that it is now viewed as a spectrum of illnesses. Bipolar disorder I and bipolar disorder II are the most widely accepted subtypes (Yatham & Malhi, 2011, p.5, NHS, 2012).

Classification

Bipolar disorder I: At least one manic episode and periods of major depression.

Bipolar disorder II: Periods of high energy levels (hypomania) less extreme than mania. These periods alternate with episodes of depression.

Cyclothymia: Mild form, involves less severe mood swings. Alternates between hypomania and mild depression (Berger, 2011).

Onset and Recurrence

The disorder may develop at any age, with the first episode occurring from childhood to old age. Manic episodes usually have a sudden onset and endure for between 2 weeks and 4-5 months, with an average of 4 months. Depressed states often last longer, averaging 6 months. Frequency of episodes is extremely variable as are the patterns of remissions and relapses, but remissions tend to get shorter as time goes on and depressions become commoner and longer lasting after middle age (WHO, 1992, p.116 & NHS, 2012).

Aetiology

Bipolar disorder is considered the most heritable psychiatric disorder. Environmental factors contribute to the development of bipolar disorder; in particular those associated with interpersonal relationships can lead to onset and relapse. A significant number of adults with bipolar disorder have identified experiences of trauma and abuse as children, which may be connected to earlier onset and greater co morbidity (Yatham & Malhi, 2011, p.21-23 & NHS, 2012, Causes).

Neurochemistry of bipolar disorder

The neurotransmitter serotonin has been strongly linked with the pathophysiology of unipolar depression. Similar research involving tryptophan depletion in bipolar 1 disorder suggests that there is no significant

connection between serotonin and bipolar depression. Other neurotransmitters such as GABA and glutamate may be involved in the pathophysiology of bipolar disorder, but research in this area is still in its early phases. The mania phase is more strongly associated by dopaminergic dysfunction (Yatham & Malhi, 2011, p.24-25 & NHS, 2012).

Diagnosis

The diagnosis of bipolar disorder is mainly based on the special assessment carried out by questioning the patients and excluding other diseases. (NHS, 2012, Diagnosis) There is no universal standard of diagnosis agreed yet, and the diagnosis is not relied on laboratory tests or scanning.

Treatment - Pharmacotherapy

In the UK, lithium carbonate is the most commonly prescribed medication to treat bipolar disorder. Treatment is long-term and treats episodes of mania, hypomania and depression. It is generally prescribed for a minimum of six months.

Anticonvulsant medicines may also be prescribed. These include; valproate, carbamazepine and lamotrigine. These medications may be used to treat episodes of mania. A single anticonvulsant medicine may be used or, they may be used in combination with lithium.

Antipsychotic medicines may be prescribed to treat episodes of mania or hypomania. Antipsychotic medicines include; aripiprazole, olanzapine, quetiapine and risperidone. They may also be used as a long-term mood stabiliser. Antipsychotic medicines are an appropriate treatment when symptoms are particularly severe or behaviour is disturbed (NHS, 2012, Treatment).

Psychological treatments

Psychiatric Management is generally offered as an adjunctive treatment to pharmacotherapy, and is aimed at improving outcomes. Psychiatric management includes; monitoring the patient's state of mind, providing education, promoting regular patterns of activity and sleep, anticipating stressors, identifying new episodes early, and minimizing functional impairments. Types of psychological treatment include; psycho-education, cognitive behavioural therapy, interpersonal and social rhythm therapy and family focused therapy. Evidence suggests that psycho-education is effective in reducing relapse rates in euthymic bipolar patients, and that benefits are apparent for the long-term with some booster sessions (Yatham & Malhi, 2011, p.24-25, Hirschfeld, et al, 2010, p.9 & NHS, 2012, Treatment).

Chinese Medicine View of Bipolar Disorder

Bipolar disorder appears similar to the ancient Chinese disease known as Dian Kuang (see Fig.2), translated as “dullness and raving” or “dullness and mania” (Maciocia, 2009, p.503). In regarding to western medicine diseases, Dian is mainly in the range of depressive phase of bipolar disorder, major depression, and schizophrenia; while Kuang could be seen in manic phase of bipolar disorder, psychosis, and schizophrenia. When Dian and Kuang come together, it describes the bipolar disorder very well.

Aetiology

Emotional factors are the main underlying cause of Dian and Kuang in Chinese medicine. Emotional stress causes the Qi to stagnate; this generates Heat, which in turn harasses the Mind. When Qi stagnates in the Triple Burner its function of transformation of fluids is impaired, this leads to the generation of Phlegm. The emotions of anger and fear injure the Liver and Kidneys, resulting in deficiency, causing Dian. Excessive joy and anger damage Heart Yin, generating Heart Fire and causing mania. Anxiety impacts the Heart and Spleen, the Heart looses nourishment and the Spleen’s function to transform and transport body fluids is impaired, giving rise to Phlegm.

Diet has a role in the pathology of bipolar disorder, due to the role of Phlegm in the disorder. Excessive consumption of rich foods, along with erratic eating patterns leads to the formation of phlegm.

It is recognised that some individuals have a constitutional tendency towards developing mental-emotional problems. During gestation if the mother experiences a severe shock, the Qi rises and cannot descend to the residence of Essence [Jiang], which leads to development of Dian in the foetus (Maciocia, 2009, p.508-509).

Pathology

The pathology begins with Qi stagnation, Fire and Phlegm, later also resulting in deficiency of Qi, Blood or Yin. Mania is a Full condition, whereas the depressive stage is a mixture of Full and Empty conditions. Qi stagnation in the Three Burners leads to the formation of Phlegm. Phlegm obstructs the Mind’s orifices causing confusion and a lack of insight, this accounts for both the manic and depressive stages of the illness. Qi stagnation also generates Fire, which agitates the Mind and Ethereal Soul. When the condition is chronic Fire injures the Yin and results in Empty Heat causing further agitation to the Mind. The original Qi stagnation may also develop into Blood stasis, which further clouds the Mind’s orifices. The main organs involved in the manic phase of bipolar disorder are the Heart, Liver and Spleen. The manic phase is also caused by the excessive coming and going of the Ethereal Soul. As the Mind is unable to control and integrate the material derived from the Ethereal Soul, mental illness ensues. The depressive stage begins with Qi stagnation, and Phlegm obstructing the Mind’s orifices. In the chronic stage there is deficiency of the Heart and Spleen (Maciocia, 2009, p.509-510 and Schnyer and Flaws, 1998, 49-55).

Methodology of this project

A review of the clinical trials on the use of acupuncture in the treatment of bipolar disorder was necessary to assess if acupuncture can be implemented in the effective treatment of bipolar disorder. The inclusion criteria is that the clinical study is focused on the bipolar disorder, manic depression, bipolar depression, mania, major depression. Online search engines used are Medline, Academic Search Elite, AMED, Embase,

CINAHL, PUBMED and the Cochrane Library. and their details are in Table 1.

Six clinical trials are included in the final discussion,

Table 1. Research reporting the use of acupuncture for the treatment of bipolar disorder.

Study	N	Population (mean age in years)	Details	
Dennehy, et al, 2009.	20	ACU-ME: 39.2. ACU-OM: 35.3	**Design/Protocol**	SB, 12 week, RCT (pilot studies)
			Follow-up after completion	None
			Results	Overall decline in manic symptoms and improvement in functioning. No significant difference was found between acupuncture and control group.
			Comments	No follow up. In the control group, points may be close enough to specific points to trigger a positive result.
Dennehy, et al, 2009	26	ACU-D: 39.7 ACU-NP: 42.8	**Design/Protocol**	SB, 8 week, RCT (pilot studies)
			Follow-up after completion	None
			Results	Patients in both groups improved from moderate depression symptom scores to scores indicative of mild depression. No significant difference was found between acupuncture and control group.
			Comments	Of the 26 patients assigned, 19 completed the trial. There were more women in the ACU-D group, than in the ACU-NP group. No follow up. Few adverse effects associated with treatment.
Hechun, et al, 1990	241	36	**Design/Protocol**	RCT G1: EA daily for 6 weeks, plus PD. G2: Amitriptyline medication for 6 weeks.
			Follow-up after completion	2-4 years
			Results	Results suggest that the effectiveness of amitriptyline and electro-acupuncture are similar. Relapse rates were similar in the 2 groups. EA was more effective than amitriptyline for reactive depression, anxiety and cognitive disorder syndrome.
			Comments	It is not indicated whether treatment was carried out during the manic or depressive stage of illness. Longest follow-up.
Luo, et al, 1998	29 241	36..9 32	**Design/Protocol**	Phase 1: DB. G1: EA 6 sessions per week for 6 weeks, plus PD. G2: AD 6 weeks. G3: EA 6 sessions per week for 6 weeks, plus AD. Phase 2: G1: EA 6 sessions per week for 6 weeks, plus PD. G2: AD for 6 weeks.
			Follow-up after completion	6 weeks
			Results	Compared with amitriptyline, EA was as effective if not better towards the treatment of depressive disorders. The HRSD factor analysis showed that EA appeared to have better therapeutic effect in relieving anxiety somatisation and correcting the disturbance of cognitive process. EA was more effective in the treatment of reactive depression than amitriptyline.
			Comments	Patients with bipolar disorder and reactive depression were in the same trial.
Polyakov , 1987	167	Unknown	**Design/Protocol**	ACU treatment daily, 12-15 sessions.
			Follow-up after completion	1-2 years
			Results	Acupuncture was most effective in the treatment of mild to moderate depression.
			Comments	Virtually no side effects to acupuncture treatment.
Rogers, 2010/11	8 13	Unknown	**Design/Protocol**	ACU treatment twice weekly, until signs of improvement, followed by weekly until good results established, followed by every fortnight.
			Follow-up after completion	4-6 weeks
			Results	Improvement in depression and anxiety. Better sleep patterns. Increased well-being.
			Comments	Small scale trial, needs to be conducted on a larger scale.
Yang, et al., 1994	20 21	Unknown (age ranged from 22 to 57)	**Design/Protocol**	G1: ACU treatment 6 times a week, for 6 weeks. G2: Amitriptyline medication for 6 weeks.
			Follow-up after completion	At end of therapeutic course.
			Results	ACU group had total effective rate of 90%, control group had total effective rate of 95.2%. No significant difference between the two groups. Anxiety levels decreased more in ACU compared to control group.
			Comments	No information as to duration of treatment. No follow up. Not enough observation on changes in emotional states before, during and after treatment.

RCT = randomized controlled trial; SCT=single-controlled trial; non-CT = non-controlled trial; DB= Double blinded; ACU= acupuncture treatment; EA – electro-acupuncture; [?] = mean age not reported; HRSD=The Hamilton Rating Scale for Depression, ACU-ME=acupuncture for mood elevation, AC-OM= acupuncture-off meridian group, ACU-D=acupuncture for depression,

ACU-NP=non-psychiatric acupuncture.

Results

Clinical Trial 1 (Rogers, 2010-11):

Data recorded before and after treatment show patients improved in their levels of depression and anxiety. 9 participants were assessed using the *SQI, 7 of them reported significant improvement in their sleep patterns. The results from the *ESSQ show all but 1 of the participants experienced an overall improvement. Results from the validated quantitive research tools and the semi-structured interviews show that the participants and their carers perceive there to be significant improvements in their well-being and mental health following treatment. Reported changes include; increased energy levels, less racing thoughts, increased confidence, less agoraphobia, more interest in everyday activity, optimistic about future, increased ability to cope, improved general health, better self-esteem, less anxiety, increased calmness, stable sleep patterns, reduction in physical problems, and better eating habits (Rogers, 2010-11, p.64-67).

Clinical trial 2 (Dennehy, et al, 2009):

Study 1 - Adjunctive acupuncture for mood elevation in bipolar disorder

Each group experienced an overall decline in manic symptoms and improvement in functioning (see Table 4). In both groups most of the patients received stable doses of medication. The most common medications were valproic acid and lithium.

Study 2 – Adjunctive acupuncture for depression in bipolar disorder

Both groups improved over time on the *IDS-C, the *GAF, the *CGI depression, and the CGI overall scales (see Table 4). Neither group improved on the *YMRS or *CGI-mania scales. Both groups experienced an overall reduction in symptoms and improvement in functioning, with no evidence of a group effect over time.

Clinical Trial 3 (Hechun, et al, 1990):

The results based on the *HRSD show there was significant difference in the before and after mean scores (see Table 3). The results suggest that the effectiveness of acupuncture and amitriptyline are similar. The recurrence rate in the electro-acupuncture group was 64.8%, while in the amitriptyline group the rate was 53.3%. The difference was not considered significant showing a similar long-term therapeutic efficacy in both groups. The results on the HRSD show significant difference in the electro-acupuncture group in the scores for anxiety somatic syndrome and cognitive disorder syndrome (see Table 3, A & C). This may indicate that electro-acupuncture, is superior over amitriptyline for the treatment of these disorders.

Clinical Trial 4 (Luo, et al, 1998):

Scores on the HRSD reduced significantly after the six week treatment period. The results from the HRSD were similar in all groups (see Table 1). The results in the CGI scores were also similar in each of the groups. The GSC rating showed that the overall effective rate was 75.2% in the electro-acupuncture group and 66.7% in the amitriptyline group. Results from the HRSD showed that electro-acupuncture has a better therapeutic effect for anxiety somatisation and cognitive disturbance than amitriptyline (see Table 3, A & C). There were significantly fewer side effects reported in the electro-acupuncture group compared with the amitriptyline group.

Clinical Trial 5 (Polyakov, 1988):

Acupuncture was inferior in effectiveness to tricyclic antidepressants in patients with depressions of a psychotic nature. Acupuncture was similarly effective as antidepressants in patients with cyclothymic depression. The best results were achieved in patients with melancholic depression; poor results were obtained in patients with anxious or apathetic depressions.

Clinical Trial 6 (Yang, et al, 1994):

The results were divided into four grades with the results being: 5 cases cured, 5 markedly improved, 8 improved and 2 failed, giving a total effective rate of 90%. In the control group 6 cases were cured, 8 markedly improved, 6 improved and 1 failed, resulting in a total effective rate of 95.2%. The difference was considered insignificant and therefore the therapeutic effects in the needling group were similar to those in the control group. Results from the HRSD showed significant difference in the mean value of factors before and after treatment (see Table 3), with the factor of anxiety somatisation more markedly influenced in the needling group than in the controls.

Discussion

Clinical Trial 1 – Dennehy, et al, 2009.

This study represents the first randomized trials for both the treatment of mood elevation and depression in patients with bipolar disorder. The control group in the hypomania study received acupuncture to points off the meridian, in order that they receive a similar needling experience, but one that is believed to have no benefit. In the control group of the depression study, patients received acupuncture for non-psychiatric complaints, that wasn't believed to be helpful in treating depression. The two approaches were an attempt to design randomized acupuncture trials that are scientifically rigorous and ethical. The issues with the design of the control groups is that in needling points off the acupuncture meridians, these points may be close enough to trigger a therapeutic response. In the case of acupuncture that targets somatic rather than psychiatric complaints, it is possible that these points could also improve depression, particularly as depression can have a somatic component.

Clinical Trial 2 – Hechun, et al, 1990.

This trial was ahead of it's time in its exploration of electro-acupuncture in the treatment of depressive psychosis. The study included 193 patients with bipolar disorder who were in the depressive stage of the illness. Asberg's Table was used to assess side effects, amitriptyline was shown to have a negative effect in the cardiovascular system and anti-cholinergic reactions,

22.7% of patients had abnormal ECG, and 54.8% had elevated SGPT. Electro-acupuncture had no such side effects. The two groups were parallel to each other during follow-up showing a similar effectiveness. Relapse rates show that

Table 2 Acupuncture points used, manipulation technique and treatment duration in the reviewed trials.

Study	Points used	Needle type	Technique	Duration (min)
Dennehy, et al, 2009	Individualised treatment plans, including 7 acupuncture points & 3 ear points (associated with hypomania or mania).	Unknown	Unknown	20
Dennehy, et al, 2009	Individualised treatment plans, including 7 acupuncture points & 3 ear points (associated with major depressive disorder).	Unknown	Unknown	20
Hechun, et al, 1990	EA, DU-20, Yintang.	Unknown	Average 2.24 scales, output 9mA.	60
Luo, et al, 1998	EA, DU-20, Yintang.	Unknown	2 Hz, and 3.0-5.0 mA	45
Polyakov, 1988	E-36, MC-5, C-7, GI-4, AT affect, AT shenmen, AT zero	Unknown	Standardized method.	15-30
Rogers, 2010-11	Individualised treatment dependant on syndrome differentiation. Including; Liv-3, LI-4, ST-36, LI-4, HT-7, PC-6, Yintang, PC-6, ST-40, REN-12, PC-8, LIV-2, ST-44, LI-11, HT-7, GB-34, SP-10, BL-17, ST-36, BL-20, BL-17, LIV-8, KID-6, LU-7, REN-4, KID-3, SP-6, LIV-8.	Natural brand 32 gauge 1 ½ inch.	Reducing	30-60
Yang	DU-24, DU-20, DU-14 & DU-12 all EA. REN-17, GB-20 & PC-6. Individualised treatments according to syndrome pattern including: ST-36, SP-6, LIV-3, LI-4, LIV-3, SP-10, HT-7, PC-7, SP-6, ST-36, KID-3, SP-3, SP-6, ST-36, REN-4.	Unknown	80-100 / second. The rest of points standard reinforcing & reducing.	No information

drugs do not prevent the recurrence of bipolar episodes. This reflects the inherent recurrent nature of the condition and it is suggested that more focus should be given to this area in future research. In would be interesting if a similar study was conducted now comparing patients in the mania stage of bipolar disorder with antipsychotic medication.

Clinical Trial 3 – Luo, et al, 1998.

From this pilot study results show that electro-acupuncture is as effective as amitriptyline if not better towards the treatment of depressive disorders. The Hamilton rating system showed that electro-acupuncture appeared to have better therapeutic effect in relieving anxiety somatisation and correcting the disturbance of cognitive process. Electro-acupuncture was also more effective in treating patients with reactive depression. Electro-acupuncture resulted in very few side effects directly associated with treatment. It is suggested that the metabolism of monoamine neurotransmitters was jeopardized in patients suffering from depression. Electro-acupuncture is known to release monoamines in the central nervous system. Results from biochemical study of the depressed patients showed that their plasma norepinephrine level altered greatly after electro-acupuncture treatment. It is suggested that the therapeutic efficacy of electro-acupuncture treatment perhaps exhibits by acting on the metabolic mechanism of NE in the central nervous system.

Clinical Trial 4 – Polyakov, 1988.

In this study patients with different types of bipolar disorder and schizophrenia were included in the trial. Due to the age of the trial it is fairly difficult to interpret the results. The conclusion is that the dynamics of psychological, biochemical and electrophysiological indices of depressive patients during the course of acupuncture was similar to changes observed in equivalent indices during the process of treatment with antidepressants. Results indicate that acupuncture can be recommended in the treatment of patients with mild to moderate depression.

Clinical Trial 5 (Rogers, 2010-11)

In this small pilot study there was no control group in which to compare results with, and participants were either bipolar or schizophrenic. Results showed there to be significant improvement to participants' mental well-being. Due to the small nature of the study and its lack of control conditions, results remain inconclusive.

Clinical Trial 6 – Yang, et al, 1994.

In this study the focus was on pattern differentiation providing patients with tailored treatments according to their individual diagnosis. The treatment was shown to have no side effects and therefore to be safe. The results from both the acupuncture and amitriptyline control group show that both treatments are effective at reducing the 7 factors on the Hamilton depression scale. The needling treatment is shown to have a superior effect on the factor of anxiety somatisation than drugs. Results from the needling group showed that the score on the Hamilton scale continues to decrease during the first four weeks, and from the 5th week remains stable. This trial was unique in that it analysed the brain waves of patients. The results of brain waves before and during treatment were insignificant, whereas the results post-treatment were significantly different. This suggests that needling affects the brains electrical activity only after continuous treatment for a certain period of time. Needling treatment results in normal brain activity in patients with depression. There is little information given about the amitriptyline control group, such as whether there were side effects. It is not indicated in the study whether the patients with

bipolar disorder were in the manic or depressive stage of illness. It is vital to know this information to properly evaluate the results.

Conclusion

From those available studies, it seems that acupuncture is effective in the treatment of depression, with equal or slightly greater effective rates compared with amitriptyline medication. Two studies found acupuncture to be superior in the treatment of anxiety somatisation and cognitive disturbance, when compared with drug medication. Acupuncture increases a persons overall wellbeing, and needling results in normal brain wave activity in people with depression. An overall decline in manic symptoms and improvement in functioning was reported in those patients in the elevated stage of bipolar disorder. No specific side effect of acupuncture was reported which is a major advantage against medications.

However, those studies are all in the stage of pilot study or clinical observations, not strictly following the standard methods of clinical trials. Only one of the trials splits the treatment group into two, one for the depressive stage of the illness and the other for the mania stage. Unfortunately most of the other trials fail to mention whether participants were in the manic or depressed stage of illness, and therefore it is impossible to determine whether needling was effective in treating mood elevation from these trials.

Larger scale trials are needed to assess the benefits of acupuncture for bipolar disorder, particularly of the mood elevation stage of the illness. Trials need to be conducted in a clear way so that participants in the manic phase of illness are studied in one group, rather than depressed and manic patients being studied simultaneously.

Appendix 1: The signs and symptoms of bipolar disorder

Sign / Symptom	Mania	Bipolar Depression
APPEARANCE	Colourful, strange, garish makeup or dress style	Disinterest in personal appearance, grooming and hygiene
MOOD	Prolonged elation/euphoria Excessively optimistic or cheerful Heightened irritability	Feelings of sadness Suicidal ideation
SPEECH	Talking fast and loudly Difficult to interrupt	Speech is slowed Monosyllabic and monotonous
ACTIVITY	Risk-taking behaviour Impulsive Increased psychomotor activity (restlessness)	Difficulty with initiating tasks Diminished interest in hobbies Decreased psychomotor activity
SLEEP	Decreased need for sleep	Early morning waking with insomnia OR Hypersomnia with daytime napping
COGNITION	Difficulties with planning, reasoning and decision-making Distractible	Reduced ability to concentrate Difficulties with memory
SELF PERCEPTION / THINKING	Exaggerated self-confidence Grandiose thinking	Reduced self-esteem Feelings of worthlessness and guilt Pessimistic thoughts and sense of hopefulness

(Yatham & Malhi, 2011, table 2.1, p.6).

Appendix 2: Bipolar disorder diagnosis (DSM-IV)

Bipolar I Presence of at least one episode of mania with a minimum duration of one week with or without major depressive episodes.	Mania, Hypomania, Euthymia, ≥ 7 days Major Depression
Bipolar II Presence of one or more episodes of hypomania accompanied by at least one episode of major depression with no psychotic features.	Mania, Hypomania, Euthymia ≥ 4 days Major Depression
Cyclothymia One or more episodes of hypomania and periods of depressive symptoms that do not meet criteria for a major depressive episode.	Mania, Hypomania, Euthymia Depressive symptoms Major Depression
Rapid Cycling The occurrence of four or more episodes of depression or mania during 12 months. Episodes can occur in any combination or order but must satisfy duration and symptom criteria for Major Depression, Mania or Hypomania and must be separated by either a period of remission or by a switch to the opposite pole (for at least 2 months) of illness.	Mania, Hypomania, Euthymia Major Depression
Mixed Episodes Concurrent symptoms of depression and mania. Mania plus at least two of six dysphoric symptoms: anhedonia, guilt, depressed mood, anxiety, fatigue, suicidal ideation.	Mania, Hypomania, Euthymia Depressive symptoms

(Yatham and Malhi, 2011, fig. 2.1, p.10).

References

Acupuncture Research Resource Centre. (2002) Depression, Anxiety and Acupuncture: The evidence for effectiveness. 2002 (9), pp. 1-13. British Acupuncture Council. Available at: http://www.edinburgh-acupuncture.co.uk/pdf/anxiety.pdf [Accessed 23 Feb 2012].

Andreescu, C; Glick, RM; Emeremni, CA; Houck, PR; and Mulsant, BH. (2011) Acupuncture for the Treatment of Major Depressive Disorder: A Randomized Controlled Trial. Journal of Clinical Psychiatry. 72, (8), pp.1129-1135.

Andreescu, C; Mulsant, B; Emanuel, J. (2008) Complementary and alternative medicine in the treatment of bipolar disorder- A review of the evidence. Journal of Affective Disorders. 110, (1-2), pp.16-26.

Berger, F. PubMed Health. (2011) Bipolar disorder. A.D.A.M medical encyclopaedia. 3 March, 2011. [Online] Available at: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001924/ [Accessed: 2 April 2012].

Chen, A. (1992) An Introduction to Sequential Electric Acupuncture (SEA) in the Treatment of Stress Related Physical and Mental Disorders. Acupuncture Electrotherapy Research. 17, pp.273-283.

Coryell, W. (2009a) Bipolar disorders. The Merck Manual.. [Online]

Coryell, W. (2009b) Cyclothymic Disorder. The Merck Manual. [Online]

Deadman, P. (2006) A Manual of Acupuncture. 8th edition. East Sussex: The Journal of Chinese Medicine Publications.

Deadman, P and Al-Khafaji, M. (1995) The Treatment of Psycho-Emotional Disturbance by Acupuncture with particular reference to the Du Mai. Journal of Chinese Medicine. 47, pp.30-34.

Dennehy, E; Schnyer, R; Bernstein, I; Gonzalez, R; Shivakumar, G; Kelly, D; Snow, D; Sureddi, S; and Suppes, T. (2009) The Safety, Acceptability, and Effectiveness of Acupuncture as an Adjunctive Treatment for Acute Symptoms in Bipolar Disorder. Journal of Clinical Psychiatry. 70 (6) pp.897-905.

Dennehy, E; Webb, A; Suppes, T. (2002) Assesment of Beliefs in the Effectiveness of Acupuncture for Treatment of Psychiatric Symptoms. The Journal of Alternative and Complementary Medicine. 8, (4), pp.421-425.

Dezheng, D. (2001) Personal Experience in Acupuncture Treatment of Mental Diseases. Journal of Traditional Chinese Medicine. 21, (4), pp.277-281.

Dong, ZL; Han, XS; Hua, TY; and Bing, ZW. (1990) A Comparative Study of the Treatment of Schizophrenia with Electric Acupuncture, Herbal Decoction and Chlorpromazine. American Journal of Acupuncture. 18, (1), pp.11-14.

Fengqi, W. (1995) Treatment of Schizophrenia with Acu-moxibustion and Chinese Medicine. Journal of Traditional Chinese Medicine. 15 (2), pp.106-109.

Fountoulakis, KN; Vieta, TE; Sanchez-Moreno, J; Kaprinis, SG; Goikolea, JM; and Kaprinis, GS. Treatment guidelines for bipolar disorder: A critical review. 86 (1), pp. 1-10. Journal of Affective Disorders.

Gang, Z; Shu-bai, J; and Liang-dong, Z. (1997) Comparative Clinical Study on the Treatment of Schizophrenia with Electroacupuncture and Reduced Doses off Antipsychotic Drugs. American Journal of Acupuncture. 25, (1), pp.25-31.

Greenwood, MT. (2002) Acupuncture And Evidence-Based Medicine: A Philosophical Critique. Medical Acupuncture Journal. 13 (2), pp. 1-12. [Online]

Han, JS. (1985) Electroacupuncture: An Alternative to Antidepressants for Treating Affective Diseases? International Journal of Neuroscience. 29, pp.79-92.

Hechun, L; Yungui, J; Xuzhong, W; and Weimin, D. (1990) Electro-Acupuncture in the Treatment of Depressive Psychosis. International Journal of Clinical Acupuncture. 1, (1), pp.7-13.

Hechun, L; Yunkui, J; and Li, Z. (1985) Electro-acupuncture vs. amitriptyline in the treatment of depressive states. Journal of Traditional Chinese Medicine. 5, (1), pp.3-8)

Hermann, C and Chow, V. (2005) Pocket Atlas of Acupuncture. 6th edition. Munich: Thieme.

Hirschfeld, R; Bowden, C; Gitlin, M; Keck, P; Suppes, T; Thase, M; Wagner, K and Perlis, R. (2010) Practice Guideline for the Treatment of Patients With Bipolar Disorder Second Edition. American Psychiatric Association. (pp.1-82)

Jinsheng, H. (1996) Acupuncture Treatment of Manic Psychosis. Journal of Traditional Chinese Medicine. 16, (3), pp.238-240.

Johnston, HF. (2009) Bipolar Disorder in Children and Adolescents. The Merck Manual. April 2009. [Online] Available at:http://www.merckmanuals.com/professional/pediatrics/mental_disorders_in_children_and_adolescents/bipolar_disorder_in_children_and_adolescents.html?qt=bipolar%20disorder&alt=sh [Accessed: 2 April 2012].

Kilbourne, AM; Copeland, LA; Zeber, JE; Bauer, MS; Lasky, E; Good, CB. (2007) Determinants of Complementary and Alternative Medicine Use by Patients with Bipolar Disorder. Psychopharmacology Bulletin. 40 (3), pp. 104-115. [Online] Leibenluft, E; Charney, D.S; Towbin, K.E.; Bhangoo, R.K; and Pine, D.S. (2003) Defining Clinical Phenotypes of Juvenile Mania. American Journal of Psychiatry. 160, (3), pp.430-437.

Leo RJ, Ligot Jr, JSA. (2006) A systematic review of randomized controlled trials of acupuncture in the treatment of depression. Journal of Affective Disorders. 97 (1-3), pp. 1-10.

Lewis, GB and Litt, M. (1987) An Alternative Approach to Premedication: Comparing Diazepam with Auriculotherapy and a Relaxation Method. American Journal of Acupuncture. 15, (3), pp.205-213.

Liang-dong, Z; Yu-hua, T; Wei-bing, Z; and Sheng-han, X. (1987) Comparative Study of Schizophrenia Treatment with Electroacupuncture, Herbs, and Chlorpromazine. Chinese Medical Journal. 100, (2), pp.152-157.

Luo, H; Meng, F; Jia, Y; Zhao, X. (1998) Clinical research on the therapeutic effect of the electro-acupuncture treatment in patients with depression. Psychiatry and Clinical Neurosciences. 52, S338-340.

Machovec, F and Man, S. (1978) Acupuncture and Hypnosis Compared: Fifty-eight Cases. The American Journal of Clinical Hypnosis. 21 (1), pp. 45-47.

Maciocia, G. (2005) The Foundations of Chinese Medicine. 2nd edition. London: Elsevier.

MacPherson, H; White, A; Cummings, M; Jobst, K; Rose, K; Niemtzow, R. (2002) Standards for reporting interventions in controlled trials of acupuncture: the STRICTA recommendations. Complementary Therapies in Medicine. Elsevier Science. pp.246-249.

McIntosh, B; Zhang, XY; Kosten, T; Tan, SP; Xiu, MH; Rakofsky, J; and Harvey, P. (2011) Performance-based assessment of functional skills in severe mental illness: Results of a large-scale study in China. Journal of Psychiatric Research. 45, (2011), pp.1089-1094.

Mingjiu, Z. (1988) Treatment of 296 Cases of Hallucination with Scalp-Acupuncture. Journal of Traditional Chinese Medicine. 8 (3) 193-194.

Moher, D; Schulz, KF; and Altman, DG. (2001) The CONSORT Statement: Revised Recommendations for Improving the Quality of Reports of Parallel-Group Randomized Trials. Annals of Internal Medicine. 134 (8), pp. 657-662. Moss, A; Monti, D; Amsterdam, J; and Newberg, A. (2011) Complementary and alternative medicine therapies in mood disorders. Expert Review Of Neurotherapeutics. 11 (7), pp.1049-1056.

Mukaino, Y; Park, J; White, A and Ernst, E. (2005) The effectiveness of acupuncture for depression – a systematic review of randomised controlled trials. Acupuncture in Medicine. 23 (2), pp. 70-76.

Muskin, PR. (ed.) (2000) Complementary and Alternative Medicine and Psychiatry. Review of Psychiatry series, Oldham JM and Riba MB series eds. 19 (1) pp. 89-91. Washington: American Psychiatric Press.

NHS. (2012) Bipolar disorder. Direct Gov. 29 Feb 2012. [Online] Available at nhs at:

http://www.nhs.uk/Conditions/Bipolar-disorder/Pages/Introduction.aspx [Accessed: 2 April 2012].

Polyakov, S. (1987) Acupuncture in the Treatment of Endogenous Depressions. Soviet Neurology and Psychiatry. 21, (4), pp.36-44.

Potter, M; Moses, A; and Wozniak, J. (2009) Alternative Treatments in Pediatric Bipolar Disorder. Child and Adolescent Psychiatric Clinics of North America. 18 (2), pp.483-514.

Prady, S; Richmond, S; Morton, VM; and MacPherson, H. (2008) A Systematic Evaluation of the Impact of STRICTA and CONSORT Recommendations on Quality of Reporting for Acupuncture Trials. PLoS one. Department of Health Science,. University of York. 3 (2), pp. 1-10. [Online] Available at blackboard.lincoln at:http://blackboard.lincoln.ac.uk/@@/A1631D41428F832F823D5DCA43F52617/courses/1/CPM3114M-1112/content/_574884_1/SRICTA-review.pdf [Accessed: 16 Feb. 2012].

Quah-Smith, JI; Tang, WM and Russell J. (2005) Laser acupuncture for mild to moderate depression in a primary care setting – a randomised controlled trial. Acupuncture in Medicine. 23 (3), pp. 103-111.

Quinton, N. (2010-11) Managing Psychosis with Acupuncture: A Clinical Perspective. The European journal of oriental medicine. 6 (5), pp.68-70.

Reid, T. (2010-11) Depression – A Multifaced Problem. The European journal of oriental medicine. 6 (5), pp.32-47.

Rogers, H. (2010-11) The Effectiveness of Acupuncture in the Management of Psychosis - An Evaluation. The European journal of oriental medicine. 6 (5), pp.64-67.

Schnyer RN and Flaws, B. (1998) Curing Depression Naturally with Chinese Medicine. 3rd edition. Boulder: Blue Poppy Press.

Shuaib, B and Haq, MF. (1977) Electro-Acupuncture Treatment in Psychiatry. American Journal of Chinese Medicine. 5, (1), pp.85-90.

Spence, DW; Kayumov, L; Chen, A; Lowe, A; Jain, U; Katzman, MA; Shen, J; Perelman, B; and Shapiro, CM. (2004) Acupuncture Increases Nocturnal Melatonin Secretion and Reduces Insomnia and Anxiety: A Preliminary Report. The Journal of Neuropsychiatry and Clinical Neurosciences. 16 (1), pp. 1-10.

Tao, DJ. (1993) Research on the Reduction of Anxiety and Depression with Acupuncture. American Journal of Acupuncture. 21, (4), pp.327-329.

Vincent, CA and Richardson, RH. (1987) Acupuncture for some common disorders: a review of evaluative research. Journal of the Royal College of General Practitioners, 37 (295), p.79.

Wenhe, Z; Hechun, L; Yucun, S. (1981) The Effect of Electric Acupuncture Treatment on Urinary MHPG-Sulphate Excretion in Unmedicated Schizophrenics. International Journal of Neuroscience. 14, pp.179-182.

World Health Organisation (1992) The ICD-10 classification of mental and behavioural disorders: clinical description and diagnostic guidelines. 8th edition. Geneva: WHO.

Xiujuan, Y; Xiang, L; Hechun, L; and Yunkui, J. (1994) Clinical observation on needling extrachannel points in treating mental depression. Journal of Traditional Chinese Medicine. 14 (1) pp.14-18.

Yatham, L. and Malhi, G. (2011) Bipolar Disorder. 1st edition. Oxford: Oxford University Press.

Yunkui, J; Hechun, L; Li, Z; Tingzhen, J; and Min, Y. (1987) A Study of the Treatment of Schizophrenia with HE-NE Laser Irradiation of Acupoint. Journal of Traditional Chinese Medicine. 7 (4), pp.269-272.

Zhengxiu, S. (1988) Observation on the Therapeutic Effect of 120 Cases of Hallucination Treated with Auricular Acupuncture. Journal of Traditional Chinese Medicine. 8 (4), 263-264.

Zhengxiu, S and Meizhun, T. (1986) An analysis of the therapeutic effect of acupuncture treatment in 500 cases of schizophrenia. Journal of Traditional Chinese Medicine. 6, (2), pp.99-104.

Zhenying, Z; Yumin, Y; Bingwen, Y; Yaqin, T; Wei, W; and Liming F. (1987) An Observation of 1316 Cases of Hysterical Paralysis Treated by Acupuncture. Journal of Traditional Chinese Medicine. 7 (2), pp.113-115.

Does acupuncture have therapeutic effects on chemotherapy-induced peripheral neuropathy in cancer patients? – A randomised, double blinded and placebo-controlled feasibility trial

Yang Xiang

Linconln College

Author's Note: This was a design about acupuncture's therapeutic effects on chemotherapy-induced peripheral neuropath for a clinical feasibility trial, which would be conducted in an NHS cancer hospital if the author had not quited from a master degree programme in clinical research due to personal circustances. This would be the very first step for a clinical investigator to conduct research in a hospital setting, and there would be hundreds of pages of forms to be completed. The author's intention is that demonstrating the first document in the early stage in processes of clinical trial in hospital would be required. Hopefully this might be of a bit help for anyone with an interest in this areas and also for practioners who might have a CIPN patient.

1. Background

Neuropathy is 'a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body. It usually begins in the hands or feet and gets worse over time. Neuropathy may be caused by physical injury, infection, toxic substances, diseases (such as cancer, diabetes, kidney failure, or malnutrition), or drugs, including anticancer drugs. It is also called peripheral neuropathy (Dictionary, National Cancer Institute. 2012.). Furthermore, chemotherapy -induced peripheral neuropathy (CIPN) describes damage to the peripheral nervous system, the system that transmits information between the central nervous system (e.g. the brain and spinal cord) and the rest of the body, caused by some chemotherapy agents. Commonly used chemotherapy agents associated with peripheral neuropathy include taxanes class (paclitaxel, docetaxel), vinca alkaloid class (vincristine and vinorelbine) platinum compounds (cisplatin, carboplatin and oxaliplatin) (Meredith, et al. 2012).

CIPN is the most common neurological complication of cancer patient undergoing chemotherapy, which affects about a third of all cancer patients who is undertaking chemotherapy. There are around 300,000 new cases of cancer dignosed in the UK annually (cancer research UK website, 2012). It is estimated that about 100,000 cancer patients developing CIPN. CIPN not only impairs patient's functional capacity, but also compromises their quality of life. It leads to dose reduction or cessation of chemotherapy, representing a dose-limiting side effect of many anti-neoplastic drugs. Many agents have been claimed to be neuroprotectors but not showing any significant results in large randomised clinical trials. Therefore, the early recognition and subsequent dose reduction/discontinuation of the offending agent is the only way to decrease the development of this potentially debilitating complication. Because of lack in effective prophylactic or symptomatic therapy up to date, monitoring neurological symptoms would be required for patients who are treated by neurotoxic antineoplastic agents, mainly when they present baseline neuropathy (Velasco and Bruna. 2010). Also painful CIPN is still under recognized and under treated. It is a most important cause of pain during chemotherapy and also a common pain in the cancer survivors. Difficulties in assessment and limitations in treatment lead to CIPN's management problems. It is required for improvements in education both patient and clinician. Assessment and treatment would potentially reduce the often debilitating effects of painful CIPN (Farquhar-Smith, 2011).

A review of the clinial research literature regarding treatment for CIPN in cancer patients has been conducted as background to this research. This review showed that both prophylactic and symptomatic treatments have not proven effective yet. Not sufficient evidence for treatment can be recommended to patients developing with CIPN. Chemotherapeutic drugs cause the direct injury to the peripheral nervous system. For most toxic neuropathies, the initial solution would be quite simple—remove the offending drug and the neuropathy should improve or even resolve. But this is not so easy in the cancer treatment, because the offending drug is very often a potentially life-saving therapy, but not an unwanted toxin. This has impact on both patients and physicians as well. In some cases, patients may not report neuropathic symptoms for they are fearful of missing out on an effective cancer treatment (Kaley and DeAngelis. 2009).

However, this review also demostrated that a pilot study on acupuncture suggest there is a positive effect of acupuncture on peripheril neuropathy (NP) of underlined aetiology as measured by objective parameters (Schroder, 2007). A retrospective service evaluation of acupuncture in the mamagement of CIPN is encouraging (Donald, 2011).

There are key questions about the poor quality of research on acupuncture's effect on CIPN. A RCT research on acupuncture's feasibility trial can be designed, as suggested by the MRC framework guiding the evaluation of complex interversion (Medical Research Council, 2008). This study proposed here will begin to emphasis this issue, focusing on evaluation of acupuncture's effect on CIPN, to facilitated future research exploring and improving care for cancer patients who develoed CIPN during their chemotherapy treatment. This study has the petential to both evalutating and influencing current and future treatment.

2. Purpose of the research

The specific aims of this study are:

1) To recruit 20 cancer patients with CIPN, over 18 years old into a randomized blinded placebo-controlled trial of the effects of therapeutic acupuncture.
2) To test the hypothesis that compared with patients assinged to receive a placebo non-therapeutic acupuncture treatment, those assigned to receive the therapeatic acupuncture treatment will have:
   i. Less severe symptoms and signs of CIPN
   ii. Better quality of life

Rationale for the research is that acupuncture is a Chinese medical procedure, inserting a fine needle into an acupoint, to manage many diseases and disorders, including cancer's symptomes. Its logic or/rationale –the theory of meridians or meridians--is highly controverisal because there is no specific physiological structure or tissues found along the meridians. However, studies in the early 1970s first elucidated the mechanisms for the effect of acupuncture anesthesia. Further experiments showed that this effect can be transferred from one rabit to another by cerebrospinal fluid (CSF) transfusion. Further investigation explored the role of classical central neurotransmitters in the mediation of acupuncture analgesia, including catecholamines and serotonin (Han, 2007). Recent research showed that adenosine mediates the effects of acupuncture and that inferfering with adenosine metabolism may prolong the clinical benefit of acupuncture (Goldman, et al, 2010).

Kim (2005:135) states: "Eastern medicine is based on holistic patterns, empirical observation, and nonlinear logic. Western medicine is based on reductionistic theory, linear causality, and scientific theory. You can say that Eastern views represent processes, and Western views represent the steps within those processes. In that respect, Eastern and Western views are actually looking at the same things, but from different perspective, both inherently valuable in their own way and related to each other." When we look at the therapeutic and preventive approaches of CIPN, it does not really matter from perspective of western or eastern medine as long as it helps the patients. Patients do matter.

As for cancer and CIPN, the most common two symptoms are numbness and pain. First of all, numbness is the almost occurring in all patients undergoing neurotoxic drugs. Actually, I suppose that numbness is caused by dual deficiency of Qi/Energy and Blood, and Blood stasis as well. The reason is that when chemotherapeutic agent damage the Qi and blood, leading to the poor supply of Qi and Blood within the meridians in the extremities. This is shown by cancer patients starting their CIPN symptoms from fingers or and toes. Another major symptom is pain in cancer patient with CIPN. Under any circumstance in Chinese medicine, pain is caused by blockage of Qi in the meridians. Cancer itself can cause blockage of Qi as well as blood stasis; and blood stasis worsen the Qi blockage. Therefore, the selection of acupuncture point should be on basis of the above hypothesis and theory.

Most recently study has suggested that adenosine A1 receptors mediate the effects of acupuncture and that interfering with adenosine metabolism may improve the clinical benefit of acupuncture (Goldman, et al. (2010). Adenosine plays a key role in energy transformation and if we look back at the theory of Qi/Energy and meridians in Chinese medicine. Perhaps it may be able to convince some of those sceptics about the philosophy of Chinese medicine and one way or other Chinese medicine's theory does make sense. Both theoretically and practically, the theory of Qi and meridians are good enough to instruct Chinese physician's clinical practice in acupuncture and Chinese herbal medicine; a set of scientific term and tangible evidence-based new theory are needed to replace these empirical observation, ancient theory, and invisible meridian. This will broaden the horizon of acupuncture and Chinese medicine. The day will come only if scientists, practitioners and researchers contribute their energy, time and wisdom into the old but modern, silent but exciting, and theoretical but very practical useful research domain in acupuncture and Chinese medicine. The potential of acupuncture in the management of CIPN and beyond of it is incredibly huge. Acupuncture and Chinese medicine is a great treasure storehouse, and it needs to be explored in width, dug in depth, and understood in multiple dimensions.

The key research area to be addressed is that whether acupuncture is able to reduce symptomes of CIPN in cancer patients with chemotherapy and to improve patients' quality of life. Just as Andreas, et al (2012) claimed: "A deeper knowledge should, therefore, be achieved an this goal may be accomplished only through an extensive collaboration between all the healthcare professionals involved in cancer patient management, focused on the common aim to opimize cancer treatment while minimizing potentially disabling side effects such as CIPN."

3. Mathods

The overall design of the Study

This study is a randomised, double blinded, placebo contolled feasiblility trial. The duration of study is one year. The subjects are adult cancer patients with CIPN who are over 18 years. It is planned to recruit that 20 adult patients within one year.

Sampling

The patients will be recruited from a cancer clinic in Manchester both inpatients and outpatient could be taken into this trial. These patients who are undergoing chemotherapy with symptoms and signs in the clinic would be the potential participants.

Inclusion criteria

The most reliable and sensitive approach for diagnosing CIPN is by history taking and physical examination, with a specific attention of questioning about the neuropathy symptoms like numbness, tingling, pain, distal weakness, the physical signs of reflexes (especially the ankle jerks), sensory and motor examinations (Ocean and Vahdat. 2004). The Total Neuropathy Score (TNS) provides the most comprehensive, composite and measurement tools to have been tested in oncology settings (Lavoie Smith et al. 2008) and it is criteria here used for the diagnosis of CIPN. The multidimensional instrument was developed by Chaudhry et al (1994, 1996), which

evaluate the presence, charcteristics, and location (distally versus proximally) of symptoms, as well as the presence, severity, and location of several physical findings. When patients used chemotherapy agents associated with peripheral neuropathy include taxanes class (paclitaxel, docetaxel), vinca alkaloid class (vincristine and vinorelbine) platinum compounds (cisplatin, carboplatin and oxaliplatin), which are eligieble for this trial.

Exclusion criteria

a) CIPN coexisting respiratory disease such as asthma, cystic fibrosis or chronic lung disease
b) Severe heart disease
c) Severe liver disease
d) Severe renal disease
e) Known to be pregnant
f) Patients who present with life threatening symptoms.
g) Patients who had acupuncture before

Withdrawal from trial intervention

a) Any unexpected symptoms from chemotherapy;
b) Any unexpected symptoms form acupuncture;
c) Any change in the patient's condition which wants to withdraw from the trial intervention.

The intervention will continue unless the patient withdraws from the trial. Details of reasons for withdrawal from the trial will be reconded.

Enrolment and randomision

The screening will be conducted after an oncologist (s) refer patient to the trial. In practice, the trial will need permission access to patients via oncologist in a cancer clinic in Manchester. Patient information and consent forms will be given to these potential participants. If patients meet the inclusion criteria, and that the written consent has been gained. Then the patient is formally enrolled as a participant in this trial. The screening will include:

a) Confirmation that the patient is aged over 18 years;
b) Assessment of baseline of CIPN severity, i.e. TNS (Lavoie Smith, et al.2008) and QLQ CIPN20 (Postma, et al. 2005);
c) Measure of heart rate, blood pressure;
d) Collection of demographic information including age of cancer onset;
e) Length of CIPN onset;

For each patients who might be considered suitable for inclusion in this trial. The following formal sequence of events should take place:

a) Patient require treatment;
b) Patient eligible for inclusion in the trial;
c) Oncologist willing to accept randomization;
d) Patient informed consent is obtained;
e) Patient formally entered in on the trial;
f) Treatment assignment obtained from the randomization list;
g) On-study forms are completed;
h) Treatment commences.

By following the above procedures make the registration of patients into the trial to go ahead in an efficient and ethical manner. If patients meet the inclusion criteria, and that the written consent has been gained, the patient will be eligible for randomisation. Patients who are randomised will have their contact details (name, address, telephone number and email) and GP details. The randomization list will be sealed in twenty evelopes each containing either therapeutic or non-therapeutic acupuncture treatment on a card. The nurse who will be trained perfoming acupuncture treatment then opens the next envelop in the sequence when the patient has formally enters the trial. The nurse commences the treatment according the instruction from the card. So, both the patient and the nurse do not know which treatment the patient is in, because when we train the nurse, I will not let her know which is therapeutic or non-therapeutic acupuncture treatment.

Therapeutic and non-therapeutic acupunture and point selection

The selection of acpuncture points showed different points (Zhang, 2010; Shiflett, 2011). The following points were chosen and the procedure in STRICTA (Mac Person, et al. 2010) will be followed when conducting the treatment of acpuncture. The protocol planned for up to 10 treatments per patient, 10 needles per session. A total of 200 of acupuncture sessions will be provided for the planned 20 participants.

The therapeutic acupuncture points include the following points. They are PC6 Neiguan, LI4 Hegu, ST36 Zusanli, SP6 Sanyinjiao, LV3 Xingjian. The depth of insertion will depend upon the location of point. PC6 for 1 to 1.5 cm; LI4 for 1 to 2 cm; ST36 for 3 to 6 cm; SP6 for 2 to 4 cm; LI 3 for 1 to 3 cm. Response sought: De qi or muscle twitch response for therapeatic acupuncture group when inserting the needle but staying for 25 minutes without further manipulation, which is called as an even acupuncture technique in Chinese medical terms.

The control or placebo or non-therapeutic acupuncture prescription points are 4 point around both shoulders where are 2 cm away from classical acupuncture points and 6 random points four cm around both hip joints. The rational for application of hip joint area as control is that there are the least acupuncture points on this area. Non-therapeatic acupuncture only inserting needle and staying for 25 minutes without De qi i.e. muscle twitch response.

The rational of selection of these points is on basis of theory of Chinese medicine; but at the same time, an attempt of application of the most recently updated scientific research is under consideration for its impact on human physiological responses to the stimulus of acupuncture needle in the different way from nervous, endocrine and immune systems.

What we are trying to do in this trial is that attempt of achieving scientific evidence prove acupuncture's effect on CIPN in cancer patients, which is the main aim of the trial. As for the dosage of acupuncture, selection of acupuncture points and which style of acupuncture working most efficient, these questions are beyond this trial.

Administration of acupuncture

Patients will receive ten consecutive acupuncture treatments, either therapeutic or non-therapeutic, on weekly basis for ten weeks. The nurses will be trained to

perform acupuncture treatment. Two nurses in a cancer clinic do not have any knowledge about acupuncture, will be trained to provide therapeutic and non-therapeutic acupuncture treatment. The nurses would not know which is the active acupuncture or placebo acupuncture.

4. Data collection methods

Firstly, ensuring nurses who recruit and manage acupuncture have the appropriate forms for every patients entered in the trial. Secondly, instructions about which forms should be completed and at what time should be in the formal research protocol. Thirdly, it should also be made clear who is responsible for completing each form.

The registration form for entrance to the trial should be collected by the nurse who screen and registrate the patient. The form should be sent to the main investigator who should store the data in a locked cabinet unit.

5. Data analysis

The hypothesis for the trial is that the therapeutic acupuncture treatment will have a better effect on cancer patients with CIPN. There are quite a few tests, such as chi-squared test, two-sample t-test and Wilcoxon test for comparing two arms trial, to apply the analysis of significance of the trial, to interprete the meaning of the data from the trial.

An independent statistician will be employed to analyse the data. Individual graphical data could be displayed because this is a small size sample trial. It can describe what actually happens to individual patients. Of course the two groups could be shown and compared in a diagram.

6. Deliverables

The study will produce knowledge about acupuncture's effect on CIPN in cancer patients. The impact would facilicate further research to benefit many more CIPN patient because there is no effective pharmaceutical drug treatment proven beneficial to CIPN patients.

7. Scheduling of the study

If one to two patients would be recruited within the first twenty weeks, the trial could be completed within six months. It is all up to the recruitment of patients. Recruiting patient and managing treatment are keys for the trial's success. Three months to recruit 20 patients is realistic. The duration of acupuncture treatment will last only six weeks for each patient. Therefore, as a whole, the trial is realistic, practical and manageable.

Table 1 study timeline for a randomized, blinded, placebo-controlled trial of the effect of therapeutic acupuncture on cancer patients with CIPN

	Screening	*randomization*	*3months*	*6months*	*12months*
Medical history	□	□	□	□	□
Blood pressure	□	□	□	□	□
Heart rate	□	□	□	□	□
TNS score	□	□	□	□	□
QLQ-CIPN20	□	□	□	□	□
Adverse events	□	□	□	□	□

8. Estimation of the resources required to complete the study

Each patient needs about 45minutes per visit for 10 visits. The total hours of staff time would be about 150 hours, excluding training hours in perfoming acupuncture treatment. The researcher will provide the consumable material such as acupuncture needles and surgical spirit.

9. Ethical issues

Ethics approval: The researchers will obtain approval from the Manchester University Research Ethics Committee (if any other location involve the trial, local committee will be contacted to obtain approval). The study will be conducted in accordance with the recommendation for physicians involved in research on human subjects adopted by the18th World Medical Assembly, Helsinki 1964 and its most recently undated revisions (2008).

Consent: Consent to enter the study must be sought from each participant only after a full explaination has been given, an information leaflet offered and 48 hours allowed for consideration. Signed participant consent should be obtained. The right of the participant to refuse to participate without giving reasons must be respected. All participants are free to withdraw at any time without giving reasons and without prejudicing further treatment. On withdrawal from the study, identifiable data will be destroyed securely. Non-identifiable data will be deleted from the database only at the request of the participant.

Confidentiality: The researchers will preserve the confidentiality of participants taking part in the study and is registered under the Data Protection Act.

Offer of acupuncture treatment: If the trial shows significant improvement in patient with CIPN which is very likely, then the patients assigned to therapeutic acupuncture group will be offered further acupuncture treatment after the trial ended and patients who were assigned to the non-therapeutic acupuncture treatment will be offered therapeutic acupuncture treatment at the 11th week. I think this offer may encourage cancer patients with CIPN to participate in this trial. In addition, acupuncture is a remedy which does not involve any intaking of medication. In other words, acupuncture should not affect

any of standard chemotherapy and any medication at all, which is an advantage of this trial.

10. Reflection on this trial

The strength of the trial would be the study design. A randomised, double blinded, placebo controlled trial is the best of all research design or the most powerful tool in modern clinical research. This trial is random assignment of patients, which minimises the main source of bias in clinical research, i.e. selection bias. Also it is double blinded, meaning the patient, nurse who manage the intervention are unware of which treatment has been given to individual patients. Care provider bias is minimised.

The trial will produce scientific knowledge about acupuncture effect on CIPN in cancer patients, which is the main aim achieved by the trial. As well as it should be a good foundation for further research in the foreseeable future. The trial is to test acupuncture's acceptability, to estimate the likely rates of recruitment and retention of participants, to evaluate its effecacy as well.

The limitation is that this is only a feasibility trial with a strict inclusion criterion for entrance of trial, resulting in its limitation of generality of its application or implementation into real practice.

Acknowledgements

A special big thanks to Professor Molassiotis, the Univeristy of Manchester, who suggested this research question, i.e. acupuncture for treatment of chemotherapy-induced peripheral neuropathy in cancer patients when I met him for the first time in 2011. Also, it has been Dr. Zhao, the chief editor of JATCM, who spurs me to write some papers. Without her encouragement, I would not have written these papers.

References

[1] Andreas A. et al. (2012) Chemotherapy-induced peripheral neurotoxicity (CIPN): an update. Oncology Hematology. 82 (2012) 51-77.

[2] Anonymous. Dictionary, National Cancer Institute 2012. http://cancer.gov/dictionary?cdrid=46041[3March2012]

[3] Argyriou, AA., and et al. (2005) Vitamin E for prophylaxis against chemotherapy-induced neuropathy , Neurology, Vol. 64, pp. 26-31.

[4] Argyriou. AA., and et al. (2006a) Preventing paclitaxel-induced peripheral neuropathy: a phase of I trial of vitamin E supplementation, Journal of Pain and Symptom Management, Vol.32, pp.237-244.

[5] Argyriou, AA., and etal. (2006b) Preventing paclitaxel-induced peripheral neuropathy: a phase of I trial of vitamin E supplementation , Journal of Pain and Symptom Management, Vol.32, pp.237-244.

[6] Caraceni, A., and et al., (2004) Gabapentin for neuropathic cancer pain: a randomized control trial from the gabapentin cancer pain study group , Journal of Clinical Oncology, Vol.22, pp. 2909-2917.).

[7] Carozzi, VA., and et al.,(2010) Neurophysiological and Neuropathological charaterization of new murine models of chemotherapy-induced chronic peripheral neuropathies, Experimental Nerology, Vol.226, No. 2, Sep., pp.301-9.

[8] Donald, GK., Tobin, I,. and Stringer, J., (2011) Evaluation of acupuncture in the management of chemotherapy-induced peripheral neuropathy, Acupuncture in Medicine, Vol.29, pp. 230-233.

[9] Farquhar-Smith, P. (2011) Chemotherapy-induced neuropathic pain', Curr Opin Suport Palliat Care, Vol.5 (1), Mar, pp.1-7.

[10] Flatters, SJ. And Bennett, GJ. (2006) Studies of peripheral sensory nerves in paclitaxel-induced painful peripheral neuropathy: evidence for mitochondrial dysfunction, Pain, Vol.122, No.3, Jun, pp. 245-57.

[11] Gamelin, C., and et al. (2004) Prevention of oxaliplatin-related neurotoxicity by calcium and magnesium infusions: a retrospective study of 161 patients receiving oxaliplatin combined with 5-fluorouracil and leucovorin for advanced colorectal cancer, Clinical Cancer Research. Vol. 10. pp. 4055-4061.).

[12] Gianoccare, MP., and et al. (2011) Somatic and autonomic small fibre neuropathy induced by bortezomib therapy: an immuofluarescence study, Neurol Sci, Vol.32,NO.2,Apr, pp.361-3.

[13] Goldman, N. and et al. (2010) Adenosine A1 receptors mediate local antinociceptive effects of acupuncture, Nat Neurosci. Vol.13, No.7, Jul, pp. 883-8. Epub 2010 May 30.).

[14] Hammack, JE., et al. (2002) Phase III evaluation of nortriptyline for alleviation of symptoms of cisplatinum-induced peripheral neuropathy, Pain, Vol.98, pp. 195-203.

[15] Han, JS. (2007) Physiology of acupuncture: review of thirty years of research. Alternative and complementary medicine. Issue 3 supplement 1: September 10, 2007.

[16] Hochster, HS., and et al. (2007) Use of calcium and magnesium salts to reduce oxaliplatin-related neurotoxicity, Journal of Clinical Oncology, Vol. 25, pp. 4028-4029).

[17] Kaley, TJ. and DeAngelis, LM. (2009) Therapy of chemotherapy-induced peripheral neuropathy, British Journal of Haemotolgy,Vol.145, Iss.1, pp.3-14.

[18] Kautio, AL., and et al. (2008) Amitriptyline in the treatment of chemotherapy-induced neuropathic symptoms, Journal of Pain and Symptom Management, Vol.35, pp.31-39.

[19] Kim, DH. (2005) Evolution of acupuncture for pain management, Seminars in Integrative Medicine, pain management solution, Inc, Moorestown, NJ. Email: davidkinmd@aol.com 1543-1150/05/$-see front matter ©2005 Elsevier Inc. All right reserved. Doi:10.1016 /j.sigm.2005.01.003.

[20] Lavoie Smith EM, Beck SL, and Cohen J. (2008) The Total Neuropathy Score: A tool for measuring chemotherapy-induced peripheral neuropathy. Oncology nursing forum. Vol.35. No.1. 96-101.

[21] MacPherson H, Altman DG, Hammerschlag R, Youpin L, etc. Revised Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA): Extending the CONSORT Statement, June 2010, Volume 7, Issue 6, E1000261.

[22] Medical Research Council. (2008) Developing and evaluating complex interventions: new guidance.

[23] Melemedjian, OK., and et al. (2011) Targeting adenosine monophosphate-activated protein kinase (AMPK) in preclinical models reveals a potential mechanism of treatment of neuropathic pain, Mol Pain, Vol.7, Sep., pp70.

[24] Meredith A, and et al. 2012 Chemotherapy-induced peripheral neuropathy Fact sheet. http://www.cancersupportivecare.com/nervepain.php [23 Nov. 2011]

[25] Ocean, AJ. and Vahdat, LT. (2004) Chemotherapy-induced peripheral neuropathy: pathogenesis and emerging therapies, Supportive Care in Cancer, 12. 619-625.

[26] Pace, A., and et al. (2003) Neuroprotective effect of vitamin E supplementation in patients treated with cisplatin chemotherapy, Journal of Clinical Oncology, Vol.21, pp. 927-931.

[27] Schroder S, Liepert J, Remppis A, Greten JH. (2007) Acupunture treatment improves nerve conduction in peripheral neuropathy. European Journal Neurology. 14 (3): 276-81.

[28] Postma, et al. (2005). The devolopment of an EORTC quality of life questionnaire to assess chemotherapy -induced peripheral neuropath: The QLQ-CIPN20. European Journal of Cancer. Vol.41 (8) 1135-1139.

[29] Shiflett SC and Schwartz GE. (2011) Effects of acupuncture in reduced attrition and mortality in HIV-infected men with peripheral neuropathy. Explore May/June Vol.7, No.3148-154

[30] Zhang C, et al. (2010) Clinical effects of acupuncture for diabetic peripheral neuropathy. Journal of Traditional Chinese Medicine. Vol. 30. No.1. 13-14.

Biography: Mr Yang Xiang, with Master degree of Medicine from China, has been practising acupuncture and Chinese medicine since 1984, as well as a part-time acupuncture lecturer at the University of Lincoln (now transferred to Lincoln College) since 2008. He has an intention of bridgeing the two medical systems, i.e. western and Chinese medicine. His special interests include dermotology, neurology, paediatrics and neuroscience. He has treated hundreds of patients, ranging from eczema and infertility to leukaemia since he moved to the UK in 2000.

Chinese Medical and Skin Centre
25 Birch Terrace, Stoke on Trent, ST1 3JN
Telephone: 01782 287200.
Email: yxiang@lincoln.ac.uk;
chinesepharmacy1@gmail.com

浅谈现代销售理念在英国中医店的应用

倪建平

当前英国中医店处境艰难：无成药可进；英国经济低迷，病人无钱买中药；中医店太多，竞争激烈；中医负面新闻不断等等。笔者认为应用现代销售理念可帮助中医店取得好业绩。

现代销售理念很多，我想推介如下几点，供各位参考，不妥处，欢迎联系作者。

第 1：销售过程中 销 的是什么？**职业形象**

销售任何产品之前首先注重的是你本人的职业形象。因此，中医店前台，医师 应着装整洁，精神饱满，给 病人一个好的第一印象。如果你不修边幅，没有一个好的职业形象，病人怎么会相信你推介的药物和治疗。

第 2：销售过程中 售 的是什么？**观念**

在向顾客推介你的产品前，先想办法搞清他们的观念，再去配合它。是顾客花钱买他想买的产品，而不是你。销售员 的职责是协助顾客买到他认为最合适的产品。因此病人进店后，不要急于推介，而应先聊天，了解他的观念，再配合他的观念去推介。

第 3：买卖过程中，顾客买的是什么？**感觉**

顾客买不买某产品有一个决定性的力量，那就是感觉。产品、人、环境、语言、语调及肢体动作都会影响顾客的感觉。在整个销售过程中为顾客营造一个好的感觉，那么他们就愿意在此消费。因此，前台说话要清楚，语言要礼貌，语调要根据病人调整，环境要温馨。

第 4： 买卖过程中卖的是什么？ **效果**

客户不会因产品而购买，买的目的是通过这个产品或服务能带给他好的效果；只有当客户明白产品能带来好的疗效，他才会舍得消费。因此，耐心讲解中药和针灸 的良好效果，如无副作用，有 3000 年以上的使用历史，疗效慢但能除病根等，也可举出老病人治疗 的成功例子来说明。

第 5：销售中推介产品时如何与竞争对手比较

不贬低对手，否则客户会认为你人品不好，客户会弃你而跑。切忌拿自己的三大优势与对手的三点不足作客观比较。中医店已饱和，一个镇常有 2-3 个店，有的病人喜欢比较。因此，中医店不要相互损，病人问起时，可强调本店的优势，如年老医师就说有经验，年轻医师就说精力充沛，按摩有体力，反应快。若医师自己开店，就说责任心肯定强；若是连锁店就说公司有规模，可到任何连锁店治疗，方便病人。

第 6：售前售后服务

好的服务能让客户感动，你能感动他， 他就会买你的产品。让客户感动的三种服务：诚恳关心客户及家人；主动帮客户拓展他的事业；与销售无关的服务。因此，记住：来的都是客，假使 这次不买，也要给 他们留下好印象。不能他们不买，就冷脸。对行动不便的病人为他们找车回家等。病人回家后有问题要耐心解答，有病人要退药也要微笑服务。

总之，望各位同仁充满信心，抖擞精神，善用智慧，为中医在英国发扬光大，昂首挺立贡献力量。

(作者：英国君健公司董事)

Research News in Traditional Chinese Medicine

Complied and abstracted by Liqin Zhao

Research News summarises some recent researches in traditional Chinese medicine which mainly includes Chinese herbs and acupuncture. This updated research information will help practitioners to get even better understanding of TCM, therefore offering precise and positive answers to patients, improving your practice.

1. Chinese herb casts new light on the treatment of cancer patients

There are many studies have shown that some Chinese herbs can be benefit for cancer patients. Chinese herb Gnetum Cleistostachyum has been used as a remedy for cancers for hundred years, however, the active compounds and molecular mechanisms underlying its anti-cancer activity have not been explored.

A recent study by researchers from China has found a new derivative of stilbene compound, Isorhapontigenin (ISO), from this Chinese herb. They have examined the potential of ISO in anti-cancer activity and the mechanisms involved in human cancer cell lines, and have found that ISO exhibited significant inhibitory effects on human bladder cancer cell growth that was accompanied by marked apoptotic induction as well as down-regulation of X-linked inhibitor of apoptosis protein (XIAP). Further studies have shown that ISO Down-regulation of XIAP protein expression was only observed in endogenous XIAP, but not in constitutionally exogenously expressed XIAP in the same cells, excluding the possibility of ISO regulating XIAP expression at the level of protein degradation. They have also identified that ISO Down-regulated XIAP gene transcription via inhibition of Sp1 trans-activation. There was no significant effect of ISO on the apoptosis and colony formation of cells transfected with exogenous HA-tagged XIAP. Collectively, for the first time, this study has identified ISO as a major active compound for the anti-cancer activity of Gnetum Cleistostachyum by down-regulation of XIAP expression and induction of apoptosis through specific targeting of Sp1 pathway, and cast new light on the treatment of the cancer patients with XIAP overexpression.

(The Chinese herb isolate isorhapontigenin induces apoptosis in human cancer cells by downregulating overexpression of antiapoptotic protein XIAP. http://www.jbc.org/content/early/2012/08/15/jbc.M112.389494.short *J. Biol. Chem. 2012 287: 35234-35243.*)

2. Chinese herb helps with brain cancer

For centuries, natural plant remedies have been used to treat disease and maintain health, especially in China. More than 3200 herbs and 300 minerals are routinely applied to patients as a mixture or formula. Traditional Chinese medicine (TCM) believes that disease primarily arises from imbalances in the body. The therapeutic purpose is therefore to bring the human body back into equilibrium. Treatments undertaken with this goal are called 'Fu Zheng (扶正)', and are given as complementary therapy intended to reduce the side effects of conventional Western medical treatment. Chinese herbal medicine is independent of conventional Western concepts of medical diagnosis and treatment.

One aspect of Chinese medicine is to bolster resistance to disease by strengthening a person's immunity. Chinese herbs attempt to prevent and treat physiological imbalances, such as those caused by cancer and other diseases, with combinations of herbs, minerals, and plant extracts. Diseases that cannot be cured by modern medical treatments, such as diabetes and cancer, may be alleviated by TCM.

Angelica sinensis is one of the most popularly used Chinese herbs. Research carried out in Taiwan has suggested that Angelica sinensis may be a potential treatment against brain tumors, with minimal toxicity. The main compounds found in the acetone extract of Angelica sinensis (AS-AC) are ferulic acid, ligustilide, brefeldin A, butylidenephthalide, and polysaccharides, the latter with potential therapeutic effect on various human cancers.

However, brain tumors are hard to treat, since any efficacious drug must cross the blood-brain barrier. The molecular mechanisms involved include butylide-nephthalide-stimulated translocation of Nur77 from the nucleus to the cytoplasm, leading to tumor apoptosis. Butylidenephthalide likewise suppresses telomerase activity, resulting in tumor senescence. Finally, a controlled release system can increase localized utylidenephthalide concentration. Importantly, butylide-nephthalide can cross the blood-brain barrier. Current evidence suggests its efficacy against brain tumors and therefore potential clinical applications.

(Angelica sinensis: A Chinese herb for brain cancer therapy. http://www.kaiser.com.tw/upload files/1/news/e-news/Angelica%20sinensis.pdf BioMedicine 2012, 2 (1); 30–35.)

3. Chinese herbal formula can increase pregnancy rate

A randomized, double-blinded, placebo-controlled clinical trial was conducted by Chinese researchers, to explore the effects of Erzhi Tiangui Granule (ETG) on DNA methyltransferases (DNMT) 1 protein expression in endometrium of infertile women with Kidney-yin deficiency syndrome. They concluded that Chinese herbal formula ETG can improve the clinical pregnancy rate for the infertile patients undergoing IVF.

66 infertile patients who had Kidney-yin deficiency syndrome and who were to undergo in vitro fertilization -embryo transfer (IVF-ET) were randomly assigned to

either a treatment group or a control group according to a random table. Besides gonadotropin (Gn) therapy in both groups, the treatment group received ETG for 3 menstrual cycles before IVF, and the control group received placebo granules. The ETG and the placebo granules were made with similar colour and shape, as well as in the same packaging. The scores of the Kidney-yin deficiency syndrome were assessed. Other outcome measures included the dosage and duration of Gn, the number of retrieved eggs, the rate of high-quality eggs, the rate of high-quality embryos, the fertilization rate, and the clinical pregnancy rate. DNMT1 protein expression in the endometrium was measured in the mid-luteal phase.

The difference in the syndrome score change before and after treatment between the two groups was statistically significant ($p<0.05$). The dosage and duration of Gn were significantly lower in the treatment group than those in the control group ($p<0.05$). The high-quality egg and embryo rates, and clinical pregnancy rate were all higher in the treatment group than those in the control group ($p<0.05$). The fertilization rate was not significant when compared to the placebo group. No difference was found in the number of retrieved eggs between the two groups. The DNMT1 protein expression in the endometrium was much more abundant in the treatment group than that in the control group ($p<0.05$). The result indicated that using ETG for tonifying the Kidney as an adjunct treatment could reduce Gn dosage and treatment duration, alleviate clinical symptoms, increase the level of DNMT1 protein expression after treatment, therefore enhances endometrial receptivity and improve the clinical pregnancy rate.

(Effects of Chinese Medicines for Tonifying the Kidney on DNMT1 Protein Expression in Endometrium of Infertile Women During Implantation Period. J Altern Complement Med. 2012 Oct 17. [Epub ahead of print] http://www.ncbi.nlm.nih.gov/pubmed/23075413)

4. Chinese herb enhances recovery of hemorrhagic stroke

A double-blind, placebo-controlled, randomized study was recruited by the researchers in Taiwan, to test the effect of *Astragalus membranaceus* (AM) on acute hemorrhagic stroke. 78 patients were randomly assigned to Group A (3g of AM three times/day for 14 days); or Group B (3g of placebo herb). A total of 68 patients (Group A 36, Group B 32) completed the trial.

The increase of functional independence measure scale score between baseline and week 4 was 24.53 ± 23.40, and between baseline and week 12 was 34.69 ± 28.89, in the Group A was greater than 11.97 ± 11.48 and 23.94 ± 14.8 in the Group B (both P _ 0.05). The increase of Glasgow outcome scale score between baseline and week 12 was 0.75 ± 0.77 in the Group A was greater than 0.41 ± 0.50 in the Group B ($P < 0.05$). The results are preliminary and need a larger study to assess the efficacy of AM after stroke.

(Chinese Herb Astragalus membranaceus Enhances Recovery of Hemorrhagic Stroke: Double-Blind, Placebo-Controlled, Randomized Study. http://www.hindawi.com/journals/ecam/2012/708452/abs/ Evidence-Based Complementary and Alternative Medicine. Volume 2012, Article ID 708452, 11 pages.)

5. Chinese herb can significantly improve the quality of life for patients with stable angina

Researchers from China have performed a prospective multicenter placebo controlled trial to evaluate the long term quality of life after Chinese herb treatment. The Chinese herbs are made from Chinese sage (石见穿) and Trichosanthes（天花粉）.

A total of 132 patients from four participated centres were enrolled in the study from 2008 to 2009. All the patients got standardized therapy included Aspirin, simvastatin and isosorbide dinitrate according to the guideline for the management of stable angina. On the top of these standardized treatments, 66 patients got Chinese herb treatment and the other half got placebo. All patients were followed up for one year. The primary outcome was the change of SF-36 and Seattle Angina Questionnaire (SAQ).

The results showed Chinese herb treatment can significantly improve the quality of life in the stable angina patients when compared to placebo controls as assessed by SF-36 and SAQ. There were no significant differences were observed in the baseline characteristics and comorbidities between two groups. The mean age is 61±9 in herb group vs. 62±8 in placebo controls, 74% male versus 72%, hypertension present 50% vs. 61% and hyperlipedimia 32% vs. 30% respectively. The score of short form-36 (SF-36) increased significantly from 58±10 to 77±15 ($P<0.01$) in herb treatment group, but no significant increase in control group from 58±11 to 67±12 ($p=0.09$). The SAQ score increased significantly after one year treatment in both groups. The increase of SAQ is significantly higher in herb treatment group (35±15) when compared to the placebo controls (15±10).

This trial indicates that integrated therapy included both Chinese herb and standardized western medicine can improve one year health status of stable angina patients. The nature herb should be considered as an important adjutant therapy for stable angina patients.

(Quality of Life and Health Status after Chinese Herb Treatment in Stable Angina Patients http://journal.publications.chestnet.org/article.aspx?articleid=1376579 CHEST Journal. October 2012; 142 (4_Meeting Abstracts): 85A-85A.)

6. Compatibility art of traditional Chinese medicine

A systematic search of herb pair related research was carried out using multiple online literature databases, books and monographs published in the past 20 years. A comprehensive introduction to the compatibility of TCM, the position of herb pairs in TCM and the progresses of several famous herb pairs were provided in this review, and the clinical study and the future research trends of herb pairs were also discussed.

The results showed herb pairs have played, and may continue to play a key role in full investigation of general herb compatibility for their indispensable position in TCM.

Over the past decades, research of TCM mainly focused on developing potential candidates from Chinese medicinal herbs, while the wisdom of applying these traditional herbs has not been paid as much attention as it deserves. As is well-known, multi-herb therapy is one of the most important characteristics of TCM, but the modernization drive of this conventional wisdom has faced many obstacles due to its unimaginable complexity. Herb pairs, the most fundamental and the simplest form of multi-herb formulae, are a centralized representative of Chinese herbal compatibility. In light of their simplicity and the basic characteristics of complex formulae, herb pairs are of great importance in the studies of herb compatibility. However, much more research is needed for the standardization, safety evaluation, and mechanism exploration of herb pairs.

(Compatibility art of traditional Chinese medicine: From the perspective of herb pairs http://www.sciencedirect.com/science/article/pii/S0378874112005028 Journal of Ethnopharmacology 2012, 143 (2): 412-423.)

7. Acupuncture can help patients with Cancer-Related Fatigue

Researchers in the UK conducted a pragmatic, randomized controlled trial comparing acupuncture with enhanced usual care, aimed to assess the effectiveness of acupuncture for cancer-related fatigue (CRF) in patients with breast cancer. Three hundred and two outpatients with breast cancer participated. They randomly assigned 75 patients to usual care and 227 patients to acupuncture plus usual care (random assignment of 1:3 respectively) with minimization controlling for baseline general fatigue and maintenance treatment. Treatment was delivered by acupuncturists once a week for 6 weeks through needling three pairs of acupoints (Zusanli St 36, Sanyinjiao Sp 6, and Hegu LI 4). The usual care group received a booklet with information about fatigue and its management. Primary outcome was general fatigue at 6 weeks, measured with the Multidimensional Fatigue Inventory (MFI). Other measurements included the Hospital Anxiety and Depression Scale, Functional Assessment of Cancer Therapy–General quality-of-life scale, and expectation of acupuncture effect. Analyses were by intention to treat.

The results showed significant improvement in overall fatigue, mental and physical fatigue, motivation, activity, psychological distress and quality of life. 246 of 302 patients randomly assigned provided complete data at 6 weeks. The difference in the mean General Fatigue score, between those who received the intervention and those who did not, was −3.11 (95% CI, −3.97 to −2.25; $P < .001$). The intervention also improved all other fatigue aspects measured by MFI, including Physical Fatigue and Mental Fatigue (acupuncture effect, −2.36 and −1.94, respectively; both at $P < .001$), anxiety and depression (acupuncture effect, −1.83 and −2.13, respectively; both at $P < .001$), and quality of life (Physical Well-Being effect, 3.30; Functional Well-Being effect, 3.57; both at $P < .001$; Emotional Well-Being effect, 1.93; $P = .001$; and Social Functioning Well-Being effect, 1.05; $P < .05$). They have concluded that acupuncture is an effective intervention for managing the symptom of CRF and improving patients' quality of life.

(Acupuncture for Cancer-Related Fatigue in Patients with Breast Cancer: A Pragmatic Randomized Controlled Trial. The Journal of Clinical Oncology. 29th Oct. 2012). http://jco.ascopubs.org/content/early/2012/10/29/JCO.2012.41.6222.abstract

8. Acupuncture can enhance the effect of Antidepressants

A study conducted by researchers in China has found that both verum acupuncture and electro-acupuncture can improve quality of life in depressed patients undergoing Paroxetine treatment. They randomly assigned 157 patients with depression into three treatment groups, all three groups of patients with scores of 17 or more on the 17 items of the Hamilton Depression Rating Scale were treated with the antidepressant drug Paroxetine, while two groups of them also underwent verum acupuncture or electro-acupuncture at *Baihui* (Du 20), *Yintang* (Du 29), Fengfu (Du 16), Dazhui (Du 14), Neiguan (P 6) and Sanyinjiao (Sp 6), three sessions per week for six weeks. The World Health Oganization Quality of Life Scale Brief Version showed a significant increase in the total scores of patients who underwent verum acupuncture and electro-acupuncture for 6 weeks compared with those who were given Paroxetine only; significantly increased physical domain and social relationship scores in verum acupuncture patients compared with Paroxetine only; and significantly elevated psychological domain scores with electro-acupuncture compared with Paroxetine only.

(Improvement in quality of life in depressed patients following verum acupuncture or electroacupuncture plus paroxetine: A randomized controlled study of 157 cases. NEURAL REGENERATION RESEARCH Volume 7, Issue 27, September 2012 *Neural Regen Res. 2012;7 (27) :2123-2129.* 2123. http://www.acatcm.com/professional-training/students-centre/download-centre/file/36-improvement-in-quality-of-life-in-depressed-patients-following-verum-acupuncture-or-electroacupuncture-plus-paroxetine

Daoqi Acupuncture Combined with Antidepressant for Depression

Tianjun Wang[a], Linlin Wang[b], Wenjian Tao[b], Li Chen[b]

[a] University of East London, UK; [b] Nanjing University of Chinese medicine, China

Abstract

Objective: To assess the effectiveness of Daoqi acupuncture combined with antidepressant for depression.

Methods: The 71 patients were randomly divided into two groups (random assignment of 2:1 respectively). The 45 patients in the acupuncture group were treated with acupuncture and SSRI and the 26 patients in the control group were treated only with SSRI. Changes in HDRS scale and factor scales were observed after one, two, four and six weeks of the treatment.

Results: There were significant differences in Hamilton Depression Rating Scale (HDRS) and factor scales between acupuncture treatment group and control group. The treatment group marked improved emotions, sleep and anxiety from the first week. After treatment of two weeks, there were significant differences in HDRS scale and factor scales of emotion, sleep, spiritual anxiety, somatic anxiety and cognitive handicap between treatment groups and control group. There were significant differences in HDRS scale and factor scales of emotion, sleep, anxiety between treatment group and control group. After treatment of six weeks, there were significant differences in HDRS scale and factor scales of emotion and anxiety between treatment group and control group. There were no significant differences in factor scales of sleep and cognitive handicap. Intervention of acupuncture showed improvement in the depression condition compared with SSRIs only.

Conclusion: Acupuncture combined with SSRIs can quickly improve depression condition and most of the other complaints surpass the intervention of SSRIs only. This rise continued throughout six weeks of management. Earlier intervention of acupuncture has positively contributed in the treatment of depression.

Key Words: Depression; Acupuncture; Daoqi; SSRIs; HDRS

Introduction

Depression is predicted to become the second leading contributor to disease all over the world by 2020, affecting at least 350 million people (WHO, 2012) and depression is the leading cause of disease burden for women in both high-income and low- and middle-income countries (WHO, 2008). Antidepressant therapy is one of the major treatments, represented by selective serotonin reuptake inhibitors (SSRIs), but still not satisfactory as there are unresponsive patients, undesirable side effects and delayed onsets (Arroll et al, 2005).

As one of the key complementary medicines, Acupuncture has been involved in the treatment and research of depression for more than 20 years (Meng et al, 2002). The application of acupuncture on depression is increasing (Barnes et al., 2007) and in general achieved significant clinical efficacy, but still questions remain in some areas (Pilkington et al, 2010. Smith et al, 2010).

This pragmatic randomised controlled trial aimed to assess the effectiveness of Daoqi acupuncture combined with antidepressant on the treatment of depression.

Subjects

Including criteria: 71 patients who were in line with the ICD-9 (The International Classification of Diseases Version 9) were recruited in April 2006 — November 2006 in Nanjing Brain Hospital (NBH) in-patient Department of Medical Psychology. The total score of first 17 The Hamilton Depression Rating Scale (HDRS) of participants were all more than 17, age 22-73 years. Excluding criteria was serious physical disease; brain organic diseases, alcohol and drug addiction and allergy, at least 1 month not served on hormone drugs, nerve blockers, and immune modulators.

Accordance with the order admitted, patients were randomized into acupuncture treatment group and medication group. Acupuncture treatment group total 45 cases, 11 males (24.4%) and 34 females (75.6%); mean age (52.2 ± 13.1) years; the first occurrence age less than 30 years was 5 cases (11.1%) ,31-50 years 18 patients (40.0%), more than 50 years 22 cases (48.9%); one single incidence of 21 cases (46.7%), recurrent disease 24 patients (53.3%). The control group, 8 males out of total 26 cases (30.8%) and 18 females (69.2%); mean age (52.1 ± 14.9) years; the first occurrence age less than 30 years was 4 cases (15.4%) ,31-50 years old 10 patients (38.5%), more than 50 years old 12 cases (46.1%); one single incidence of 12 cases (46.2%), recurrent disease in 14 patients (53.8%). The above information is analyzed by ANOVA in each group showed no significant difference ($P > 0.05$) and was comparable.

Methods

All the patients were prescribed one of following medication: fluoxetine, paroxetine, sertraline, citalopram, fluvoxamine or other SSRIs in the term of routine oral dose by a qualified specialist in the NBH. Based on the same above medication the treatment groups were combined with acupuncture intervention by one senior acupuncturist who was a registered Chinese medicine doctor and certified by the professional body in China. Two groups were all treated for 6 weeks. The study was approved by the ethics committee of Nanjing University

of Chinese Medicine.

The key points of treatment group were GV24 (Shenting), GV20 (Baihui), GV14 (Dazhui) and GV4 (Mingmen) which were applied to all the patients in the treatment group. Additional points according to Traditional Chinese Medicine differentiations: Liver depression and Spleen deficiency plus LR3 (Taichong), SP9 (Yinlingquan); Liver Qi stagnation plus LR3 (Taichong) LR14 (Qimen), Heart and Spleen deficiency plus HT7 (Shenmen) and ST36 (Zusanli), Liver and Kidney Yin deficiency plus KI3 (Taixi) and LR3 (Taichong). In addition, if insomnia and forgetfulness, plus HT7 (Shenmen) and An'mian; palpitation and chest tightness, plus PC6 (Neiguan); constipation plus ST25 (Tianshu) and ST37 (Shangjuxu) and et al.

The needles were used are size of 0.25x40mm (HUATUO Suzhou China) and depth of insertion was 1-3 cum accordance. After achieved Deqi needling sensation, Daoqi technique acupuncture has been applied for the key acupoints as following: The manipulation is lifting-thrusting and rotating the needle with light and smooth stimulation for a long time at: amplitude for 1-2mm, the needle rotated angle was less than 90 degrees and with frequency of 60-100 times per minute for 1-2 minutes. GV14 (Dazhui) and GV4 (Mingmen) were needled at sitting position for 5 minutes retention and then in the prone position for the other points. All other points needed Deqi sensation and retention were 30 minutes with once per day five days per week for 6 weeks.

Measurement and Statistic analysis

Test of HDRS scales and factor scales, including emotion (Factor 1, 2, 3, 7), sleeping (Factor 4, 5, 6), emotional anxiety (EA) (Factor 8,9,10) and body anxiety (BA) (Factor 11, 12, 13, 14, 16), cognitive handicap (CH) (Factor 15, 17), before the treatment as the baseline and after the intervention of 1, 2, 4, 6 weeks of treatment by a trained psychiatrist. Statistical analysis was applied by SPSS commercial statistics package (SPSS Inc., USA) and the mean of groups with ANOVA and t-test. A two-side P value of <0.05 was considered statistically significant.

Results

Both groups demonstrated comparable start HDRS scales and all the factor scales of emotion, sleep, emotional anxiety, body anxiety and cognitive handicap. After one week of treatment, the factor scales of emotion, sleeping, body anxiety and total scale of treatment group was significant improvement than control group ($P<0.01$). All the factor scales and total scale on treatment was significant better compared with medication group. The factor scale of cognitive handicap had no significant difference within two groups while the other scale was still significant different. When all the intervention completed after six weeks, the sleeping and cognitive handicap factor scales were no different. While other scales of acupuncture treatment group were still better than control group.

Table 1 Average HDRS factor scales and total scale for DQAT and control group over weeks

	Week	Emotion	Sleeping	E Anxiety	B Anxiety	CH	Total Scales
Control	0	5.92±0.25	4.46±0.28	2.50±0.13	7.03±0.26	2.16±0.12	22.07±0.33
Group	1	4.88±0.20	3.86±0.21	2.06±0.14	5.39±0.27	2.15±0.12	18.34±0.55
	2	3.20±0.21	3.08±0.23	1.84±0.12	4.04±0.30	1.93±0.16	14.09±0.45
	4	2.58±0.22	2.40±0.22	1.16±0.11	2.96±0.23	1.36±0.11	10.46±0.43
	6	1.92±0.21	1.88±0.20	1.03±0.15	2.26±0.30	1.06±0.12	8.15±0.35
Acupuncture	0	5.91±0.34	4.56±0.15	2.50±0.16	6.98±0.30	2.20±0.17	22.15±0.60
Group	1	4.48±0.24**	2.93±0.24**	2.10±0.20	4.04±0.40**	2.08±0.14	15.63±0.81**
	2	2.98±0.32**	2.02±0.21**	1.56±0.17**	2.74±0.26**	1.70±0.19**	11.01±0.59**
	4	1.98±0.14**	1.38±0.20**	1.11±0.12*	1.76±0.20**	1.39±0.20	7.62±0.28**
	6	1.21±0.24**	1.97±0.23	0.90±0.20**	1.13±0.21**	1.07±0.12	6.28±0.49**

* Significant difference in the average scale between two groups (*$P<0.05$, **$P<0.01$)

Discussion

Although a significant proportion (50–60%) of patients with depression does not fully respond to medication (Fava, 2003), antidepressant, as a sample of Selective Serotonin Reuptake Inhibitors (SSRIs), are the major medication and can successfully treat depression (Mann, 2005). Most of the patients in the in-patient wards of Nanjing Brain Hospital were prescription with one of the SSRIs as well.

The pragmatic RCT effectiveness trial compared the control group with conventional antidepressant and the treatment group with antidepressant combined with acupuncture; there was no non-treatment group. That was the day-to-day real practice and only in this pragmatic trial could benefit giving advices to the public health service guidance (Foster, 2007).

All the included patients were diagnosed with major depression and in a relatively serious condition as their HDRS total scales were all over 17. These serious cases cannot be treated by complimentary medicine only, such as acupuncture, as the medical ethics request (Smith et al, 2010).

Placebo or Sham acupuncture control study has the benefits of identifying different acupuncture interventions

but did not contribute to acupuncture specification efficacy (Molassiotis et al, 2012). They are not the real clinical practice and leading a long way to popularize to clinical practice. In addition placebo or sham acupuncture control designs were challenged by researchers particularly the TCM researchers and practitioners that they may cause ethical and practical dilemmas (Park et al, 2011). The study (Andreescu C, 2011) controlled group with 1-3 cm away of acupoint compared with standard acupuncture group both resulted in similar absolute and relative improvement in depressive symptoms could not negate the effectiveness of acupuncture on depression. In addition, the design of acupuncture combined with medication versus medication only could not be blind (Smith et al, 2010).

Acupuncture combined with antidepressant could quick launch the clinical effect, particular the emotion, sleeping, body anxiety and total scales, even from the first week of treatment. It could last the clinical responses till the last week of study. These founds were supported with a recent study (Guo et al, 2012).

The limitation of this study was small size of population and without a long term follow-up investigation.

References

WHO.(2012).http://www.who.int/mental_health/management/depression/who_paper_depression_wfmh_2012.pdf (Accessed 06/11/2012).

WHO,(2008).http://www.searo.who.int/LinkFiles/Reports_GBD_report_2004update_full.pdf (Accessed 06/11/2012).

Arroll B, Macgillivray S, Ogston S, et al., (2005). Efficacy and Tolerability of Tricyclic Antidepressants and SSRIs Compared With Placebo for Treatment of Depression in Primary Care: A Meta-Analysis. Annals of Family Medicine, 3:449-456.

Meng.FQ, Luo HC, Ureil H. (2002) Concepts, techniques and clinical application of acupuncture. Psychiatric Annals, 32:45-49.

Barnes, P.M., Bloom, B. Nahin R, (2008). National Health Statistics Report. Complementary and Alternative Medicine Use Among Adults and Children: United States, 2007. Centers for Disease Control and Prevention National Center for Health Statistics. http://friendsnippets.net/nchs/data/nhsr/nhsr012.pdf (Accessed 06/11/2012).

Pilkington K. (2010). Anxiety, depression and acupuncture: A review of the clinical research. Autonomic Neuroscience: Basic and Clinical. 157: 91–95.

Smith CA Hay PPJ, Macphersonl. (2010). Acupuncture for depression (Review), The Cochrane Library 2010, Issue 1. http://www.thecochranelibrary.com/userfiles/ccoch/file/Acupuncture_ancient_traditions/CD004046.pdf (Accessed 06/11/2012).

Fava M. (2003). Diagnosis and definition of treatment resistant depression. J Biological Psychiatry 53:649–659.

Mann JJ. (2005). The Medical Management of Depression. The New England Journal of Medicine. 353:1819-34.

Foster E N, Thomas E, Barlas P et al. (2007). Acupuncture as an adjunct to exercise based physiotherapy for osteoarthritis of the knee: randomized controlled trial. British Medical Journal, 335(7617): 436.

Molassiotis A, Bardy J, Fennegan JJ, et al. (2012). Acupuncture for Cancer-Related Fatigue in Patients With Breast Cancer: A Pragmatic Randomized Controlled Trial. Journal of Clinical Oncology (online). doi: 10.1200/JCO.2012.46.0436.

Park JJ, Bang H. (2011). Methodological advances needed in analysis and interpretation of sham acupuncture validation studies. Acupuncture Medicine, 29:168-169.

Andreescu C, Glick RM, Emeremni CA, et al. (2011). Acupuncture for the treatment of major depressive disorder: a randomized controlled trial. J Clin Psychiatry, 72: 1129–35.

Guo T, Wang Y, Sun L, et al. (2012). P02.99.Acupuncture combined with an antidepressant has a better effect on major depression: a multi-center, randomized, controlled clinical trial. BMC Complementary and Alternative Medicine 12(Suppl 1): P155.

Corresponding author and reprint:

Tianjun Wang PhD.
School of Health, Sports and Bioscience,
University of East London,
Stratford Campus, London, UK. E15 4LZ
(email: t.wang@uel.ac.uk)

导气针灸结合抗抑郁药治疗抑郁症的临床对照研究

王天俊[1]，王玲玲[2]，陈理[2]，陶文剑[2]
[1]东伦敦大学，伦敦 英国；[2]南京中医药大学，中国

摘要

目的： 动态观察导气针灸结合SSRI类药物治疗抑郁症对HAMD量表各症状群改善的差异。

方法： 71例住院抑郁症患者按照2:1的比例随机分为两组，针灸治疗组45例采用以导气针法为主的针刺结合SSRI类药物治疗；药物对照组26例单纯给予SSRI类药物治疗。分别观察两组治疗前及治疗1、2、4、6周后HAMD量表总评分和各因子分变化情况。

结果： 针灸治疗组HAMD总评分和各因子分改善显著优于对照组，且随治疗时间延长而保持此结果。治疗组从第1周开始就可显著改善各种情绪、睡眠和躯体焦虑症状；皮下针组在精神焦虑和认知障碍的改善上与对照组比较有优势。治疗2周后，治疗组在情绪、睡眠、精神焦虑、躯体焦虑、认知障碍因子分值以及总评分的改善上与药物对照组比较，均有极显著性差异。治疗4周后，针刺治疗组在情绪、睡眠、躯体焦虑因子分值以及总评分的改善上与药物对照组比较，有极显著性差异。治疗6周后，针刺治疗组在情绪、躯体焦虑因子分值以

及总评分的改善上与药物对照组比较，有极显著性差异；而两个组在睡眠和认知障碍因子分值的改善上已无显著性差异。结论：导气针灸针刺结合SSRI类药物可快速而明显地改善抑郁症患者各症状群，且此疗效可以保持到治疗6周后，针灸的及早介入对该病治疗无疑起到积极的作用。

关键词：抑郁症；针刺治疗；导气针法；SSR1类药物；HAMD量表。

针灸介入抑郁症的治疗与研究已经有20多年，取得了明显的临床疗效，也已经开始了机理的研究[1] [2]。但是目前多数的研究集中在针刺与电针上，对于其他的针灸治疗方法，涉及的比较少，更缺乏深入的研究。导气针法是传统的针灸临床常用的方法之一，但是还缺少相应的临床研究。为了探讨导气针法针灸对抑郁症的治疗作用及其优势，我们观察和比较了导气针法针刺结合选择性5-羟色胺再摄取抑制剂（SSRIs）对抑郁症患者汉密尔顿抑郁量表（HAMD）各症状群改善的差异，并与单纯使用该类药物作对照，现将结果报告如下。

1. 资料与方法

1.1 一般资料

71例病人均为2006年4月一2006年11月在中国南京脑科医院医学心理科住院病人，符合中国精神疾病分类方案与诊断标准 (CCMD III)[3]中抑郁症诊断标准，汉密尔顿抑郁量表（HAMD）前17项总分》17分，年龄22-73岁，排除严重躯体疾病、脑器质性疾病、酒精药物依赖及过敏体质者，至少一个月未服激素类药物、神经阻滞剂、免疫调节剂，按照入院先后顺序并已2:1 的比例将病人随机分为导气针法针刺治疗组和药物对照组。导气针灸治疗组45例中，男11例(24.4%)，女34例(75.6%)；平均年龄52.2±13.1岁；最初发病年龄在30岁以下5例(11.1%)，31-50岁18例(40.0%) ，50岁以上22例(48.9%)；其中单次发病21例(46.7%)，反复发病24例(53.3%)。药物对照组26例中男8例(30.8%)，女18例(69.2%)；平均年龄(52.1±14.9)岁；最初发病年龄在30岁以下4例(15.4%)，31-50岁10例(38.5%)，50岁以上12例(46.1%)；其中单次发病12例(46.2%)，反复发病14例(53.8%)。以上资料经ANOVA分析，各组间均无显著性差异(P>0.05)，具有可比性。

1.2 治疗方法

1.2.1 用药方法:

药物对照组选用氟西汀、帕罗西汀、舍曲林、西酞普兰、氟伏沙明等SSRI类药物中之一种，常规剂量口服。治疗组在对照组用药的基础上加用针刺治疗，两组均治疗6周。

1.2.2 针灸治疗方法

主穴：神庭、百会、大椎、命门。

辨证加减：肝郁脾虚加太冲、阴陵泉；肝郁气滞加太冲、期门；心脾两虚加心俞、足三里；肝肾阴虚加太溪、肝俞。失眠、健忘加神门、安眠；心慌、胸闷加内关；便秘加天枢、上巨虚等。

操作方法：针具与穴位处常规消毒后，均采用30号1.5寸毫针，缓慢刺入，主穴采用导气针法，要求：提插、捻转的频率每分钟约60－100次；捻转角度小于90度；提插幅度不超过1-2毫米；均匀地、和缓地边捻转、边提插；上提与下插、左转与右转的用力均匀、幅度、频率相等、速度缓慢、始终如一而有连续性。所有穴位得气后留针30分钟，每日治疗一次，每周共治疗5次，一共6周。

1.3 疗效评定

根据HAMD各因子分分类(情绪：第1、2,、3、7项；睡眠：第4、5、6项；精神性焦虑：第8、9、10项；躯体性焦虑：第11、12、13、14、16项；认知障碍：第15、17项)，分别比较各组治疗1、2、4、6周后HAMD总评分和各因子分值变化情况。参加评定的为经过量表系统训练的精神科医生，一致性测定kappa系统为0.87，然后分别计分。

表 1 治疗前 HAMD 量表评分比较 （分，x±s）

组别	n	情绪	睡眠	精神焦虑	躯体焦虑	认知障碍	总评分
药物组	26	5.92±0.25	4.46±0.28	2.50±0.13	7.03±0.26	2.16±0.12	22.07±0.33
针刺组	45	5.91±0.34	4.56±0.15	2.50±0.16	6.98±0.30	2.20±0.17	22.15±0.60

表 2 治疗后各组评价 HAMD 以及个因子分值变化

	周次	情绪	睡眠	精神焦虑	躯体焦虑	认知障碍	总评分
药物组	0	5.92±0.25	4.46±0.28	2.50±0.13	7.03±0.26	2.16±0.12	22.07±0.33
	1	4.88±0.20	3.86±0.21	2.06±0.14	5.39±0.27	2.15±0.12	18.34±0.55
	2	3.20±0.21	3.08±0.23	1.84±0.12	4.04±0.30	1.93±0.16	14.09±0.45
	4	2.58±0.22	2.40±0.22	1.16±0.11	2.96±0.23	1.36±0.11	10.46±0.43
	6	1.92±0.21	1.88±0.20	1.03±0.15	2.26±0.30	1.06±0.12	8.15±0.35

治疗组	0	5.91±0.34	4.56±0.15	2.50±0.16	6.98±0.30	2.20±0.17	22.15±0.60
	1	4.48±0.24**	2.93±0.24**	2.10±0.20	4.04±0.40**	2.08±0.14	15.63±0.81**
	2	2.98±0.32**	2.02±0.21**	1.56±0.17**	2.74±0.26**	1.70±0.19**	11.01±0.59**
	4	1.98±0.14**	1.38±0.20**	1.11±0.12*	1.76±0.20**	1.39±0.20	7.62±0.28**
	6	1.21±0.24**	1.97±0.23	0.90±0.20**	1.13±0.21**	1.07±0.12	6.28±0.49**

与对照组比较，*：P< 0.05，**：P < 0. 01

1.4 统计分析

将所获资料用SPSS13.0统计软件进行统计分析，组间均值比较用ANOVA及t检验。

2. 结果

各组治疗前HAMD量表评分比较，见表1。从表1可以看出，治疗前两个组的HAMD各因子（情绪、睡眠、精神焦虑、躯体焦虑、认知障碍分值以及总评分均无显著性差(P>0.05)，具有可比性。

两个组治疗后HAMD量表评分比较，见表2。治疗组从第1周开始就可显著改善各种情绪、睡眠和躯体焦虑症状。治疗2周后，治疗组在情绪、睡眠、精神焦虑、躯体焦虑、认知障碍因子分值以及总评分的改善上与药物对照组比较，均有极显著性差异。治疗4周后，针刺治疗组在情绪、睡眠、躯体焦虑因子分值以及总评分的改善上与药物对照组比较，有极显著性差异。治疗6周后，针刺治疗组在情绪、躯体焦虑因子分值以及总评分的改善上与药物对照组比较，有极显著性差异；而两个组在睡眠和认知障碍因子分值的改善上已无显著性差异。

3. 讨论

3.1 导气针灸结合SSRI类药物可明显改善抑郁症患者各症状群

本研究显示，与单纯药物治疗相比，导气针灸结合SSRI类药物从治疗的第一周开始就可以显著地改善情绪、睡眠和躯体焦虑症状，且这种优势可以保持到治疗的第6周；对于精神焦虑和认知障碍的改善，从第二周开始也有了明显的优势。针刺结合SSRI类药物的治疗也有类似的疗效，这与本人导师领导的研究小组以往的报道相类似 [4] [5] 。

3.2“调督”是针灸治疗抑郁症的有效方法

督脉通过主干及其分支与脑发生了直接与间接的联系，成为与脑联系密切、与各脏器联系广泛的经络。因此本研究继续了本课题组“调督理神”治疗抑郁症的大法，选用以督脉经穴为主的穴位处方[4][5]，分别针刺结合抗抑郁药物的方法，取得了显著的疗效，尤其是在快速取效方面要优于单独使用抗抑郁药物。本人导师课题组的另外一项动物实验也证实了头部督脉经穴“百会”“神庭”或其与四肢部经穴“内关”，“三阴交”结合，在改善抑郁症行为学方而存在一定的优势，尤其是在治疗的早中期[6]。

3.3 导气针法的特点及其治疗抑郁症的优势

导气针法源于《灵枢•五乱》，“徐入徐出，谓之导气，补泻无形，谓之同精，是非有余不足也，乱气之相逆也。”因为抑郁症患者的阴性证候决定了针刺刺激不能太强，抑郁症病人感知迟滞决定针刺感应不能太弱，抑郁症患者心理消极的特点又决定了针刺操作时间不能太短。因此导气针法低频率、小角度、小幅度均匀提插捻转，以产生柔和、舒适、持久的针感正符合了抑郁症患者的治疗要求，有其治疗抑郁症的优势。

3.4 针灸治疗的频次

针灸治疗的频率是临床经常遇到的一个问题，目前尚缺少相应的临床研究，比如针灸治疗抑郁症，不管是临床研究还是机理研究，目前国内基本上都是采用每日治疗的方法[6][7][8]，与西方国家每周1-2次的针灸治疗有明显的差异[9-11]。二者都可以产生积极的治疗效果，其原理尚不清楚，有待今后的进一步研究。

参考文献

[1] 罗和春，贾云奎，詹丽，等.电针治疗情感性精神病〔抑郁状态〕疗效观察. 中国针灸，1984, 4:1.

[2] Meng.FQ, Luo HC, Ureil H. Concepts, techniques and clinical application of acupuncture. Psychiatric Annals, 2002, 32:45-49.

[3] 陈彦方.CCMD III诊断标准. 济南:山东科技出版社，2001. 243.

[4] 吕梅，王玲玲，刘兰英，等. 针药结合治疗抑郁症的临床研究. 南京中医药大学学报，2004，20（3）：149.

[5] 刘兰英，王玲玲，吕梅，等. 电针结合SSRI类药物对抑郁症患者HAMD量表的影响. 四川中医，2005，23（7）：96.

[6] 张建斌，王玲玲，吕梅，等. 针刺不同输穴对抑郁症模型大鼠行为学的影响. 中国针灸2005，25（9）：639.

[7] 罗和春，Ureil Halbriech，沈渔饨，等. 电针与氟西汀治疗抑郁症疗效的对照研究. 中华精神科杂志，2003,36(4):215.

[8] 米希塔梁•淑沙尼克 (M khitaryan Shushanik)，指导：图娅. 电针与百优解对照治疗抑郁症的临床观察. 2006, 31 (4):242.

[9] 王天俊. 针刺治疗抑郁症临床观察.中国针灸，2005, 25(2)：107.

[10] Nassim P. Assefi,Karen J. Sherman,et al. A Randomized Clinical Trial of Acupuncture Compared with Sham Acupuncture in Fibromyalgia. Annals of Internal Medicine, 2005,143(1):10.

[11] Beatricf Knight, Catherine Mudge, Sheila Openshaw, et al. Effect of Acupuncture on Nausea of Pregnancy: A Randomized Controlled Trial. Obstetrics & Gynecology, 2001; 97: 184.

通讯作者：王天俊

Dr. Tianjun Wang,
School of Health, Sports and Bioscience,
University of East London,
Stratford Campus, London, UK. E15 4LZ
(email: t.wang@uel.ac.uk).

The Effectiveness of Acupuncture for Lower Back Pain - A Clinical Study

Qinglin Yang

Abstract: According to 'Huangdi Neijing Suwen, Lingshu' and TCM basic theory, this study was to investigate the effectiveness of Acupuncture on Dumai-Bladder Meridian Points (ADBMP) for lower back pain. 28 participants were selected in the study. The needles (size 0.25×25 mm) were inserted into the points of Dumai-Bladder meridians perpendicularly to the depth of 0.5 cun without rotation and pistoning for de qi. The needles were retained for about 30 minutes. Treatment was given two sessions in first week and then once a week for a total of 10 sessions. The results showed that ADBMP can help reduce the severity and duration of back pain and leg pain. It was effective for muscular disorder, disc disorder, osteo- disorder and sciatica. The total effective rate was 82.14%, with the significant effective rate being 67.86% (19 cases), effective rate 14.28% (4 cases), and ineffective rate 17.86% (5 cases). In conclusion, ADBMP is a safe and effective way to treat lower back pain, easy to learn and implement, and also easy to be accepted by the patients.

Key Words: Acupuncture, Lower back pain, Dumai-Bladder meridian points.

Introduction

Lower back pain may affect anyone at any age. It is the UK's leading cause of disability and one of the main reasons for work-related sickness absence. The condition affects more than 1.1 million people in the UK, with 95% of patients suffering from problems affecting the lower back. Costs NHS and community care services more than £1 billion each year (British Acupuncture Council 2011). Therefore, how to relieve lower back pain becomes an important subject. There are some ways to help patients to alleviate lower back pain, such as exercise, drugs, massage, acupuncture, physiotherapy, etc. Acupuncture is a different method for treating lower back pain, which involves puncturing different points on the different meridians. We need to find out which way is the best way for relieving lower back pain, which one is more safe and economic, which way is preferred by patients.

This research aims to investigate that if acupuncture therapy is an essential treatment for low back pain, introduce the treatment method of ADBMP, including muscular pain disorders, disc and facet segment degeneration; herniated disks and osteal problem, osteoporosis, spinal stenosis, lumbar hypertrophy, osteophyte formation and spondylosis with canal stenosis.

In the study, ADBMP comes from Suwen, Lingshu and Chinese classical medicine theory: "If the patient suffers from low back pain, --- cannot move the waist. Do acupuncture on point of condyles between the waist and buttocks." (Suwen Ciyaotong 41), "if the patient suffers from low back pain and feel cold on the back area, do acupuncture on the bladder meridian of foot-taiyang and stomach meridian of foot-yangming." (Lingshu, Zabing 26)

Method

This study is to investigate the effect of clinical application in puncturing acupoints on Dumai and bladder meridian (BL) to treat low back pain, and then further discuss its availability, feasibility and applicability. According to Charlotte Paterson's 'Measure Yourself Medical Outcome Profile' method (Charlotte Paterson, 1996), we designed MYMOP form 1, this MYMOP form 1 designed by Chinese medicine clinic doctors. It contained 18 questions, each question include 10 scores.

Participants

Eligibility criteria

Inclusion criteria:

- Clinical diagnosis of low back pain;
- Patients should have no acupuncture treatment and did not take any medicine for three months;
- Patients with long term low back pain had taken medicine for a long time without improvement;
- Patients had lumbar muscle injured, lumbar muscle degeneration, degenerative disc, herniated disc, thinning disc, vertebral stenosis and sciatic;
- Patients are over 18 years old, and under 70 years old;
- Patients can speak, read and write English.

Exclusion criteria:

- Referred pain from abdominal or pelvic organs, peripheral vascular diseases, urinary system diseases, etc;
- Spinal infection or tumors;
- Spinal fracture;
- Pregnant women;
- Under 18 years old or over 70 years old;
- Patients who are unable to consent to participate in the study will be excluded.

Table 1 General data

	N=28
Men	14 (50%)
Women	14 (50%)
Age(year)	49.75 ± 15.16

21-30 y	7.14%
31-40y	32%,
41-50y	10.71%
51-60y	25%,
61-70y	25%
History of back pain(month)	72.07 ± 93.88
History of damage	4 (14.29%)
Muscle disorder	5(17.85%)
Disc disorder	12(42.86%)
Osteal disorder	6(19.39%)
Unclear or other	5(17.85%)

The distributions of age, gender, disorder, sick time

28 patients attended this study. General data (See Table 1 and Figure 1)

In the figure 2, it shows the distribution of the disorder (See Figure 2)

Figure 3 shows the sick time of low back pain. It is normal distribution. Mean ± SD 72.07 ± 93.88 months. The longest one lasted 444 months, the shortest one only lasted for 1 month. (See Figure 3)

MYMOP Form1 was designed and used in the practice. It consists of 18 items, each scored by patient on a 10 point scale. Patients filled in the form before each treatment.

Interventions

All interventions comprised ten 30-minute sessions, generally 2 sessions in first week, then once a week.

The sterile disposable needles used for the patients. 0.25×25 filiform needles were inserted to a point by a depth of 0.5 Cun. No twirling of needle or stimulation, no induction of de Qi, and no moxibustion and electric heating. Twisting waist was recommended after treatment.

Selection of Acupoints:

Shiqizhui	Dumai	Yaoyangguan
Du3	Xiajishu	Dumai
Mingmen	Du4	Shenshu
BL23	Qihaishu	BL24
Dachangshu	BL25	Guanyuanshu
BL26	Chengfu	BL36
Weizhong	BL40	Chengshan
BL57	Huantiao	GB30

(Jin Shiying, 2006; Zhang enqin, 1990; Shi Xuemin, 2002; Qiu Maoliang, 1985)

Selection of needles: the filiform needle, size 0.25×25 mm.

Method: quickly put needles in the surface of the skin then slowly perpendicular puncture in 0.5 Cun. No rotating and pistoning for de qi, retain the needles for 30 minutes, and then quickly take it out.

Treatment: two sessions in first week, then once a week, total 10 sessions.

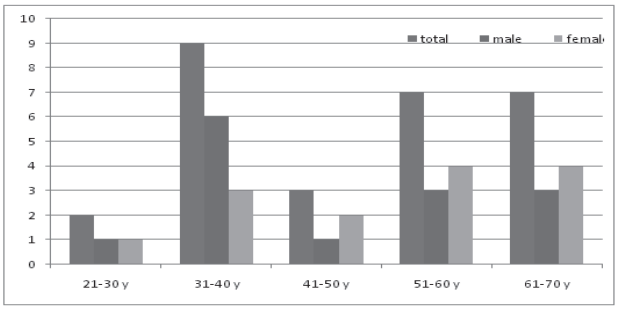


Figure 1 Age and gender distribution

21-30 (7.14%), 31-40(32.14%), 41-50(10.71%), 51-60(25%), 61-70 (25%)

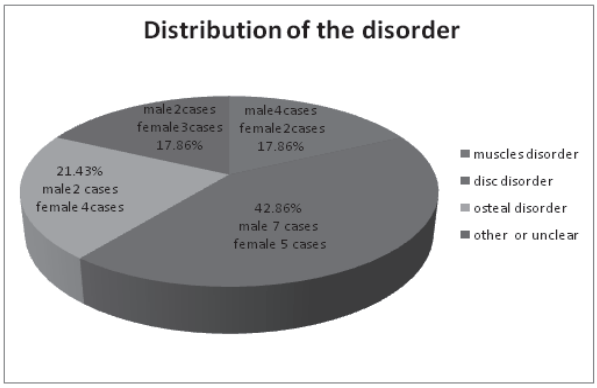


Figure 2 Distribution of disorder

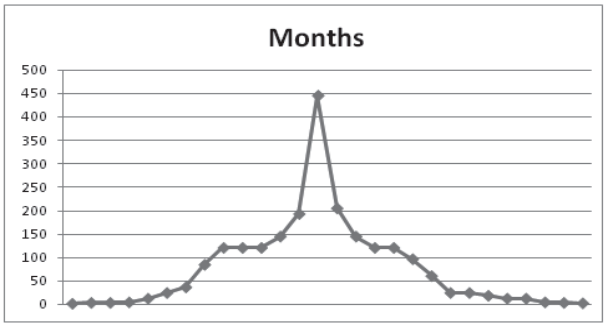


Figure 3 The sick time of the low back pain

Outcome measurement

On patient's arrival, fill in essential basic data and MYMOP (Charlotte Paterson，1996) form 1, check the patient's body condition, clinical diagnosis was low back pain. Chose the patient according to the include criteria and exclude criteria. Then do acupuncture for selected patients. All the patients filled in the files and the form 1 before each session of treatment, and with a total of ten times.

Data collection, safekeeping and Statistical analysis

Distribute advertisement on the window of clinic. The patients come after seeing the advertisement. Then patients filled in the essential files on first visit and the form 1 before every treatment. This study chose patients according to the inclusion criteria and exclusion criteria. Data kept in the clinic.

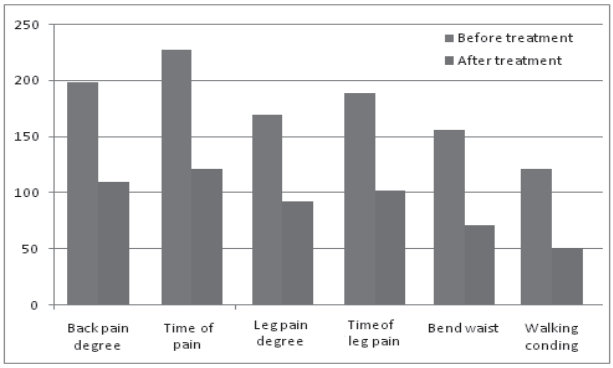


Figure 4 Compare main symptoms of before and after treatment (total scores)

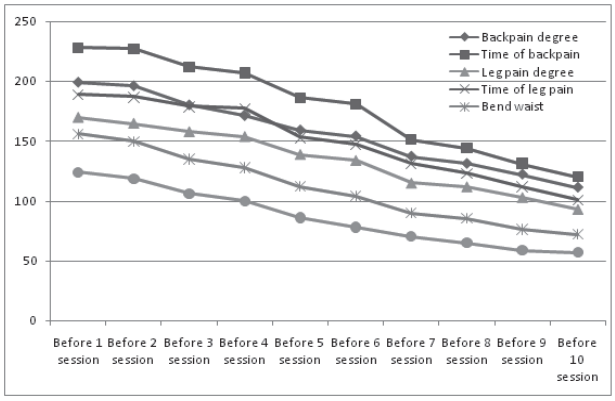


Figure 5 Total scores of main symptoms changes in different session

Table 2 Changes of main symptoms before and after treatment

	Before treatment	After treatment	HAD, P
Back pain degree	7.107 ± 1.012	3.929 ± 1.75	HAD = 2, P < 0.01
Time of pain	8.143 ± 0.953	4.357 ± 2.022	HAD = 3, P < 0.05
leg pain degree	6.071 ± 2.267	3.321 ± 1.774	HAD = 1, P < 0.01
Time of leg pain	6.750 ± 1.993	3.643 ± 1.797	HAD = 2, P < 0.01
Pain relief medicine	2.310 ± 2.155	0.785 ± 1.719	P <0.01
Numbness	3.821 ± 1.891	1.714 ± 1.729	HAD = 1, P < 0.01
Period of numbness	4.821 ± 2.403	2.071 ± 2.359	HAD = 1.5, P < 0.01
Bend waist	5.571 ± 2.145	2.536 ± 1.783	HAD = 2, P < 0.05
Walking condition	4.357 ± 2.594	1.821 ± 2.054	HAD = 1, P < 0.01
Lame	3.429 ± 2.691	1.143 ± 1.903	HAD = 1, P < 0.01
Rest after walk	1.964 ± 2.337	0.929 ± 1.944	HAD = 0, P < 0.01
Flexibility	2.357 ± 2.108	0.964 ± 1.592	HAD = 1, P <0.01
For work	1.179 ± 2.0	0.75 ± 1.883	HAD = 1, P < 0.01
Ability	1.071 ± 1.771	0.64 ± 1.493	P < 0.01

Data are given as mean ±SD; HAD: hypothetical average deviation

Table 3 Total scores of main symptoms changes in different session

	Low back pain	Time of LBP	Leg pain	Time of leg pain	Bend waist	Walking
1st sesion	199	228	170	189	156	124
2nd sesion	196	227	165	187	150	119
3rd session	180	212	158	179	135	106
4th session	171	207	154	177	128	100
5th session	159	186	139	153	112	86
6th session	154	181	134	147	104	78
7th session	137	154	115	131	90	70
8th session	131	144	112	123	85	65
9th session	122	131	103	112	76	59
10thsession	111	120	93	101	72	57

The primary analysis included all selected patients on the intent-to-treat basis. Microsoft office excel software

2003 (Chinese) and 2007 was used for statistical analysis, MYMOP changed scores had a normal distribution, T test and X2 test was used for the results.

Results

Between January 2012 and July 2012, overall 28 patients attended this study. 14 patients were men and 14 patients were women. 28 patients received 280 sessions of treatment in total, 10 sessions per patient.

Overall changes after acupuncture treatment

Changes of main symptoms (See Table 2). Total effective rate was 82.14% (23 cases), significant efficiency rate was 67.86% (19 cases), normal efficiency rate was 14.28% (4 cases), inefficiency rate was 17.86% (5 cases). (See Figure 4).

Progressive improvement with the acupuncture treatment course

The Table 3 and Figure 5, shown that 28 patients filled in scores about main symptoms at different sessions, and the changes of total scores with main symptoms at different sessions. (See Table 3 and Figure 5).

Influence of age to patients' responses to the acupuncture treatment

Reduce the degree of main symptoms and effective rate in different group (See Table 4, figure 6, 7).

Response to acupuncture treatment in LBP with different pathology

Muscular problem: Effective rate was 57.14%; Disc problem: Effective rate was 43.68%.

Osteal problem: Effective rate was 45%; unknown or other problem: Effective Rate was 33.33%. (See Table 5).

Table 4 Reduce main symptoms degree and effective rate in different age group

Symptom	Ages	Before treatment	After treatment	effective rate
Back pain	21 - 30y	7 ± 1.414	2.5 ± 1.5	64.29%
	31 - 40y	6.778 ± 0.741	3.333 ± 1.732	50.82%
	41 - 50y	7.0 ± 0.667	4.667 ± 0.444	33.33%
	51 - 60y	7.143 ± 0.735	4.571 ± 1.347	36%
	61 - 70y	7.571 ± 0.898	4.143 ± 1.592	45.28%
Leg pain	21 - 30y	5.5 ± 2.5	1.5 ± 0.5	72.73%
	31 - 40y	5.889 ± 1.9	2.556 ± 1.333	56.60%
	41 - 50y	6.333 ± 0.444	4.3 ± 0.444	31.58%
	51 - 60y	4.429 ± 2.0	3.286 ± 2.0	25.81%
	61 - 70y	6.857 ± 2.204 t	4.143 ± 1.102	11.11%
Difficulty of bending waist	21 - 30y	5.5 ± 2.5	1.5 ± 0.5	83.33%
	31 - 40y	5.889 ± 1.9	2.556 ± 1.333	51.28%
	41 - 50y	6.333 ± 0.444	4.3 ± 0.444	50.00%
	51 - 60y	4.429 ± 2.0	3.286 ± 2.0	51.28%
	61 - 70y	6.857 ± 2.204	4.143 ± 1.102	54.00%
Difficulty of walking	21 - 30y	4.5 ± 2.5	0 ± 0	100%
	31 - 40y	2.444 ± 1.506	1.0 ± 0.691	68.18%
	41 - 50y	4.333 ± 1.111	2.0 ± 0.667	53.84%
	51 - 60y	4.286 ± 2.612	1.531 ± 2.163	50.00%
	61 - 70y	6.857 ± 1.306	3.286 ± 1.551	52.08%

Data are given as mean ±SD; Effective rate: reduced score / before treatment total score × 100%

Table 5 Changes in different disorder

Diseases	Low back pain	Time of LBP	Leg pain	Time of leg pain
Muscular disorder	7.0 ± 0.7 to 3.0 ± 1.8 (P < 0.01)	8.0 ± 1.0 to 3.4 ± 2.3 (P < 0.01)	5.4 ± 2.8 to 2.4 ± 1.1 (P < 0.05)	6.8 ± 1.9 to 3.5 ± 1.9 (P < 0.05)
Disc disorder	7.3 ± 1.1 to 4.1 ± 1.6 (P < 0.01)	8.2 ± 1.6 to 4.5 ± 2.4 (P < 0.01)	6.3 ± 1.9 to 3.5 ± 1.9 (P < 0.05)	6.8 ± 1.9 to 3.5 ± 1.9 (P < 0.05)
Osteal disorder	7.3 ± 1.2 to 4.0 ± 2.3 (P < 0.01)	8.2 ± 1.6 to 4.5 ± 2.4 (P < 0.01)	6.7 ± 3.2 to 4.2 ± 2.0 (P < 0.05)	7.5 ± 2.5 to 4.5 ± 2.4 (P < 0.05)
Unknown or other	6.6 ± 0.9 to 4.4 ± 1.8, (P >0.05)	8.2 ± 0.4 to 4.8 ± 1.9 (P <0.05)	5.6 ± 2.1 to 2.8 ± 1.1 (P <0.05).	6.4 ± 1.9 to 3.6 ± 1.1 (P <0.05).

Data are given as mean ±SD.

Discussion

28 patients were selected for this study which including an equal number of male and female patients. There were two patients in the age group of 21–30,nine patients in the age group of 31–40, while three patients in the age group of 41–50, and seven patients in both age groups of 51-60 and 61-70.

ADBMP can reduce the degree and time of low back pain

ADBMP has an obvious effect on treating low back pain. It helped many patients to reduce the low back pain and leg pain, reduce the degree and suffering time of symptoms. Patients who suffer from muscular problem, disc problem, osteal problem and unclear problem in the lower back should consider ADBMP.

ADBMP may be more effective for the patients group with muscles problem, it reduced low back pain degree by 57.14%.It showed a similar effect in the patients group of disc problem and osteal disorder. It reduced the degree of lower back pain by 44.68% for the group with disc problem, 55.45% for the group with osteal disorder, and 33.33% for the group with unclear or other problem.

Muscular problems include acute muscular injury and chronic muscles problem. “Low back pain is common throughout the adult years in both men and women; first episode most frequently occur among people in their 20s and 30s.” (Kelsey JL et al., 1990)

Recovering from acute muscle injury is easy than chronic muscular problem. Acupuncture can help patients with chronic muscular problem by decreasing pain degree. In the study, one patient damaged her back when she was 10 years old, and she still fell the back pain after 37 years, the clinical diagnosis was lumbar muscle degeneration and L4/5 bulging disc. Her back pain improved a lot after 10 sessions of acupuncture, both the degree and time of back pain had reduced from 8 to 5, and the degree of leg pain had reduced from 7 to 5, and the time had reduced from 7 to 4.

ADBMP can treat long term low back pain

Patients usually recover very slowly after suffering back injury for more than 12 weeks. There are approximately half of those patients disabled for longer than 6 months before returning to work, and, the return-to-work rate is close to zero if suffered back problem for more than two years (Spitzer WO et al., 1987).

Some people think these patients would not be able to recover after been suffered from long term low back pain, especially after two years of absence from work. However, in my opinion, if proper treatment is applied, the problem can still be cured, therefore the patients can still return to work.

In the study, there are nine patients suffered from low back pain for over 10 years, three patients for over 5 years, one patient for over 3 years, two patients for over 2 years, and one patient for 37 years.

In the group of those nine patients whom suffered from low back pain for over 10 years, acupuncture reduced back pain degree from 7.222 ± 0.833 to 3.333 ± 1.936 ($P < 0.01$), reduced the time of back pain from 8.333 ± 0.707 to 3.889 ± 2.315 ($P < 0.01$), reduced leg pain degree from 6.333 ± 1.871 to 3 ± 1.581 ($P < 0.01$), reduced time of leg pain from 6.778 ± 2.167 to 3.111 ± 1.616 ($P < 0.01$).

The above data showed that ADBMP can treat long term low back pain, even for those suffered from low back pain for over 10 years or 37 years can still achieve curative effect.

ADBMP for patients with disc disorder

LBP is the most common symptom in the early stage of disk degeneration, which Kirkaldy-Willis called this as the stabilization phase. Impaired healing of the inter-vertebral disk due to its poor peripheral blood supply has been proposed as a possible explanation for the divergent behavior of this structure, which can produce chronic nociception. And also, the discovery of the biochemical factors that are responsible for causing increased sensitization of the disk and other pain-sensitive structures within the tri-joint construct will eventually explain the mechanism of this discrepancy (Anthony H wheeler. 2011).

In the clinical study, 12 patients suffer from disc disorder problem in total, nine of them had been admitted to the hospital, had checked by CT or MRS, and diagnosis with bulging disc, hernia disc, or/and degenerative disc. There was one patient had suffered from bulging disc, hernia disc and degenerative disc for as long as12years,

Prolapsed lumbar disc most often affects individuals in the age range of 25-45 years, rarely occurs in persons below 20 years old or over 65 years old (Kelsey JL et al., 1990).

ADBMP reduced the degree of low back pain from 7.250 ± 1.138 to 4.083 ± 1.564, ($P < 0.01$); Reduced time of low back pain from 8.167 ± 0.835 to 4.500 ± 1.977, ($P < 0.01$); Reduced the degree of leg pain from 6.250 ± 1.865 to 3.500 ± 1.865, ($P < 0.01$); Reduce time of leg pain from 6.750 ± 1.865 to 3.500 ± 1.883, ($P < 0.01$). Effective rate was 43.68%.

As above data showed that ADBMP can significantly reduce the degree of back pain and leg pain for patients with bulging disc or/and hernia disc. When the pain degree has reduced, this means bulging disc or/and hernia disc moved away from nerves, stopped pressing the nerves, so the patients suddenly feel more relaxed.

ADBMP help relieving symptoms for patients with osteal problem

In the study, all the patients with osteal disorder were old people, six patients’ average age was 69.67 years old. ADBMP reduced low back pain degree from 7.333 ± 1.211 to 4.0 ± 2.280, ($P < 0.01$), reduced time of low back pain degree from 8.167 ± 1.602 to 4.5 ± 2.429, ($P < 0.01$), reduced leg pain from 6.667 ± 3.204 to 4.167 ± 2.041, ($P < 0.05$), reduced time of leg pain degree from 7.5 ± 2.509 to 4.5 ± 2.429, ($P < 0.05$). Effective rate was 45%.

Above data told us that although ADBMP cannot cure the osteal problems, however, can help the patient to decrease the degree of low back pain and leg pain, decrease time of low back pain and leg pain, can reduce the symptom, improve patient’s movement and avoid taking the anodyne.

Conclusions

Scientists have concluded that the ancient Chinese practice of acupuncture works better than anything modern medicine has devised for the treatment of back pain. The findings add to evidence according to accumulated experiences over the past 10 years, which suggesting that the 4,000-year-old practice of acupuncture is an effective treatment for back pain.

Acupuncture can help patients get rid of low back pain, reduce the degree of lower back pain and leg pain, reduce the time of low back pain and leg pain, improve patients' life quality greatly. Nowadays, more and more study stated that acupuncture care is significantly more effective in reduce physical pain than usual care at 24 month follow –up (K J. Thomas, 2005). There are many different kind of acupuncture for low back pain, ADBMP is an easy way to be administered and can achieve good result. It is a safe method for patients. It can help all the patients whom suffer from low back pain and leg pain, either young people or old people, short term patients or long history patients, muscles disorder, disc disorder, or degeneration and nerves problems.

The efficacy of ADBMP is depends on the character of the disease, the term of problem, the age of patients. Degenerative problems are hard to be improved than other problems; structural change problems are difficult to be treated than functional changes problem; long term problems are hard to be recovered than short term problems; old patients' problems are hard to be treated than young patients' problems. However, patients with long history problems still have chance to get better and may even able to recovered completely, but they may need a longer term of treatment.

ADBMP can reduce the degree and time of lower back pain by stimulating the nerves located in the facial planes and muscles, the nerves in the connective tissue under the skin play a important role. The needles stimulate acupuncture points can induce the release of endorphins and other nerohumoral factors (Pomeranz, 1987, Zhao, 2008).

There were only 28 patients attended this study, and some patients had only been clinically diagnosed rather than confirmed with MRI scan. Therefore the diagnosis was not precise, the result may have deviation. The patients should be given another MRI scan once they completed their course of treatment, but we cannot do this for patients due to some limitation. The patients feel better with reduced symptom only, but we don't know the pathogenic changes. The design of the study, manipulation, the data collection and data analysis were administered by the same doctors.

This study is lack of data, the result should be further tested and identified in a larger study, Administer, data collector and data analyst should be different people rather than same person. The design should be further improved to suit clinical and patient's conditions.

References

[1] British Acupuncture Council. (2011). Back pain. Available at: http://www.acupuncture.org.uk/research-fact-sheets/1127-acupuncture-and-back-pain.htm [Accessed: 15/11/2011]

[2] Luying (2008), TCM four classics. The Yellow Emperor's Classic of Internal Medicine-Simple Question (Huang Di Nei Jing Su Wen). Shanxi science technologic press. Taiyuan.

[3] Luying (2008). TCM four classic. Yellow Emperor's Classic of Internal Medicine (Huang Di Nei Jing Linshu). Shanxi science technologic press. Taiyuan.

[4] Spiritual Pivot (Ling shu). People's Health Publishing House. Beijing,1963.

[5] Charlotte Paterson (1996). Measuring outcomes in primary care: a patient generated measure, MYMOP, compared with the SF-36 health survey. BMJ 1996; 1016-20. 20 April 1996.

[6] Jin Shiying (2006). Chart of meridians and points illustration. People's Health Publishing House, Beijing, China.

[7] Zhang Enqin. (1990). A Practical English-Chinese Library of TCM. Shanghai TCM University Press, China.

[8] Shi Xuemin.(2002). Acupuncture and moxibustion. New century TCM text book of universities. Traditional Chinese medicine press, Beijing, China.

[9] Qiu Maoliang (1985). Acupuncture and moxibustion. TCM text of universities. Shanghai science and technology press, Shanghai, China.

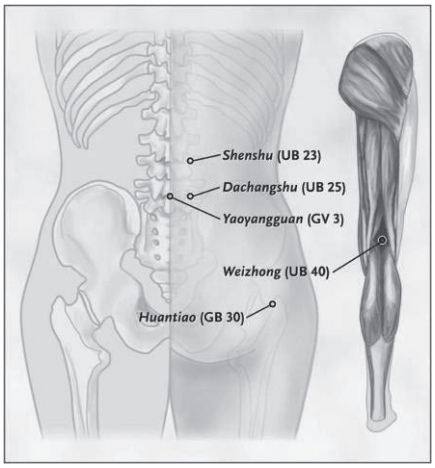
[10] Kelsey JL, Golden AL, Mundt DJ. (1990). Low back pain/prolapsed lumbar inter-vertebral disc. Rheumatic Diseases Clinics of North America [1990, 16(3):699-716]

[11] Spitzer WO, LeBlanc FE, Dupuis M, et al. (1987). Scientific approach to the assessment and management of activity-related spinal disorders: a monograph for clinicians. Report of the Quebec Task Force on Spinal Disorders. *Spine* 1987; 12: S1–S59.

[12] Rowbotham MC, (2001). What is a "clinically meaningful" reduction in pain? Pain 2001; 94:131–2.

[13] Jing Yuan, Nithima Purepong, Daniel Paul Kerr, Jongbae Park, Ian Bradbury and Suzanne McDonough. (2008). Effectiveness of Acupuncture for Low Back Pain A Systematic Review. SPINE Volume 33, Number 23, pp E887–E900 ©2008, Lippincott Williams & Wilkins

[14] Anthony H wheeler. (2011). Low back pain and sciatica. Updated: 16/05/ 2011,http://emedicine.medscape.com /article/1144130-overview [Accessed: 15/11/2011]



针刺疗法治疗腰痛的有效性临床研究

杨青林

摘要：根据《黄帝内经・素问・灵枢》和传统的中医理论，该研究讨论浅刺以督脉-膀胱经(ADBMP)为主的穴位治疗腰痛的效果。选择28个病患参与该研究。用毫针0.25mm x25mm针入督脉-膀胱经的穴位，深0.5寸，不提插捻转来获得得气的效果，保留30分钟。第一周治疗两次，以后每周一次，共10次。结果显示针刺以督脉-膀胱经为主的穴位治疗腰痛，能减轻腰痛与腿痛的程度和疼痛的时间。对有关肌肉、腰椎间盘、骨结构和坐骨神经方面的疾病均有效。总有效率82.14%，显效率67.86%（19例），有效率14.28%（4例），无效率17.86（5例）。此疗法治疗腰腿痛是一个安全有效的方法。易学易行，病人乐意接受。

关键词：针疗，腰痛，督脉-膀胱经， 0.5寸。

腰痛可发生在任何人的不同年龄时段。它是导致病人因病而停止工作的一个主要原因。在英国95%的人患有腰痛，超过一百一十万人，为此每年NHS花费至少10亿英镑(British Acupuncture council 2011)。 因此，如何治疗缓解腰痛成为一个重要的课题。治疗缓解腰痛的办法有很多：锻炼，药物，按摩，针灸，物理疗法，等等。针刺疗法也有多种，针刺不同的经络和穴位。我们需要找出一个好的方法来治疗缓解腰痛。找出一个安全有效，经济且病人易于接受的方法。

此研究试图探讨针刺疗法作为治疗腰痛的一个基本疗法，介绍针刺督脉-膀胱经治疗腰痛，包括：肌性， 椎间盘性，骨性问题，骨质疏松，腰椎肥大，椎管狭窄。

在此研究中，针刺督脉-膀胱经的穴位是根据《黄帝内经・素问、灵枢》和中医的传统理论：“腰痛----，不可以仰，刺腰尻交者。”（《素问刺腰痛篇第四十一》）“腰痛，痛上寒，取足太阳阳明。”（《灵枢杂病第二十六》）

方法

研究针刺督脉-膀胱经穴位治疗腰腿痛，进一步讨论它的有效性、可行性和实用性。病人是18岁以上70岁以下神志正常人。选择28例从2012年1月到2012年8月的病人。28例病人年龄18岁到70岁（平均值 ± 标准差 49.75 ± 15.16) 有长时间腰痛病史 (平均值 ± 标准差 72.07 ± 93.88 月) 资料收集在中医诊所。按照 Charlotte Paterson’s Measure Yourself Medical Outcome Profile method (Charlotte Paterson, 1996), 我们设计了MYMOP 表格 1, 它包含了18个问题，每个问题包含有10个等级，由病人填写。研究的方法和针刺疗法由中医师实施。

参与者

1. 筛选标准

（1）入选标准：

- 临床诊断为腰痛；
- 病人三个月内没有做过针刺治疗，没有服过任何药物；
- 病人长时间患腰痛，服药没有改善，仍疼痛；
- 病人有腰肌损伤、腰肌退行性改变、退行性腰椎间盘改变、腰椎间盘突出、腰椎间盘狭窄、椎管狭窄、坐骨神经痛；
- 年龄在18-70岁之间；
- 能够说英语，读、写英文。

（2）排除标准 ：

- 腹部、盆腔部反射性疼痛，周围血管性疾病，泌尿性疾病等；
- 椎骨感染、椎骨肿瘤；
- 椎骨骨折；
- 孕妇；
- 病人年龄在18岁以下，70岁以上；
- 病人不同意参与的。

2. 病人年龄、性别、患病时间分布

28个病人参与了这个研究，基本资料如下（见表1和图1）。疾病分布（见图表2）。图表3 病程长短分布，属正态分布，平均SD 72.07 ± 93.88（月），最长病程444个月，最短病程1个月。（见图表3）。MYMOP 表格包含18个项，每项有10个等级，由病人在治疗前填写。

	N=28					
男性	14 (50%)					
女性	14 (50%)					
年龄	49.75 ± 15.16					
	yr	21-30	31-40	41-50	51-60	61-70
	%	7.14	32.14	10.71	25	25
腰痛病史 （月）	72.07 ± 93.88					
损伤病史	4 (14.29%)					
腰肌性疾患	5(17.85%)					
腰椎间盘性疾患	12(42.86%)					
骨性疾患	6(19.39%)					

表1 基本资料

不清楚	5(17.85%)

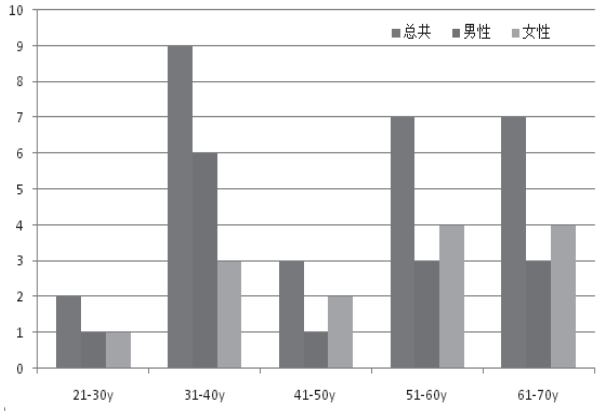


图 1 年龄性别分布

针疗方法

所有的针疗包含10次治疗，每次30分钟，第一个星期一周2次，以后每周1次。使用一次性消毒针，025×25毫针，刺入0.5寸，不捻转不提插得气，不使用灸法，不使用烤灯。治疗后建议作腰部活动。

穴位选择

命门	下极俞	腰阳关	十七椎
肾俞	气海俞	大肠俞	关元俞
承扶	委中	承山	环跳

(靳士英主编，2008， 张恩勤主编1996，石学敏主编 2002，邱茂良主编 1985)

针的选择：毫针0.25mm×25 mm。

方法：快速针入皮肤，再深入至 0.5寸，不捻转不提插，保持30分钟后， 快速拔出。

治疗：第一周每周2次 ，以后每周1次，共10次。

结果测量

当病人加入此研究后，填写基本资料和MYMOP 表1(Charlotte Paterson，1996), 检查病人的情况，临床诊断腰痛，按照入选和排出标准选择病人，给与病人针刺治疗，所有的病人在每次治疗前填写MYMOP 表1，共填写10次。

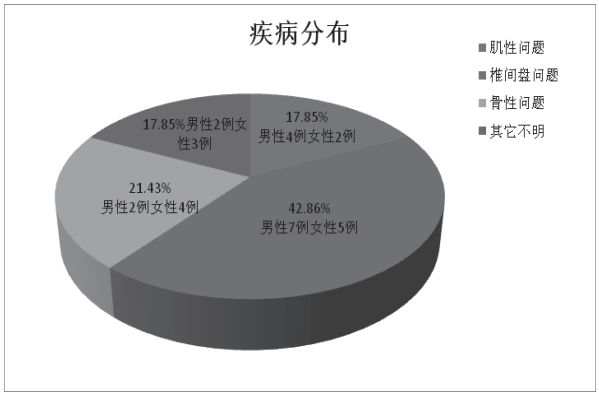


图 2 疾病分布

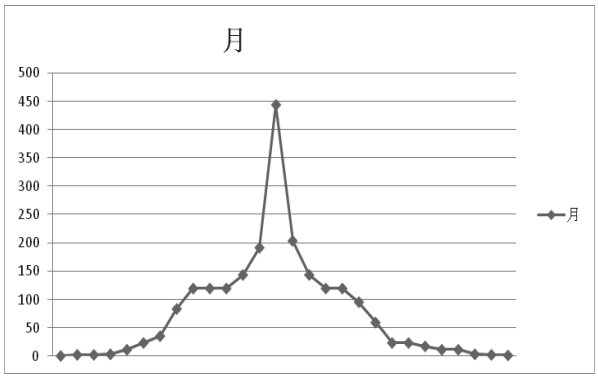


图 3 病程长短分布

资料收集、保存和资料分析

张贴布告。病人填写基本资料和MYMOP 表格，给与体查，做出诊断，符合标准选留，然后作治疗。每次治疗前病人填写MYMOP表格。完成资料收集和初步分析。分析使用微软2003和2007 EXCEL软件，做T-试验和卡方试验。

结果

2012年1月至2012年8月，28例病人参与了研究，男性和女性病人各14例。每个病人治疗10次。

针刺疗法治疗后改变

治疗前后的改变（见表2）。

总有效率82.14%（23例），显效率67.86%（19例），有效率14.28%（4例），无效率17.86（5例）。

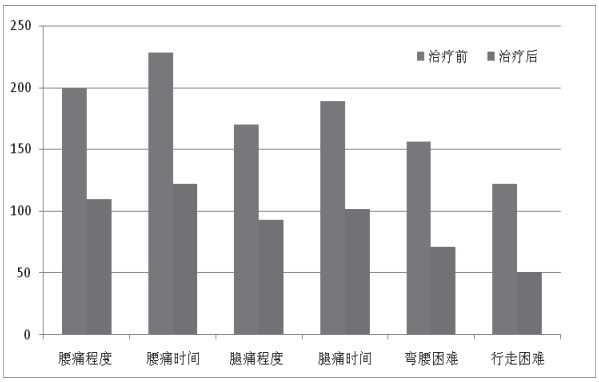


图 4 治疗前后主要症状比较

针刺疗法后的情况变化

在表3和图5中，每次治疗后28例病人主要症状的变化。

不同年龄的病人对针刺疗法的反应

显示不同年龄组减少主要症状和有效率（见表4和图6，7）

表2 治疗前后主要症状的变化

	治疗前	治疗后	HAD, P
腰痛程度	7.107 ± 1.012	3.929 ± 1.75	HAD = 2, P < 0.01
腰痛时间	8.143 ± 0.953	4.357 ± 2.022	HAD = 3, P < 0.05
腿痛程度	6.071 ± 2.267	3.321 ± 1.774	HAD = 1, P < 0.01
腿痛时间	6.750 ± 1.993	3.643 ± 1.797	HAD = 2, P < 0.01
服药止痛	2.310 ± 2.155	0.785 ± 1.719	P <0.01
麻木	3.821 ± 1.891	1.714 ± 1.729	HAD = 1, P < 0.01
麻木时间	4.821 ± 2.403	2.071 ± 2.359	HAD = 1.5, P < 0.01
弯腰困难	5.571 ± 2.145	2.536 ± 1.783	HAD = 2, P < 0.05
行走困难	4.357 ± 2.594	1.821 ± 2.054	HAD = 1, P < 0.01
跛行	3.429 ± 2.691	1.143 ± 1.903	HAD = 1, P < 0.01
行走后疼痛休息	1.964 ± 2.337	0.929 ± 1.944	HAD = 0, P < 0.01
腰部弯曲难度	2.357 ± 2.108	0.964 ± 1.592	HAD = 1, P <0.01
不能工作	1.179 ± 2.0	0.75 ± 1.883	HAD = 1, P < 0.01
不能自理	1.071 ± 1.771	0.64 ± 1.493	P < 0.01

- 数据：平均±标准差 Data are given as mean ±SD.
- HAD: 假设均差hypothetical average deviation

表3 不同次数治疗前主要症状点数的变化

	腰痛	腰痛时间	腿痛	腿痛时间	弯腰困难度	行走困难度
第 1 次	199	228	170	189	156	124
第 2 次	196	227	165	187	150	119
第 3 次	180	212	158	179	135	106
第 4 次	171	207	154	177	128	100
第 5 次	159	186	139	153	112	86
第 6 次	154	181	134	147	104	78
第 7 次	137	154	115	131	90	70
第 8 次	131	144	112	123	85	65
第 9 次	122	131	103	112	76	59
第 10 次	111	120	93	101	72	57

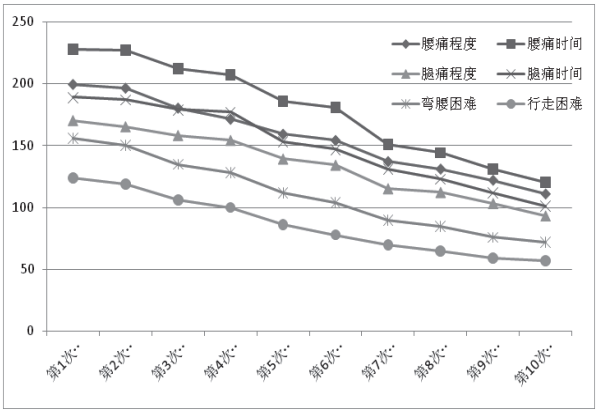


图5 治疗疗程中主要症状的改变

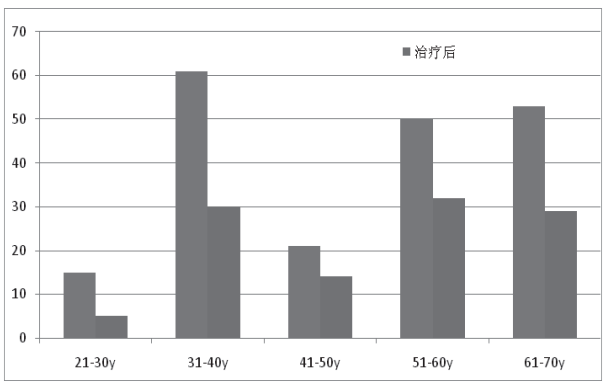


图6 不同年龄组治疗前后减少腰痛的对比

表4 不同年龄组减少主要症状程度和有效率

症状	年龄	治疗前	治疗后	有效率
腰痛	21 - 30y	7 ± 1.414	2.5 ± 1.5	64.29%
	31 - 40y	6.778 ± 0.741	3.333 ± 1.732	50.82%
	41 - 50y	7.0 ± 0.667	4.667 ± 0.444	33.33%
	51 - 60y	7.143 ± 0.735	4.571 ± 1.347	36%
	61 - 70y	7.571 ± 0.898	4.143 ± 1.592	45.28%
腿痛	21 - 30y	5.5 ± 2.5	1.5 ± 0.5	72.73%
	31 - 40y	5.889 ± 1.9	2.556 ± 1.333	56.60%
	41 - 50y	6.333 ± 0.444	4.3 ± 0.444	31.58%
	51 - 60y	4.429 ± 2.0	3.286 ± 2.0	25.81%
	61 - 70y	6.857 ± 2.204 t	4.143 ± 1.102	11.11%
弯腰困难	21 - 30y	5.5 ± 2.5	1.5 ± 0.5	83.33%
	31 - 40y	5.889 ± 1.9	2.556 ± 1.333	51.28%
	41 - 50y	6.333 ± 0.444	4.3 ± 0.444	50.00%
	51 - 60y	4.429 ± 2.0	3.286 ± 2.0	51.28%
	61 - 70y	6.857 ± 2.204	4.143 ± 1.102	54.00%
行走困难	21 - 30y	4.5 ± 2.5	0 ± 0	100%
	31 - 40y	2.444 ± 1.506	3.0 ± 0.691	68.18%
	41 - 50y	4.333 ± 1.111	4.0 ± 0.667	53.84%
	51 - 60y	4.286 ± 2.612	1.531 ± 2.163	50.00%
	61 - 70y	6.857 ± 1.306	3.286 ± 1.551	52.08%

- 数据显示：平均值 ±标准差.
- 有效率：减少的点数÷治疗前的点数× 100%

表 5 不同疾患治疗前后的变化

疾患	腰痛	腰痛时间	腿痛	腿痛时间
肌性问题	7.0 ± 0.7 to 3.0 ± 1.8 (P < 0.01)	8.0 ± 1.0 to 3.4 ± 2.3 (P < 0.01)	5.4 ± 2.8 to 2.4 ± 1.1 (P < 0.05)	6.8 ± 1.9 to 3.5 ± 1.9 (P < 0.05)
腰椎间盘问题	7.3 ± 1.1 to 4.1 ± 1.6 (P < 0.01)	8.2 ± 1.6 to 4.5 ± 2.4 (P < 0.01)	6.3 ± 1.9 to 3.5 ± 1.9 (P < 0.05)	6.8 ± 1.9 to 3.5 ± 1.9 (P < 0.05)
骨性问题	7.3 ± 1.2 to 4.0 ± 2.3 (P < 0.01)	8.2 ± 1.6 to 4.5 ± 2.4 (P < 0.01)	6.7 ± 3.2 to 4.2 ± 2.0 (P < 0.05)	7.5 ± 2.5 to 4.5 ± 2.4 (P < 0.05)
不清楚	6.6 ± 0.9 to 4.4 ± 1.8, (P >0.05)	8.2 ± 0.5 to 4.8 ± 1.9 (P <0.05)	5.6 ± 2.1 to 2.8 ± 1.1 (P <0.05).	6.4 ± 1.9 to 3.6 ± 1.1 (P <0.05).

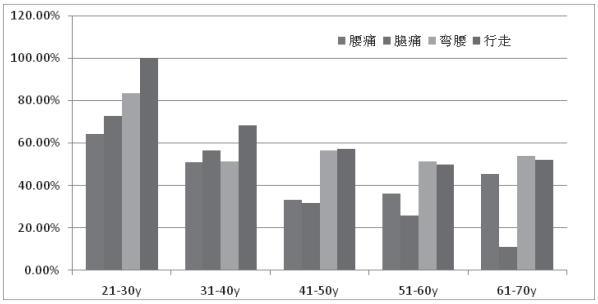


图7 不同年龄组的有效率比较

不同病因腰腿痛病人对针刺疗法的反应

肌性问题腰腿痛治疗有效率57.14%。腰椎间盘问题腰腿痛治疗有效率43.68%。 骨性问题腰腿痛治疗有效率45%。不明原因腰腿痛治疗有效率33.33%。(见 表 5)

讨论

28 例病人参与该研究。其中男性和女性病人各为14例。21-30岁组2例，31-40岁组9例，41-50岁组3例，51-60岁组和61-70岁组均为7例。

针刺督脉膀胱经穴位（ADBMP） 能减少腰痛程度和腰痛时间

ADBMP 治疗腰痛有效性是明显的，大多数病人减轻了腰痛和腿痛的程度与时间，患肌性问题腰痛，腰椎间盘性问

题腰痛，骨性问题腰痛，和不明原因性腰痛病人都有疗效。ADBMP 治疗腰痛，减少肌性问题腰痛程度 57.14%，减少腰椎间盘性问题腰痛程度 44.68%， 减少骨性问题腰痛程度55.45%，减少不明原因性腰痛程度33.33%。

患肌性问题腰痛的包括急性肌肉损伤和慢性问题。“成年男性和女性患腰痛很常见，首次发生通常在20-30岁。”(Kelsey JL et al., 1990)

急性腰肌损伤较慢性腰肌问题容易康复。针刺疗法能帮助慢性腰肌问题患者减轻疼痛程度，即便是损伤肌肉已经很长时间， 针刺疗法仍可以减轻疼痛程度。在这个研究中，其中一个病人10岁损伤背部肌肉，37年以后，仍有腰痛，临床诊断腰肌劳损和腰4/5椎间盘突出，治疗10次得到很大改善，减少腰痛程度从8到5，减少腰痛时间从8到5，减少腿痛程度从7到5，减少腿痛时间程度从7到4。

ADBMP 能治疗长期腰痛

腰部损伤12周以后恢复时非常慢的和不确定的。近半数病人在经过超过六个月以后不能重新工作，超过两年后重新工作的可能性几乎为零(Spitzer WO et al., 1987)。

积极地评价控制组，消极地评价治疗组，最小的临床差异基础线，应不小于20%，减少50%，可能更严格，但正如作者所指出的，减少病人50%的疼痛感觉，是病人认为的最大的改善。(Rowbotham MC, 2001, Jing Yuan et al., 2008).

有些人认为病人长时间患腰痛不可能治愈，患病停止工作两年后康复的可能性为零。也就是说患病停止工作两年不可能康复。本作者认为只要治疗正确，病人可以治愈，病人仍可以恢复工作。

在这个研究中，患病超过10年的9例，超过5年的 3例，超过3年的1例，超过2年的2例。其中1例已经患腰痛37年。

9例患腰痛的病人超过10年，在该组中减少腰痛程度从7.222 ± 0.833 到 3.333 ± 1.936, (P < 0.01), 减少腰痛时间程度从8.333 ± 0.707 到 3.889 ± 2.315 (P < 0.01)，减少腿痛程度从6.333 ± 1.871 到 3 ± 1.581 (P < 0.01), 减少腿痛时间程度从6.778 ± 2.167 到 3.111 ± 1.616 (P < 0.01)。

从以上资料显示针刺督脉-膀胱经穴位能治疗腰痛，超过10年的可以获得很好的疗效，超过37年的仍可以获得疗效。

ADBMP 治疗腰椎间盘性腰痛

腰痛是早期椎间盘退化常见的症状， Kirkaldy-Willis 称椎间盘退化早期为稳定期。 受伤椎间盘由于缺乏足够血液供应，产生慢性伤害，而且发现生物化学因子的作用造成椎间盘和其他组织敏感，能够解释腰痛的原因机制(Anthony H wheeler. 2011)。

在这个临床研究中，12例病人患腰椎间盘疾患，9例病人曾去医院作过体检和CT或核磁共振，做过诊断。曾诊断为腰椎间盘膨出、突出或椎间盘退化。其中1例患有腰椎间盘膨出、突出和退化12年。

椎间盘突出经常发生在25-45岁之间，较少发生在20岁以下或65岁以上(Kelsey JL et al., 1990)。

患腰椎间盘疾患的减少腰痛程度从7.250 ± 1.138 到 4.083 ± 1.564, (P < 0.01); 减少腰痛时间程度从8.167 ± 0.835 到 4.500 ± 1.977, (P < 0.01); 减少腿痛程度50 ± 1.865 到 3.500 ± 1.865, (P < 0.01); 减少腿痛时间从6.750 ± 1.865 到 3.500 ± 1.883, (P < 0.01)。有效率为43.68%.

正如以上资料显示针刺督脉-膀胱经穴位能使腰椎间盘膨出或突出病人减轻腰痛和腿痛程度，减少腰痛和腿痛的时间，当病人疼痛减轻时就是膨出或突出的椎间盘移动回位，不再压迫或接触到神经，所以病人顿感轻松。

ADBMP 帮助骨性问题的病人减轻症状

所有患骨性问题的病人都是老年病人，6例病人的平均年龄69.67 岁。骨性问题病人减少腰痛程度从7.333 ± 1.211 到 4.0 ± 2.280, (P <0.01)。减少腰痛时间从8.167 ± 1.602 到 4.5 ± 2.429, (P <0.01)。减少腿痛程度从6.667 ± 3.204 to 4.167 ± 2.041, (P <0.05)。减少腿痛时间从7.5 ± 2.509 到 4.5 ± 2.429, (P <0.05)。有效率45%.

以上资料显示虽然针刺督脉-膀胱经穴位不能根治骨性问题的腰痛，可以减轻病人腰腿痛的程度减少腰腿痛的时间，能减轻症状，得到缓解，避免药物。

结论

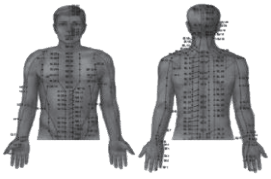
通过10年以上累积证据发现有4000年历史的针疗方法是治疗影响75-85%人的腰腿痛的有效方法，科学家们已经确论，在治疗腰腿痛方面，中国针疗方法优于现代医学方法。

针疗可以帮助病人摆脱腰腿痛，减少腰腿痛的程度，减少腰腿痛的时间，在生活和工作方面给予病人很大的帮助。现在，越来越多的研究表述在治疗后的24个月里，针疗方法在治疗身体疼痛方面明显优于通常的方法 (K J. Thomas, 2005)。治疗腰腿痛有很多种针刺疗法，针刺督脉-膀胱经穴位，是一个简单而行之有效的安全的方法。针刺督脉-膀胱经穴位能帮助所有的腰腿痛的病人，不论是年轻的还是年老的，不论是近期的还是长期的，不论是肌性问题的，还是椎间盘性的，骨性的，神经性的，都是有效的。

针刺督脉-膀胱经穴位的有效性取决于疾病的性质，病情的长短，病人的年龄。退行性病变较其他性质的病变难取得疗效，结构性病变较功能性病变难取得疗效。长时间的病变较短时间病变难取得疗效，年老的病人较年轻的病人难取得疗效。然而，长病史的病人可以康复，需要长时间的治疗。

参考文献

（详见英文稿）



中医与科学

杨青林

概要

中医是中国传统医学的一种，中国传统医学还有蒙医、藏医、苗医、羌医。

作者认为中医学是以中庸为根本，以阴阳五行、经络理论为基础，使用针灸、中草药为主要治疗手段，以健康长寿为目的，研究人体生理、病理、防病治病的一种综合性理论体系的学科。

中庸是中医的根本。中医学是一门学科，而不是科学，科学是检验真理的工具，不是真理。

关键词：传统医学，中医，中庸是中医的根本，科学是检验真理的工具

中医学的定义

什么是中医学？有很多人说中医学是中国人发明的，使用中草药的医学，这种说法是不全面的，我们现在的中医教科书对中医学的解释是：中医指中国传统医学，是研究人体生理，病理，以及疾病的诊断和防治的一门科学。这个说法也值得讨论。中国的传统医学还有蒙医、藏医、苗医、羌医。 在西方医学进入中国以前，中医被称为汉医。在西方医学进入中国后，才将汉医称为中医。按照中国全国科学技术名词审定委员会审定的名词，中医学是“以中医药理论与实践经验为主体，研究人类生命活动中医学中健康与疾病转化规律及其预防、诊断、治疗、康复和保健的综合性科学”。【1】这个定义是否准确呢？其它中国的传统医学也有阴阳平衡的概念，也使用中草药，也是以实践经验为主题。中国全国科学技术名词审定委员会给的中医定义，没有区别中医与其它中国传统医学的不同，如果说有提到中医药理论的词语的话，那么似乎是用中医学解释中医学。

五版教材《中医基础理论》中是这样给中医下定义的：中医学是研究人体生理、病理以及疾病的诊断和防治的一门科学，它有独特的理论体系和丰富的临床经验。中医学的理论体系是受到古代唯物论和辩证法思想——阴阳五行学说的深刻影响，以整体观念为主导思想，以脏腑经络的生理病理为基础，以辨证论治为诊疗特点的医学理论体系。【2】

新版《中医基础理论》给中医的定义：中医学是在中国古代元气论有机自然观指导下，主要以系统综合型意象思维方式，研究整体层次上的机体反应状态所形成的传统医学科学体系。【3】

中医是一门学科，而不是科学，它含有科学的部分和不科学的部分，中医学的精髓思想是不能用科学来解释的。中医必须整理，从中医学的名词解释开始，做到统一。大家可以来讨论，得到一个比较准确的解释。

中医者，乃中庸之医也。【4】作者认为：中医学是以中庸为根本，以阴阳五行、经络理论为基础，使用针灸、中草药为主要治疗手段，以健康长寿为目的，研究人体生理、病理、防病治病的一种综合性理论体系的学科。

为什么说中医是以中庸为根本？什么是中庸？中是不偏不倚，庸是固定不变。程子释云：“不偏之谓中，不易之谓庸。”【5】 中庸是坚持始终保持不偏不倚。不偏不倚也就是平衡，人体自身的阴阳平衡，人体与大自然的和谐平衡，人体与其它生物的平衡，都是中医讨论研究的课题。只有中医才以中庸为根本，其它的中国传统医学则不是。

我们作为中医工作者时刻要做到把中庸这个根本贯彻到言行之中，指导我们的工作，才能是真正的中医。我们是要坚持中庸，始终保持不偏不倚。脱离了中，脱离了不偏不倚，就是庸，那就不是中医，而是庸医。顺便提一下庸医的概念，我们经常说庸医害人，庸医误人，通常大家把庸医这个名词理解为医术低下的医生为庸医。医术低下的医生很大程度上会是庸医，因为水平低，很难做到不偏不倚，自然就是庸医了。水平较高的医生会不会成为庸医呢？也会的。在实际工作中要做到每时每刻每事都不偏不倚是非常难的，没有做到那就是脱离了中，只剩下庸，就是庸医。我们要时刻告诫自己要做中医，不要做庸医，就是这个意思。有些人似乎不是这样，不管什么病，也不管病人的情况，总是千篇一律，总是把上一个经验套用到下一个病人身上，那又怎么可能做到中庸呢？有些医生一开口就是吃点药吧，好象所有的病都得吃药，不吃药病就不能好。不吃药可不可以扎银针，不扎银针不吃药行不行，还是有其它办法可用的呀，这就是中医的思想。

中医与科学

现在有不少人对中医持怀疑态度，有些持反对态度，认为中医不科学，没道理，没疗效，要将中医废除。

当有人说中医不科学的时候，我们很多中医师急了，总是想如何证明中医是科学的。我们为什么一定要证明自己是科学的呢？让我们来看一看什么是科学，大家都知道中国字是象形字，什么是科？左边一个禾，是称，右边一个斗，《说文》“科，程也。”【6】程是度量衡的总名，科，从禾，从斗。科就是用秤称用斗量，稱是繁体字，简化字秤称异型同义， 科学就是用秤称用斗量的学问。 牛顿的三大定律科学不科学，大家都会说牛顿三大定律当然科学啦。是的，牛顿三大定律是科学的，但是牛顿三大定律在宇宙来说是错误的，在地球上来说有时是对的，是可称可量的，是科学的。我们来看牛顿的作用力和反作用力定律。作用力和反作用力相等，方向相反。按照此定律，我打你一下，等于你打我一下，作用力和反作用力相等，一个作用在我手上，一个作用

在你脸上。 如果你同意这个，那么请让我打你脸一下。你肯定认为这是不对的。为什么呢？因为作用力反作用定律没有考虑运动和质量的因素。爱因斯坦的相对论是科学的还是不科学的呢？是对的吗？爱因斯坦的相对论是不科学的，首先假设光的速度是不变的，许多的东西都是爱因斯坦想出来的，爱因斯坦提出光是可以偏折的，时间是可以被赶上的，当时就有非常多的人说爱因斯坦是个疯子，因为谁也没有见过光线偏折，谁也没赶上过时间。假设和想出来的东西是没有经过称量的，就是不科学的，而确实是对的。 现在已经证实爱因斯坦所想是对的，现在说他是伟人，而不是疯子。中医学的思想体系很多都是属于哲学的范畴，难道非要把属于哲学范畴的思想去称一称，去量一量？能够称，能够量就是对的，不然就是错的？爱因斯坦想出来的相对论可以被承认，为何我们前人实践得出来的中医的东西非要用科学这个框框去套呢？在西方也没有把哲学体系 放到科学体系里去称一称量一量，西方也没有说中医不对啊。西方在努力学习中医，很多医院都有针灸部门，很多大学都有中医药研究部门，对外是不公布的。媒体对外也都是报道负面的消息。

现在国内很多人都说中医不科学。而中医师们害怕别人说中医不科学，非要说中医是如何的科学。你们是不是觉得有点好笑。努力学习中医的是外国人，说中医不科学的是中国人，中国人甚至要取缔中医，而我们有些中医师却忙于证明中医是科学的。作者认为我们不需要证明中医是否科学，甚至我们可以大胆地说中医学很多地方是不科学的，而它是对的。我们一定要区分科学与正确。科学不等于正确。科学的东西不一定正确，正确的东西不一定科学，我们衡量事物不要动不动就用科学不科学来衡量。科学是工具，是我们用来检验真理的工具，实践是检验真理的唯一标准。许多科学的东西在更广阔领域是不对的。今天认为是对的东西可能在明天被证明是错的，今天认为是错的东西可能在明天证明是对的。我们中医师们为什么非要千方百计地证明中医是科学的呢？中医的精髓思想是不可以称不可以量的。但它是对的。

我们的责任

对于中医我们要抓紧时间去学，不要把它丢了，或让其他人赶在我们的前面。我们需要做的不是如何证明中医是科学的，而是要做到如何使我们每一个行医的人都成为真正的中医。如果我们的中医师个个都能像华佗、扁鹊、张仲景一样，人们佩服还来不及，如何有取缔的想法。华佗、扁鹊、张仲景是顶尖的大师，个个都如此是不可能的。北京中医学院的岳美中老师将中医师分成五等，中医师要熟读经书，熟悉和会运用经方和常用方剂，试问我们有多少人熟读了经书，我看人不多。就是把经书通读一遍的人也不多，有些人可能根本就没有读过。大家说连经书都没有看过的医师是中医师吗？是好的中医师吗？正是这样的人多了才会出现道理说不清，病也看不好的“医师”来，西医治得了的病他治不了，西医治不了的病他也治不了，甚至连试一下的勇气都没有。这样的“医师”病人怎么会相信呢？怎么能够相信呢？不相信的人多了，就有了要求取缔中医想法的人的市场，就会有要求取缔中医的闹剧。

我们可以被别人怀疑，甚至被别人反对，但关键的问题是自己要有东西可以拿出来，让怀疑的人相信，让反对的人拥护，这才是我们要做的。

参考文献

[1] 科技名词定义：中医学. http://baike.baidu.com/view/56220.htm (Visited on 06/09/2012)

[2] 印会河主编，《.中医基础理论》，高等医药院校教材- 五版，上海：上海科学技术出版社，1984年第1版，2005第40次印刷。

[3] 刘力红，《 思考中医》， 桂林：广西师范大学出版社, 2003。

[4] 朱熹，《 大学中庸章句》，中庸章句序. 宋淳熙十六年公元1189年。

[5] 刑玉瑞主编，《 中医基础理论》，新编21世纪高等中医药院校教材。西安：陕西科学技术出版社, 2005。

[6] 许慎撰，《说文解字》，汉， 公元121年.宋徐铉校定。

<英国中医针灸杂志>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。

所有来稿必须是尚未在其它杂志上发表过的文章，也不得同时投稿于其它杂志。若编辑审稿后认为需做明显改动，将会与作者联系并征得同意。本会刊保留版权，未发表的文章将不退稿。投稿一律以电子邮件发往 info@atcm.co.uk. 请注明“杂志投稿”字样。

下期来稿截至日期为 2013 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。

Call for Papers

The Journal of Chinese Medicine and Acupuncture (JCMA) is a bilingual TCM academic magazine, which is published twice annually in March and September. It is intended as a platform and a forum, where the journal concerning the profession can be developed, debated and enhanced from the greatest variety of perspectives. All of ATCM members, other TCM professionals and members of public are welcomed and invited to contribute papers for publication. The journal may feature articles on varies of topics, which including clinical experience, case studies, theory and literature, education and development, book reviews and research reports etc.

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.

All the submitted articles or papers must not being simultaneously submitted to other journals, and also have not been published in any other journals unless particularly specified. Submitted articles are reviewed by our editors. If the editors suggest any significant changes to the article, their comments and suggestions will be passed on to the authors for approval and/or alteration. JCMA maintains copyright over published articles. Unpublished articles will not be returned unless specifically arranged with the editors.

All the papers should be sent to the Editorial Committee via email info@atcm.co.uk. Please indicate "Paper for JCMA".

Deadline of submission for next Issue (Volume 20 Issue 2) is **10th August 2013**.

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

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 recommend to write case histories in past tense. eg, the patient had... (NOT is...)
(5) Use appropriate punctuation, there should be a space following a comma or full stop.
(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).
(9) All acupuncture points need to be named according to convention (Ki 7, Taixi).
(10) Illustrations/references from other sources should be numbered with a bracket, eg, [1] [2] [3].
(11) Referencing should be Harvard. Please ensure all dates and publishers' details are correct.

It should comply with the format as following:
Books: Author (year), Title. City: Publisher. Eg, Lewis R. (2004), The Infertility Cure. London: Little, Brown and Company.
Articles: Author (year), Title. Journal, Volume (Issue), pages. eg, Lei Chen (2003). Prevalence of metabolic syndrome among Shanghai adults in China. Chinese Journal of Cardiology, 31 (12), 909-912.

Welcome to China-Europe Forum on Cooperation and Development of Traditional Chinese Medicine (London, July 2013)

(London, 13th – 14th July 2013)

Dear Colleague,

We are delighted to announce that **The China-Europe Forum on Cooperation and Development of Traditional Chinese Medicine (London, July 2013**), or **LFTCM (London Forum of TCM)** for short, will be held in London on 13-14th July 2013. On behalf of the Organizing Committee we would like to invite you to this international academic event of traditional Chinese medicine (TCM). The joint hosts of LFTCM are The World Federation of Chinese Medicine Societies (WFCMS), The Association of Traditional Chinese Medicine and Acupuncture UK (ATCM), and Pan European Federation of TCM Societies (PEFOTS).

The LFTCM is a unique international academic platform for exchanging clinical experiences, broadening academic horizons and inspiring further development in the field of traditional Chinese medicine

The theme of LFTCM is "Traditional Chinese Medicine Benefits Human Health". The topics of presentations and workshops range from the study of TCM fundamental theory, clinical reports and experiences, scientific research of herbal medicine, acupuncture, moxibustion, tuina therapy and medical qigong, to the setting of standards for higher education and scientific study, the development of a global strategy of Chinese medicine, and legislation of Chinese medicine, etc. The treatment of pain-related diseases, TCM dermatology, and cancer management will be the focal points. The lectures and reports from many of the world-renowned Chinese medicine experts and scholars will be most appealing, and your personal participation will definitely contribute to painting this spectacular scroll of Chinese medicine.

For more information and registration, please visit www.lftcm.com. We look forward to meeting you in London in July 2013!

We welcome TCM professionals and medical scientists with interest in TCM research across the world to attend the LFTCM. For registration and paper submission, please visit www.lftcm.com. Or alternatively, you can email to ATCM office at info@atcm.co.uk for Forum Registration Form. The completed form should be sent via email or post to ATCM office at address given below. The forum registration fee should be paid to ATCM's bank account with details given in a separate sheet. Your registration will become valid only after we receive your registration fee in full. An early registration is highly recommended.

The Association of Traditional Chinese Medicine and Acupuncture UK
The Organizing Committee, London Forum of Traditional Chinese Medicine

ATCM, 5 Grosvenor House, 1 High Street, Edgware, London, HA8 7TA , The United Kingdom
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

For more information on LFTCM and registration, please visit www.lftcm.com

Registration Fee:

Before 30th April 2013: £325.00; after 1st May 2013: £365.00

The full registration fee covers all the costs on conference materials including paper proceedings CD, drinks with refreshments for 1.5 days, hot buffet lunch for 2 days, and a gala dinner on 13th July 2013. Hotel accommodation, travel fares including flight tickets, and sightseeing costs will be at the delegates' own cost.

ATCM/RCHM/BAcC members: £100.00, Students: £75.00 (gala dinner exclusive). An additional fee of £70.00 is chargeable for gala dinner.

Please go to www.lftcm.com for more information. You can click "Registration" to download the Registration Form. To register, you should fill in the form and email to info@lftcm.com or info@atcm.co.uk, or fax to 0044208 9513030.

Call for Papers

The China-Europe Forum on Cooperation and Development of Traditional Chinese Medicine (London, July 2013), or London Forum of TCM (LFTCM) for short, will be held in London on 13th -14th July 2013. The organisers of LFTCM call for TCM professionals and medical scientists with enthusiasm on research of TCM, in the UK or across the world, to submit papers to the forum.

The theme of LFTCM is "traditional Chinese medicine tackles various diseases", ranging from literature and theoretical study, exchange of practical experience, to evidence based research and clinical trials, with the following main topics:

1. Traditional Chinese Medicine and Cancer Treatment
2. Clinical Application and Research of TCM in Pain-related Diseases
3. Clinical Application and Research of TCM in Skin Diseases
4. Clinical Application and Research of Acupuncture
5. Clinical Application and Research of Chinese Herbal Medicine and Formulae
6. Traditional Chinese Medicine and Cancer Treatment
7. TCM Theory and Literature Study
8. TCM Internationalization, Standardization, and Patent Protection

Focal Areas: the study and treatment of TCM on pain-related diseases, skin diseases, chronic and geriatric diseases, and cancer management.

Submission Guidance

Full text papers:

All papers must be submitted via email as attachments, either in English or in Chinese. The attachment should be a Microsoft Word document. The word count is limited to 2500 words in English, or 3500 words in Chinese. For English submission, font should be Helvetica or Arial at 12 pt size. For Chinese submission, there must be an abstract in English.

We strongly recommend that the full text paper should be submitted as early as possible, this will allow the academic committee adequate time to select and edit the papers. Certainly an early submission of your full text paper will significantly increase the chance for your paper to be selected for the forum presentations. However, if delegates are not able to submit their full text papers soon enough, they should submit their abstracts first. In this case, they must submit their full text papers no later than 15th June 2013.

Abstracts

Abstracts must be submitted in English, with same font as for papers. Only submission through email attachment is acceptable. Abstracts should be no more than 300 words (in English). For those papers on clinical trial or scientific research, the abstract should be formatted according to the following headings:

1. Purpose
2. Patients (or materials) and methods, or methods (or similar heading)
3. Results
4. Conclusion

Email submission:
All full text papers and abstracts should be submitted directly to papers@lftcm.com or info@atcm.co.uk

Deadline for submission of papers/abstracts: 15th June 2013

欢迎参加中欧中医合作与发展伦敦论坛 (2013 年 7 月)

尊敬的各位中医同仁，

我们很荣幸欢迎您来到伦敦参加**中欧中医合作与发展论坛 (伦敦, 2013 年 7 月), 简称伦敦中医论坛(LFTCM)**。此次会议的共同主办者是世界中医药学会联合会(The World Federation of Chinese Medicine Societies, WFCMS, www.wfcms.org) 和英国中医药学会(The Association of Traditional Chinese Medicine and Acupuncture UK, ATCM, www.atcm.co.uk).

世界中医药学会联合会成立于 2003 年，总部位于中国北京，是唯一的和最高的全球性中医药学会团体。目前，它拥有来自 59 个国家的 209 个会员团体。世界中联会聚集了数以千计的中医药研究者和科学家，代表了世界最高的中医药研究水平。

英国中医药学会(ATCM)成立于 1994 年, 目前拥有 700 多名会员,是英国最大的中医专业团体。ATCM 所有的普通会员都是合格的中医师, 90%以上都拥有中国或英国正规大学课程的学士以上的学历, 其中不乏来自中国的高年资中医专家教授，主任医师等，代表着英国中医行业的最高学术水平。**伦敦中医论坛(LFTCM)**为交流临床经验，拓展学术视野以及激发传统中医药领域的进一步发展方面提供了一个独特的国际学术平台。

此次会议的演讲和研讨范围较为广泛，包括中医基础理论的研究, 中医药和针灸的临床报告和经验, 中草药，针灸，推拿治疗和医学气功科研, 中医针灸高等教育和科学研究的标准化, 中草药全球战略的发展以及中医立法。其中，疼痛相关性疾病，中医皮肤科, 慢性病和老年病,以及癌症的研究和治疗将是**重点内容**。我们尤其欢迎中医药和针灸等的循证临床验证等临床科研论文。这些讲座和来自世界著名的中医专家，学者的报告将是最吸引人的，而您的参与无疑将会为此次盛会锦上添花。

伦敦是世界著名的大都市，伦敦的建筑风景，风土人情，无不充满着悠久历史的辉煌沉积和生机勃勃的现代气息．相信各位代表这次在伦敦的短暂访问会给您留下美好难忘的记忆．

赵凯存医师
英国中医药学会会长
伦敦中医论坛组委会主席

沈惠军医师
英国中医药学会副会长
伦敦中医论坛组委会执行主席

欲获论坛详情和注册,请登录论坛网站 www.lftcm.com

ATCM, 5 Grosvenor House, 1 High Street, Edgware, London, HA8 7TA , The United Kingdom
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

注册费：

4 月30 日之前报名：325.00 英镑； 5 月1 日之后报名：365.00 英镑。注册费含：会议资料费、茶饮、两天的午餐(西式热餐)、7 月13 日的晚宴(西式)、会议场地费、设备使用费及翻译费。参会代表的酒店住宿，旅行费用如机票等，观光游览的开销等，将由代表自行支付。

注册：请访问论坛网站 www.lftcm.com(英文)或 www.lftcm.com/index cn.htm (中文)下载论坛报名表,请填写报名表并以邮件附件发往 infor@lftcm.com 或 info@atcm.co.uk 也可传真发往 0044 208 951 3030

论文征稿

伦敦中医药论坛组委会向英国，中国及世界各国的中医界同仁，及主流医学科学界热心中医药研究和开发德文科研人员征求学术论文，希望大家积极投稿，踊跃参加论坛。

大会征稿主题

伦敦中医药论坛的口号是 “中医药可有效防病治病”。论坛的学术内容主题，因而也是论文征稿的主题是：

1. 中医药和癌症的防治
2. 中医药防治皮肤病的临床经验和科学研究
3. 中医药防治疼痛类疾病的临床经验和科学研究
4. 针灸的临床应用和科学研究
5. 中药，方剂的临床应用和科学研究
6. 中医理论文献研究
7. 中医药高等教育和科学研究的国际标准化
8. 中草药全球战略的发展以及中医立法。

其中，疼痛相关性疾病，中医皮肤科，慢性病和老年病,以及癌症的研究和治疗将是**重点内容， 我们尤其欢迎中医药和针灸的循证临床验证**。

论文要求为英文或者中文,字数限定英文 2500 字, 中文 3500 字. 英文论文要求用 Helvetica 或者 Arial 字形 12 号字体. 中文文稿必须附有英文摘要（300 字以内）。根据论文的质量和学术价值，我们将择优选用作为论坛的主会场演讲，分会场演讲，或者会场墙报展示。对于没有被选用的论文，仍然有很好的机会被收入论坛论文集内。

我们希望论文投稿者尽最大可能在第一时间递交论文全文，如确有困难则可先递交论文摘要，随后及早补交全文。凡是临床试验和科研类的论文及中英文摘要，应该包含以下内容：

1. Purpose 目的；
2. Patients (or materials) and methods, or methods (or similar heading) 病人（或实验材料）和方法，或类似标题；
3. Results 结果；
4. Conclusion 结论。

论文投稿请一律用 WORD 文件以电子邮件附件发往论坛组委会英国分部，地址是 papers@lftcm.com 或 info@atcm.co.uk **论文征稿截止日期：2013 年 6 月 15 日。**

中欧中医药合作与发展论坛(伦敦，2013 年 7 月) （简称伦敦中医药论坛）是一个国际间中医药学术交流和合作的重要机会，在这里您可以充分展示您的学术水平，才华和地位，请不要错失良机。

英国中医针灸杂志编辑委员会 Editorial Committee of JCMA

主编：赵丽琴，范安杰
编辑：向阳，张超，George Cooper
本期编辑：赵丽琴，Andreas Feyler，沈惠军
版面设计：PCL Wollaston Print

Chief Editors: Liqin Zhao, Andreas Feyler
Editors: Yang Xiang, Chao Zhang, George Cooper
Editors of this Issue: Liqin Zhao, Andreas Feyler, Huijun Shen
Graphics: PCL Wollaston Print

英国中医药学会 The Association of Traditional Chinese Medicine And Acupuncture UK
地址 Address: 5 Grosvenor House, 1 High Street, Edgware, London, HA8 7TA, UK

电话 Tel: 0044 (0)20 8951 3030
传真 Fax: 0044 (0)20 8951 3030
电子邮件 Email: info@atcm.co.uk
网站 Website: www.atcm.co.uk

2013 伦敦中医药论坛（LFTCM）

London Forum of Traditional Chinese Medicine

LFTCM－2013

A unique international academic platform for exchanging clinical experiences, broadening academic horizons and inspiring further development in the field of traditional Chinese medicine worldwide.

英国伦敦市

London,United Kindom

2013年7月13日星期六- 7月14日 星期日

Saturday 13th – Sunday 14th July 2013

中医药能有效防病治病

Traditional Chinese Medicine Tackles Diseases

会场 Venue

英国皇家医学会
The Royal Society of Medicine, the United Kingdom

论坛详情、报名及投稿请访问：
For registration and paper submission, please visit:
http://www.lftcm.com

主办 Organisers

世界中医药学会联合会
World Federation of Chinese Medicine Societies

英国中医药学会
The Association of Traditional Chinese Medicine and Acupuncture UK

全欧洲中医药学会联合会
Pan-European Federation of Traditional Chinese Medicine Societies