ISSN: 1745-6843
Volume 20 Issue 2
第 20 卷 第 2 期

英国中医针灸杂志

The Journal of Chinese Medicine And Acupuncture

30th September 2013

PHOENIX

PHOENIX

Solution of Patent Products

中成药解决方案

根据近期英国药管局发布的最新通知：至2013年底所有无销售许可的成品中药将全面禁售，凤凰医药聚政策法规和药理专家团队之力，特别推出相应的解决方案，以协助您的诊所顺利经营。相关详情，敬请电话垂询。

Concentrated Herbal Granules
浓缩中药颗粒

先进的干式造粒工艺，浓缩比业界最高
经过GAP，GMP认证
全溶于水，口感出众
提供每批次重金属、农药及微生物残留的质检报告

DaoDi® Dry Herbs
道地生药饮片

道地原生药材，中华老字号药企鉴参出品
无硫磺蒸蒸处理
重金属、农药残留指标符合欧盟标准
提供每批次质检报告

Acupuncture & Accessories
精品针灸针及器械

27道生产，品管工艺造就的精品针灸针
铜丝柄，铜柄，铜丝缠绕柄，铜管柄，塑柄针等种类齐全
电针治疗仪，艾制品系列，TDP神灯

Nutritional Products
养生保健系列产品

跌打按摩油，养生保健胶囊，
药片制剂，功能茶包等

订货请声明

ATCM会员以获得特别优惠政策

- 英国医院系统NHS官方指定唯一中药供应商，参与英国医院中药临床科研活动；英国医药管理局质检中心实验室、英国药典委员会及皇家植物园认定中药样本提供单位。
- 我们的高浓缩配方颗粒及中药饮片均有完整生产档案，从正确种属鉴定到流程品质管理、重金属及农药残留指标完全符合欧盟规定，保证无硫磺熏蒸处理，是您临床疗效的根本保障，欢迎您及您的病患浏览我们的网站以获取您当前使用的产品质检报告。

凤凰醫藥

www.phoenixmd.co.uk info@phoenixmd.co.uk
电话：01245 350 822 传真：02145 267 001
地址：41 Beehive Lane, Chelmsford, Essex, CM2 9TQ

目录 Contents

英国中医针灸杂志编辑委员会 Editorial Committee of JCMA

英国中医药学会 The Association of Traditional Chinese Medicine And Acupuncture (UK)

地址 Address: ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ

电话 Tel: 0044 (0)20 8951 3030　　电子邮件 Email: info@atcm.co.uk

传真 Fax: 0044 (0)20 8951 3030　　网站 Website: www.atcm.co.uk

中医临床理论探讨 — 论中医学与月经不调

张恩勤（Engin CAN）

康泰诊所

摘要: 月经不调是妇女最常见的临床症情。本文首先以【黄帝内经】、【金匮要略】等中医经典著作为理论基础，结合现代医学对月经不调的研究成果，深入探讨了月经不调（月经先期、月经后期、月经先后不定期、月经过多和月经过少）的病因病机；继而阐述了月经不调之血热型、气虚型、血瘀型、血寒型、气滞型的临床特点和治疗方法。最后，根据中医学‘上工治未病’的思想，提出了月经不调的预防和护理方法。

月经乃子宫内膜的一种周期性、脱落性生理变化，一般每月一次，故称“月经”。一般说来，月经的初潮年龄是在10-16岁，一直延续到更年期，约45-55岁左右。月经周期平均时间是28天。但因个体的体质不同而有所差异，一般是24-35天左右。据英国有关资料统计，大多数妇女在其一生中经历大约500次月经。如月经的以上正常状态发生异常变化，即被视为“月经失调”。

在中医学中，“月经失调”是指月经的周期、经期、经量、经质、经色等发生异常的病理状态。

从临床角度看，中医学所讲的“月经失调”，包括了许多月经异常情况，如月经先期、月经后期、月经先后不定期、月经过多、月经过少等。事实上，绝大多数的妇女在其一生中，都曾或轻或重地经历过月经失调。

中医在治疗月经失调方面，拥有着丰富的理论知识和数千年的临床经验，确能有效地治疗月经失调的大多数症情。其治疗方法，主要包括针灸、中药、推拿和其他疗法。

病因病机

月经失调可由多种原因引起，如物理因素、情绪因素等。有时甚至由于一个十分简单的原因，如更换避孕药品种，都可引起月经失调。

雌激素和黄体酮有调节月经周期的作用。二者平衡紊乱是导致月经失调的最常见原因。激素失调可由多种因素引起，如体重过低或过高，过于剧烈的体力运动，压力过大或其他因素。此外，甲状腺激素有调节人体新陈代谢包括月经周期的作用。所以，甲状腺异常也是导致月经失调的原因之一。

中医学认为，月经的经血虽源出于子宫，但与整个人体的内脏、经脉、气、血，特别是与“肾气”密切相关。根据成书于公元前475-221年的中医经典著作【黄帝内经】记载，肾脏是与妇女的生理发育包括月经，关系最为密切。如【素问-上古天真论】云，“女子七岁，肾气盛，齿更发长。二七而天癸至，任脉通，太冲脉盛，月事以时下，故有子。…….七七，任脉虚，太冲脉衰少，天癸竭，地道不通，故形坏而无子也”。（1）此外，中医理论认为，肝脏、脾脏及其他内脏，也与月经的形成、排泄有关。

中医认为，月经不调可有以下因素引起：

1）情绪失调：如焦虑、压力、伤心、抑郁、烦躁，可引起肝气郁结，进而导致任冲二脉失调，甚至气滞血瘀， 发展为月经不调。

2）外邪内侵：如风、热、湿等邪侵入任冲二脉，影响气血运行，并引起肾、肝和脾的功能异常，进而发展为月经不调。

3）久病失养，或房劳过度，伤肾或伤血。

以上诸因素，均可致成血热、血瘀、血寒、气虚、气滞等基本病机，导致月经不调。具体地讲：

1）血热：可迫血妄行，使血溢于脉外，表现为月经先期或月经过多。

2）脾虚：不能统摄血液在脉管内运行而溢于脉外，导致月经先期或崩漏下血。

3）血瘀、血寒：均可导致血脉运行不畅，引起月经后期或经行不利。

4）肝郁气滞: 引起气血运行异常，导致经期或前或后，经期紊乱。

辨证分型

1. 月经先期

月经周期提前7天以上，甚至10余日，连续2个月以上异常的，称为“月经先期”。但是，如果仅提前3-5天，或偶然一次异常者，仍视为正常。

“月经先期”最早载于【金匮要略-夫人杂病脉证并治】，称“经一月再见”。（2）

中医学认为，导致月经先期的原因有邪热内侵，伤及冲任；或素体阳盛，过食辛辣，阴虚火旺；或肝郁化火，迫血妄行。或因脾胃虚弱，统摄无权，冲任不固所致。

西医学则认为，月经先期主要是子宫对性激素或卵巢对垂体促性腺激素反应异常，造成黄体功能不全致有排卵型的功能性子宫出血。健全的黄体功能与卵泡发育状态有关，卵

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

泡充分成熟，适时排卵与黄素化是导致健全黄体功能的重要元素。卵泡发育不良是导致本症的一个重要原因。（3）

2. 月经后期

月经延期7天以上，甚至更晚，连续2个月以上的，称为“月经后期”。偶尔一次月经延后的，仍视为正常。

“月经后期”始载于【金匮要略-夫人杂病脉证并治】称为“至期不来”。（4）

中医学认为，月经后期的原因有虚实两大类。虚者，如营血不足，血海不能按时满溢；或肾精不足，精不化血，经血不足。实者，如寒凝血瘀，痹阻血脉；或痰湿阻滞，气血运行受阻。

西医学认为，本症是由于体内外因素影响了下丘脑-垂体-卵巢轴的某一环节的调节功能，以致卵巢功能失调，性激素分泌紊乱，促卵泡成熟激素（FSH）相对不足，致使卵泡发育迟缓，卵泡期延长，不能届时成熟而排卵延后，月经后期而至；或因月经周期中不能形成促黄体生成激素（LH）高峰，卵巢不能排卵而致月经紊乱，表现为月经周期延后。（5）

3. 月经先后不定期

月经周期时而提前7-10天，时而延后7-10天，连续2个周期以上的，称为“月经先后不定期”。

“月经先后不定期”最早载于【金匮要略-妇人杂病脉证并治】，称为“经侯不均”。（6）

唐代名医孙思邈在【千金要方】“卷之二”更具体地描述为“月水或在月前，或在月后”。（7）

中医学认为，月经先后不定期主要是因情志不畅导致肝气郁结，疏泄失常，冲任不调，经血积蓄泄失常所致。其发生，也与肾、脾二脏的功能异常有关。

西医学认为，主要是由于下丘脑-垂体-卵巢轴功能紊乱，激素分泌或高或低。或因卵泡早期促卵泡成熟激素分泌相对不足，卵泡发育缓慢，不能届时发育成熟，排卵延后，而致月经延后；或虽有排卵，但促黄体生成激素分泌峰值不高，致使排卵后黄体发育不全，过早衰退，月经提前而至。（8）

4. 月经过多

月经周期、经期正常，但经量明显多于既往者，称为“月经过多”。

最早载于【金匮要略-妇人杂病脉证并治】，称为“月水来过多”。（9）

中医学认为，本症可由多种原因引起，如气虚（脾虚）不能统摄血液在脉管内正常运行而溢于脉外；或邪热入血，迫血妄行，血溢脉外；或淤血内阻，新血不得归经。

西医学的功能性子宫出血、子宫肥大、盆腔瘀血症、慢性盆腔炎、子宫肌瘤以及宫腔内节育器等导致的月经过多时，属本症范畴。认为是由于缺乏孕酮拮抗，子宫内膜不受限制的增生；与此同时，却无致密坚固的间质支持，致使组织脆弱，易自发溃破出血。无孕激素作用的子宫内膜中的血管缺乏螺旋化，不发生阶段性收缩和松弛，子宫内膜不能同步脱落，致使一处修复，另一处有破裂出血；不规则的组织破损和多处血管断裂，又因小动脉的螺型收缩不力，造成流血时间长、流血量多且不易自止。此外，多次组织破损活化了血内纤维蛋白溶解酶，引起更多的纤维蛋白溶解，血凝块不易形成，进一步加重了出血。（10）

5. 月经过少

月经周期正常，但经量明显少于既往，不足2日，甚或点滴即净者，称为“月经过少”。

“月经过少”最早载于【金匮要略-妇人杂病脉证并治】，称“在下未多”（11）。清代【女科百问】“卷上”则称之为“月假少者”。(12)

中医学认为，月经过少的病因，有虚实之不同。虚者，或因肾精虚损，精不生髓，髓不化血；或因脾胃虚弱，运化失常，气血化源不足。实者，因寒邪内侵，阻滞经脉；或因瘀血、痰湿内阻，经脉不通。

西医学也有月经过少之说，常见于幼稚子宫、子宫发育不良、长期服用避孕药或刮宫造成的子宫内膜损伤者。其发生，认为是因子宫发育不良、幼稚子宫、反复流产、子宫内膜结核、子宫内膜粘连等引起性腺激素或卵巢激素在释出或调节方面的暂时性变化，机体内部和外界许多因素，如精神过度紧张、恐惧、忧伤、环境和气候骤变以及全身性疾患如慢性消耗性疾病、贫血等，影响下丘脑-垂体-卵巢轴的相互调节，以致进一步影响激素的合成、转运及对靶器官的效应而致月经过少。（13）

临床表现

血热型：月经先期而至，或经来量过多，色鲜红，或深红，质粘稠，伴有烦躁口干，尿黄便结，舌质红，苔黄，脉数。

气虚型：月经提前而至，或经来量多，色淡，质稀，伴有神疲乏力，气短懒言，食少纳呆，面色萎黄，舌质淡，苔白，脉细弱。

血瘀型：经期延后量少，色暗有块，小腹疼痛，舌质紫暗或有瘀点，脉涩。

血寒型：月经延后，或量少，夹有血块，小腹冷痛，得温则减，肢冷恶寒，舌质淡暗，苔白，脉沉弦。

气滞型：月经先后不定，或前或后，或多或少，色暗或经行不畅，情绪不佳，时常叹气，胸乳胀痛，舌苔白，脉弦。

西医诊断

1. 患者自述有月经周期、经量、经色和经质异常的病史，或伴有其他症状。

2. 经妇科检查及其他检查，盆腔内无器质性病变。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

3. 必要时做B超、腹腔镜检查以及核磁共振检查等，以排除器质性病变。

中医治疗

1.针灸疗法

（1）体针

基本穴位：子宫穴，关元，中级，三阴交。

辅助穴位：血热，加曲池、合谷、血海；气虚，加气海、足三里、脾腧；血瘀，加血海、外关、肝腧；血寒，加百会、命门、大椎；气滞，加期门、太冲、外关。

针法：用毫针刺入所选穴位，留针30分钟左右。

血热、血瘀和气滞，用泻法；气虚、血寒，用补法，并加灸。

（2）耳针

盆腔，肾，肝，内分泌，脾。

针法：每次选3-6穴，用王不留行压豆法，每3天换新一次。

2.中药处方

(1) 血热型：

治则：清热凉血调经。

方剂：清经汤。

来源：【傅青主女科】，傅山，1827.

成分：黄柏9克，青蒿6克，牡丹皮9克，地骨皮9克，白芍9克，熟地黄9克，茯苓6克。

用法：将以上药放入砂锅内，先用冷水浸泡2-3小时，然后用文火煎煮25-30分钟，取汁；再加水少许，煎10-15分钟，取汁。两次所取药汁，混合在一起。早上服一半；晚上服一半。饭后1小时温服。

作者经验：以此方治疗“血热型”功能性子宫出血，确均有疗效。主要指征是“出血+血热症状”。出血过多时，加地榆10克，小蓟10克，仙鹤草15克。

（2）气虚型：

治则：补脾摄血。

方剂：归脾汤。

来源：同名方约有7首，始载于【济生方】，严用和，1253.

成分：白术9克，茯苓9克，黄芪12克，龙眼肉10克，酸枣仁10克，人参6克，木香6克，炙甘草3克，当归6克，远志6克。

用法：同上。煎时加生姜5片，大枣1枚。

作者经验：用此方汤剂治疗“脾虚型”功能性子宫出血，一般1-2周即获痊愈。出血重者，加蒲黄10克，仙鹤草15克，地榆10克，艾叶炭10克等，以助药力。病情控制后，可嘱患者继服归脾丸1-3个月，以维持长期疗效。

(3) 血瘀型：

治则：活血化瘀调经。

方剂：桃红四物汤。

来源：【医宗金鉴】，吴谦，1742。

成分：熟地黄9克，当归9克，白芍9克，川芎6克，桃仁6克，红花6克。

用法：同上。

作者经验：主要用此方加益母草30克、丹参15克等，治疗月经后期、月经量少和闭经；也曾用此方加减治疗一刘女士，患“血瘀型”功能性子宫出血，月经淋漓不断2个月，已先后去过多家医院就医，所给药物皆为止血类，但无效。本人用本方加生蒲黄10克，阿胶10克（另溶），黄芪15克等，服第一、二剂后，排除大量紫黑血块；服第三服后，竟获痊愈。此即对中医“瘀血不去，新血不得归经”之理论的验证。本人1978年在【山东医药】撰文《桃红四物汤加减治疗崩漏》，对该病例做过专门讨论。

(4) 血寒型：

治则：温经散寒调经。

方剂：温经汤。

来源：【金匮要略】，张仲景，公元三世纪。

成分：吴茱萸9克，当归9克，白芍6克，川芎6克，人参6克，桂枝6克，牡丹皮6克，阿胶9克，生姜6克，甘草6克，半夏6克，麦冬9。

用法：同上。

作者经验：本方为寒热消补并用，但以温养冲任为主。本人主要用此方治疗“血寒型”之月经后期、痛经和不育症，多数患者获效。此外，张氏介绍曾用本方治疗子宫发育不良。（14）

日本武谷雄二等试验证实，温经汤对排卵障碍和不孕症有效，但其详细机理尚未明确。本实验利用初级细胞培养系统研究了温经汤对垂体前叶的直接作用。实验表明，温经汤在垂体水平刺激促性腺激素的合成与释放，抑制催乳素的释放。温经汤刺激促性腺激素的作用似乎是增强了促性腺激素的对LHRH的敏感性。温经汤的这种作用可能与其临床疗效有关。（15）

(5) 气滞型：

治则：疏肝理气调经。

方剂：逍遥散。

来源：【太平惠民和剂局方】，太平惠民局，1151.

成分：柴胡9克，当归10克，白芍9克，白术9克，茯苓9克，炙甘草9克。

用法：同上。煎时加生姜3克，薄荷6克。

作者经验：以此方治疗肝郁气滞型“月经先后不定期”20余例，多数患者获效。还以此方丸剂+桃红四物丸，治疗气滞血瘀型“子宫肌瘤”2例，患者服药3个月后自觉症状消失。6个月后去英国医院检查，子宫肌瘤竟然消失。

李氏介绍，本方还可用于治疗慢性肝炎、肝硬化、消化性溃疡、乳腺小叶增生、围绝经期综合征、盆腔炎、不孕症、子宫肌瘤等。（16）

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

预防和护理

月经期间应保持阴部清洁卫生，避免精神压力过大、过度体力疲劳及在烈日下工作。经期不可游泳，不宜做妇科检查。

经期应注意腹部保温，不宜洗冷水浴，不可涉水雨淋、久坐湿地或在潮湿环境下工作。经期严禁性交。

月经期间应注意饮食，多吃清淡而富有营养的食物。不宜食用过于酸、辣或生冷食物。不宜过多饮用咖啡、茶、可口可乐等。

体重状态可影响月经。如果体重过低，激素就不能很好地发挥作用，甚至导致闭经。过于肥胖，又可引起激素代谢紊乱，引起月经失调。因此，应注意保持正常的体重，避免体重过低、过高。

参考资料

[1] 五连胜等，汉英对照【黄帝内经】，北京，中国科学技术出版社1997，9页。

[2] 阮继源等【汉英对照【金匮要略】，上海，上海科技出版社，2003，139页。

[3] 吴绪平等，【妇产科疾病针灸推拿治疗】，北京，中国医药科技出版社，2003,1页。

[4] 阮继源等【汉英对照【金匮要略】，上海，上海科技出版社，2003，139页。

[5] 吴绪平等，【妇产科疾病针灸推拿治疗】，北京，中国医药科技出版社，2003,7页。

[6] 阮继源等【汉英对照【金匮要略】，上海，上海科技出版社，2003，138页。

[7] 马宝璋等【中医妇科学】，上海，上海科学技术出版社，2006, 70页。

[8] 吴绪平等，【妇产科疾病针灸推拿治疗】，北京，中国医药科技出版社，2003,13页

[9] 阮继源等【汉英对照【金匮要略】，上海，上海科技出版社，2003，139页。

[10] 吴绪平等，【妇产科疾病针灸推拿治疗】，北京，中国医药科技出版社，2003,19页。

[11] 阮继源等【汉英对照金匮要略】，上海，上海科学技术出版社，2003,138页。

[12] 马宝璋等，【中医妇科学】，上海，上海科学技术出版社，2006,75页

[13] 吴绪平等，【妇产科疾病针灸推拿治疗】，北京，中国医药科技出版社，2003,24-25页

[14] 张庆云，【河南中医】1985；（6）:22 页

[15] Engin CAN（张恩勤），【经方研究】，济南，黄河出版社，1989, 801页。

[16] 李冀等，【方剂学】，北京，高等教育出版社，2006,52页。

“一分为三”学“中医学”

王以胜

北京同仁堂（英国伦敦）

摘要：“一分为三”方法论即“三元论”是古今中外人类文化的精髓、真谛，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。

关键词：一分为三，三元论，中医学，黄帝内经，阴阳，五行，辨证论治。

近年来，以胜倡导在“一分为二”方法论指导下，同时运用“一分为三”方法论来指导临床思维，就会更切合实际，更具有可操作性。

因为“一分为三”方法论（三元论）和“一分为二”（二元论）的“矛盾论”、“阴阳学说”一样，也是 “无处不在、无时不有”的一种哲学理念，是认识世界和改造世界、为人处事的思维方法论。

按照“一分为三”方法论，可以解决中医学许多理论和临床遇到的过去难以解决的问题，甚至导致以胜按照“一分为三”方法论来重新学习“中医学”知识而有新的认识和体会，认为有必要按照“三元论”哲学理念解释“中医学”，推出“一分为三”学“中医”，即重新认识和论述“中医学”，给“中医学”明确定义如下：

“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。

一．中国文化是中医学之母

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

“中医学”是“以中国文化为母体而构建的”：明确“中医学”的母体是中国文化。不学习中国文化，根本不可能学好“中医学”；学习中国文化，是学习中医学的必由之路，特别是中国古典文学知识。

翻开“中国医学史”，人们可以知道“中医学”实际上是伴随着中华古代文明而产生的精神文明，是古代许许多多中国人为了生存而进行的各种生产活动和社会活动之时，积累和验证“养生和治疗疾病”、保持健康的宝贵经验，再总结提高，升华到哲学层面，用中国文化的语言载体“汉字”记录传承下来的宝贵遗产。

世界上各种不同的“语言”和“文字”，都是各个民族经过长时间的社会生活和生产活动积累，形成不同的文化，记录和传承“文化”的“符号”就是“语言”（包括口头语言和书面语言）；因为“语言”是“人类文明”即“人类文化”的载体。“文化”是个“大的概念”，是人类社会各种活动的反映，是人类社会活动结晶的总的概括；各种不同地域的民族用不同的符号记录了这些文化而形成不同的“语言、文字”。“语言”和“文化”有密切相关性。以胜认为，“文化”包含了“语言”的全部，“语言”仅能表达“文化”的一部分。中国文化孕育了中医学；“中医学”是中国文化重要组成部分。现在绝大部分学者都认同“中医学是中国文化瑰宝”的说法。典型的例子，就是公元前221年秦王朝建立之后，统一“度量衡”，统一“文字”。为了建立统一而强大的秦王朝，秦始皇曾经“焚书坑儒”，但是他没有“焚医学书”，因为“焚医学书”等于自杀，会导致“人神共愤”，正常人都知道“医学书”能够“活人”，就是自命“天子”的皇帝和皇家子孙也需要“医学书”和医生为其服务。没有“焚医学书”、保留“医学书”又客观上保留了部分“中国文化”。以胜知道“先秦文化”即“春秋战国之前”的文化，由于“百花齐放、百家争鸣”而各种学术思想和诸子百家学说层出不穷，丰富多彩，为博大精深的中国文化奠定了深厚的基础。

中国传统文化是兼收并蓄的多元文化，就如近代著名学者梁漱溟先生所说：中国传统文化，如儒家文化，道家文化，佛家文化，皆系人类文化之早熟品。

“中医学”当然也是“人类文化之早熟品”。由于早熟，导致现代西方的科学技术和“西医学”理论还不能完全解释“中医学”的许多“奥秘”，反而“中医学”能够解决许多“西医学”认为没有办法解决的临床问题。其原因就是因为“中医学”是“以中国文化为母体而构建的”，而中国文化是“人类文化之早熟品”。

30多年前，以胜是第19届全国学联委员单位河南中医学院的校学生会主席，因为组织77级、78级同学共同编写《中医字典》，定稿后到北京中医学院请任应秋教授审稿和写序；在北京停留期间，通过“全国学联”安排，直接向原卫生部中医局吕炳奎老局长汇报全国中医药大学学生工作，并得到卫生部中医局对于学生工作的支持。后来以胜于1982年6月28日接到通知，将于7月25日参加全国学联委员会第二次会议（共59个委员）；于是以胜给前卫生部中医局吕炳奎老局长写信，告知此事。他于7月12日回信指出：

中医学*“是一门中国的科学，它的理论至今未被现代科学所突破。已引起国际上科学家的注意。国外的中医热，就在于中医的理论问题。认为中医的理论是系统的、完整的，一门宏观的科学，先进的科学。”*

以胜认为，中医学理论之所以“是系统的、完整的，一门宏观的科学，先进的科学”，就是因为“中医学”是“以中国文化为母体而构建的”科学。

中医学有一套比较完整的理论体系，这一套理论体系和中国文化密切相关，不了解中国文化，就不能理解中医学的真谛，也不会成为真正的中医师。

二. “阴阳、五行”是“中医学”说理工具

中医学以“阴阳”和“五行”学说为说理工具：“阴阳”和“五行”学说是中医学用以认识和解释人体生理现象和病理变化的“说理工具”，是中医理论体系的重要组成部分，就如明代中医学家张景岳所说：“为人不可不知医，以命为重也。而命之所系惟阴与阳，不识阴阳焉知医理？此阴阳之不可不论也。”

“阴阳”和“五行”学说起源于中国古代的传统辨证思想，如《易经•系辞》所说：“是故易有太极，是生两仪，两仪生四象，四象生八卦，八卦定吉凶，吉凶生大业，是故法象莫大乎天地；变通莫大乎四时；悬象着明莫大乎日月”。宋代周敦颐说：“太极动而生阳，动极而静，静而生阴，静极复动。一动一静，互为其根。分阴分阳，两仪立焉”。两仪即阴、阳。四象即“太阳、太阴、少阳、少阴”。对应到大自然，两仪即天、地。四象即“春、夏、秋、冬”。于是“四象生八卦”：乾、坤；震、巽；坎、离；艮、兑。分别表示天、地；雷、风；水、火；山、泽。

中华民族自古崇信“二元学说”，认为任何事物都具有“阴阳”对立而又统一的属性，，“阴阳”的内在联系和相互作用是事物发生、发展、变化的根源。正如《黄帝内经》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”。而且阴阳是相对的，即“阳中有阳，阳中有阴；阴中有阴，阴中有阳”。阴阳对立，互相制约、互为依存，相辅相成、相反相成，到“物极阶段”还会互相转化，就是“物极必反”：如《黄帝内经》所说“故重阴必阳，重阳必阴；寒极生热，热极生寒”。

“阴阳”学说具体运用到“中医学”也是“一分为三”：

1、说明人体组织结构：体表为阳、体内为阴；外侧为阳，内侧为阴；背部为阳，腹部为阴；上部为阳，下部为阴；腑为阳，脏为阴；脏腑各自又分阴阳，如心阴、心阳；肾阴、肾阳等等。

2、说明生理功能：机体的功能为阳，物质基础为阴。机体的正常生命活动就是“阴阳气血”相互协调平衡的结果，气属阳，血属阴。“阳化气、阴成形”、“气为血之帅，血为气之母”。

3、说明机体的病理变化：疾病就是机体阴阳平衡失常，出现偏盛偏衰的状态。即《黄帝内经》所说“阴胜则阳病，阳胜则阴病；阳胜则热，阴胜则寒”；“四时之变，寒暑之胜，重阴必阳，重阳必阴。故阴主寒，阳主热；故寒甚则热，热甚则寒。故曰：寒生热，热生寒。此阴阳之变化也”。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

关于“五行”学说，也是中华古人通过对大自然的长期观察，高度概括而提炼出来的哲学理念。以“金、木、水、火、土”相互之间的滋生、制约关系来说明事物之间的关系和关联性。

“五行”即“木、火、土、金、水”，最早出现在《周易》的《归藏易》中。因为“黄帝”兼号“归藏”，那时的《易经》就叫《归藏易》，它在《连山易》之后，在《周易》之前。

《归藏易》以地为首，八卦名称是“地、木、风、火、水、山、金、天”。八卦围绕一个“气”字，首先强调“天气归”、“地气藏”，而后是“木气生”、“风气动”、“火气长”、“水气育”、“山气止”、“金气杀”。这里的“地”，就是“土”。

关于“五行”的“行”，在《易经》的爻辞中出现过18次，其意是“动”。所以我们要用“运动、变化”的思维来学习“阴阳学说”和“五行学说”。

五行学说的基本内容即“生、克、乘、侮”：相生即帮助滋生，木生火，火生土，土生金，金生水，水生木。相克即抑制约束，木克土，土克水，水克火，火克金，金克木。而“相乘、相侮”就是“异常相克”：克制太过为“相乘”，反克为“相侮”。

需要明确的是：阴阳五行学说，是中医学的说理工具，中医师必须认真学习和熟练运用之，离开阴阳五行学说，中医学不能解释生理、病理、诊断、治疗。

三、中医学特色：“天人合一”、“辨证论治”

中医学是以“天人合一”和“辨证论治”为特色的中国医学。

世界各国都有自己民族的传统医学，但是经过几千年时间的考验，只有“传统中医学”完整地流传下来，其原因就在于中医学是以中国文化为母体、以阴阳五行学说为说理工具、以“天人合一”和“辨证论治”为特色的中国医学。

中医学理论认为，人必须与大自然相适应，与所处的自然环境、社会环境、人际关系环境相适应，机体才能保持健康状态。

如《黄帝内经》“三部九侯论篇第二十”所说：“天地之至数，始于一，终于九焉。一者天，二者地，三者人；因而三之，三三者九，以应九野。故人有三部，部有三候，以决死生，以处百病，以调虚实，而除邪疾。”这里是讨论脉象，也是“天人合一”；三部即“上部、中部、下部”，三候即“天、地、人”。

又如《黄帝内经》开篇“上古天真论篇第一”所说：“上古之人，其知道者，法于阴阳，和于术数，食饮有节，起居有常，不妄作劳，故能形与神俱，而尽终其天年，度百岁乃去。今时之人不然也，以酒为浆，以妄为常，醉以入房，以欲竭其精，以耗散其真，不知持满，不时御神，务快其心，逆于生乐，起居无节，故半百而衰也”。

中医学强调人必须和自然一致，注意“春夏秋冬”四时养生，注意“春生、夏长、秋收、冬藏”的自然规律，注意“春夏养阳，秋冬养阴”；《黄帝内经》“上古天真论篇第一”还说：“虚邪贼风，避之有时，恬淡虚无，真气从之，精神内守，病安从来。是以志闲而少欲，心安而不惧，形劳而不倦，气从以顺，各从其欲，皆得所愿。故美其食，任其服，乐其俗，高下不相慕，其民故曰朴。是以嗜欲不能劳其目，淫邪不能惑其心，愚智贤不肖不惧于物，故合于道。所以能年皆度百岁，而动作不衰者，以其德全不危也。”

中医学诊断治疗疾病主要是靠“辨证论治”，就是根据“望、闻、问、切”四诊合参，得到的病症信息，再根据“阴阳”、“五行”学说和脏腑经络学说，运用“八纲辨证”、“六经辨证”、“气血营卫辨证”、“三焦辨证”等不同的辨证方法进行“辨证论治”，“对症下药”。中医学治疗的是“病证”，不是“病名”。

例如，最常见的“感冒”，又称“伤风”，相当于西医学的“上呼吸道感染（鼻、咽、喉、扁桃腺炎症等）”。因为中医和西医的哲学理念、医学理论不同，导致二者诊断、治疗疾病的方法、结果不同。以胜25年前作为中国医疗队主治中医师在非洲行医时，与许多西医同仁进行学术交流，他们大都很诚恳地表示，不会治疗“感冒”，但是会治疗“感冒”导致的“肺炎”，因为可以使用抗菌素治疗“肺炎”，但是抗菌素对于病毒引起的感冒不仅无效，反而有害。

中医学对于“伤风、感冒”，从诊断到治疗，有一套比较完备的“理、法、方、药”，关键是“辨证论治”。近年来在英国，几乎每年都有“伤风、感冒”患者，有的久经不愈，或遗留咳嗽数周或一两个月，到不得已时才找中医治疗。

自从明代龚廷贤《万病回春》把感冒分为主要是“风寒、风热”两型之后，人们只知道“风寒、风热”，有些药厂也只是生产治疗“风寒、风热”的成药，临床上并不是这么简单两型。这仅是“八纲辨证”里的“寒、热”二纲而已。

在汉代张仲景《伤寒杂病论》已经提出“六经辨证”，并且推出许多有效的治疗方法。在宋代更是熟练地运用“六经辨证论治”治疗“伤风”，例如宋代陈无择还把“伤风”列为专题论述，在《三因极一病症方论•敍伤风论》里，明确提出，以“六经辨证”治疗伤风：

“太阳伤风”用“桂枝汤”；“阳明伤风”用“杏子汤”；“少阳伤风”用“柴胡加桂枝汤”；“太阴伤风”用“桂枝加芍药汤”；“少阴伤风”用“桂附汤”；“厥阴伤风”用“八珍汤”。

一个感冒病人，同时找十个中医大夫，可能开出十个不同的药方，就是因为每一个大夫的“辨证论治”思维不同，切入点不同，但是可能都有效，中医学的奥妙就在“辨证论治”。

（参考文献从略）

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Explanation on "Xue Bi" Syndrome in Jin Kui Yao Lue
《金匮要略》血痹之解释

Engin Can 张恩勤 Ming Zhao Cheng 程铭钊

'Xue Bi' syndrome was first described in the book 'Jin Kui Yao Lue' (Synopsis of Prescriptions of the Golden Chamber'), originally a part of 'Shang Han Za Bing Lun' (Treatise on Febrile and Miscellaneous Diseases) written by Dr Zhang Zhong-jing in the East Han Dynasty.

In Chapter 6 "On Pulse and Symptoms and Treatments of Xue Bi 血痹 and Xu Lao 虚劳" Dr Zhang Zhong-jing said that, "the patient suffering from 'xue bi' syndrome with weak pulse palpable both superficially and deeply on the 'cun' and 'guan' positions, a thin and tense pulse on the 'chi' position, and an external symptom is numbness of the limbs like that of 'feng bi' (wind paralysis)'.

On the reason of 'Xue Bi', Dr Zhang Zhong-jing said that, "powerful and wealthy people generally have weak bone and fat muscle. If they slept without cover after being exhausted with sweating, they could be attacked by slight wind; as a result, Xue Bi may occur."

Today, most of scholars believe that 'Xue Bi' belongs to categories of symptoms of peripheral neuritis and other conditions.

In Jin Kui Yao Lue, the formula for treating 'Xue Bi' is 'Huangqi Guizhi Wu Wu Tang' (Astragalus and Cinnamon Five Herb Decoction):

Ingredients

Huangqi (Radix Atragali seu Hedysari)	3 liang (9g)
Shaoyao (Radix Paeoniae)	3 liang (9g)
Guizhi (Ramulus Cinnamomi)	3 liang (9g)
Shengjiang (Rhizoma Zingiberis Recenns)	6 liang (18g)
Dazao (Fructus Jujubae)	12pcs

Original preparation and administration

Decoct the above ingredients in 6 sheng (1200 ml) of water until 2 sheng (400ml) remains. 7 ge (140 ml) is taken warmly, 3 times a day.

Actions of the formula

Tonifying qi and promoting the circulation of yang, and regulating functions of ying (nutrient qi) and wei (defensive qi) to treat numbness of limbs.

Current applications of Huang Qi Gui Zhi Wu Wu Tang

1. The formula can be applied to patients with rheumatoid arthritis, cervical spondylopathy, sciatica and peripheral neuritis manifested as numbness tingling of fingers and limbs.

2. Dr Zhang Hong-bin uses this formula for treatment of a female teacher, 31 years old, suffered from restless leg syndrome, manifested as distension and numbness of legs for 2 months. After taking 12 doses, all the symptoms cured (Enqin Zhang, Research in Classical Formulas, Yellow River Press, 1989: 677,)

Current pharmacological research

Dr Huang Zhao-sheng et al (2005) experienced Huangqi Guizhi Wu Wu Decoction and they found that this formula and its herb pairs could inhibit the acute inflammation induced by albumen and xylene and rat adjuvant arthritis, decrease the celiac capillary permeability, inhibit the proliferaction of granuloma, increase the pain threshold in mice and reduce the frequencies of body twist induced by acetic acid.

Conclusion

This formula has significant anti- inflammatory and analgesic actions, so does single herb: Radix Astragali alone, but when Radix Astragali is used with other herbs in this formula, its effect can be enhanced. (Huang Zhao-sheng, et al, Comparative study on the anti-inflammatory and analgesic actions of Huangqi Guizhi Wuwu Decoction and its compositions, New Herbal medicines and clinical pharmacological research, 2005, 2, 16:2 :93).

中医针灸治疗临床急症的体会

袁炳胜

Herbs & Acupuncture, Rotherham, UK

摘要：急症，是以急性昏迷、严重出血、高热、剧烈疼痛等为主要临床表现的病症，严重威胁健康，如缺乏及时有效的治疗，常常危及生命。在中国医学数千年的临床实践中，急症研究一直受到历代医家的高度重视。在缺乏现代实验室理化检查和临床支持疗法的情况下，中国历代医学家在急症诊断和救治方面，积累了极为丰富而系统的经验，并创造了诸如“胸外心脏按压”和“牵臂法人工呼吸”复苏术（汉《伤寒杂病论》，约公元210年）、利用葱管进行男性导尿术（唐《备急千金要方》，约公元652年）等急症诊疗技术。

笔者在二十多年来的临床工作中，曾多次以针灸中医药为主参与急症救治，获得了较为满意的效果，深感中医治疗急症，有着重要的临床意义，值得深入研究和推广。。

关键词：中医，针灸，急症，出血，中风昏迷，胆道蛔虫，治疗

概述

急症，是以急性昏迷、严重出血、高热、剧烈疼痛等为主要临床表现的病症，可因意外物理、化学或生物因素损伤，或慢性病症突发加重所致，常常带给患者难以忍受的身心痛苦，甚至严重影响心脑肺肾等重要脏器的生理功能，如缺乏及时有效的治疗，可能危及生命。笔者在20余年来的临床工作中，多次以针灸中医为主参与各科临床急症救治，获得满意疗效，兹以治疗（鼻）出血、（中风）昏迷、（胆道蛔虫）腹痛为例，介绍笔者治疗急症的体会，供同道参考。

临床案例

1. 鼻出血

Michael, 男，23岁。2010年11月14日晨8时于某地古董交易会门厅处，见其满面鲜血，自以纸巾堵塞双侧鼻孔，口中仍不时涌吐鲜血，不得不频取纸巾拭之，状甚窘迫。有保安人员为其取来一筒纸巾，任其取用。余见其情，遂前往询问。得知其曾有鼻出血史，每于冬季气候寒冷干燥易发。近日兼有感冒，咽干鼻塞。今晨冒凌冽霜风步行半小时来此，不料进门片时，即觉鼻内痒热，旋即热血汩汩涌出，已经持续10来分钟。既往有鼻出血及慢性肠炎、痔疮出血史。

诊断：鼻出血。证属胃肠湿热，外感风寒；复冒霜冷寒燥之气步行，身热血涌，与寒燥之邪相搏，鼻衄遂作。

治疗经过：急则治其标，当以止血为先。法用《百症赋》“天府合谷，鼻中衄血宜追”（1）之方。唯此时无针可用，乃以指代针。血出于左，取左天府合谷二穴，分别以双手拇指，取定二穴，其余四指，相对握其手与臂，相向均匀、深透用力，使力透穴位深部，一收一放，反复按压；并嘱放松，双足开立与肩同宽，缓慢腹式深呼吸，意在足底。

约2-3分钟，鼻中出血明显缓减，渐渐停止。继续按压3-5分钟，并点按上星、通天、孔最各1-2分钟，复按压天府、合谷3-5分钟许，出血完全停止。告4-6小时内切勿取出堵塞之棉球、清洗鼻内或揉按鼻部，以防牵动患处之血管引致再次出血。嘱次日来诊所复诊，并取中药善后。次日来告未再出血，与白茅根50克，旱莲草50克，桑叶15克，连翘12克，生甘草3克，7剂，水煎2次，早晚分服，随访1年无复发。

体会：患者青春年华，血气方刚，旧有慢性肠炎及痔疮，又有鼻衄病史，知湿、热久郁于阳明太阴；近日感冒，又晨冒风寒，步行赶路半小时，内热外寒，相搏于肺系。盖肺为五脏之华盖，通于天气，而鼻为肺窍，为人体与外界交通之门户，故首当其冲，发为鼻衄。

天府宣通肺气之郁，合谷通降阳明之热；又鼻为肺之外窍，手阳明通于鼻旁，是以取手太阴阳明此二穴，治鼻衄易于见功，古人用之有验，《百症赋》录以传世。笔者于2005年治疗重症鼻衄一例（2），亦取之以为主穴。针灸者，中医理论之临床实证也。百年来屡有中药有用中医理论无用之说，试想舍中医之理论，针灸之治疗，则何所谈起耶。

2．中风昏迷

仇母，80岁，1991年12月8日初诊。因突发昏厥，送入某西医医院内科，诊为脑出血伴梗塞、三期高血压脑病，经住院抢救治疗，并上级医院专家会诊治疗已一月，仍神智昏昧，不省人事，二便不通，饮食不入，迁延日久，诸医皆以为不治；因高龄，认为手术亦非适宜。乃迎回家中，每日以静脉滴注给药予以维持生命。

经朋友介绍，其家人约请余试予针灸诊治。查牙关紧闭，呼吸气粗，口气臭秽，鼻中息热，唇舌红绛，舌苔黄厚而干，双拳紧握，肘膝挛屈不伸，拘急强硬，腱反射亢进，腹部板胀痞硬，久按灼热；手心烘热，三部脉象弦大，按之有力，血压182/106毫米汞柱。

余颇诧异，询其家人，知自发病以来，导尿褐黄，大便一直未解，每一周用导泻药（开塞露）一次，但仍不得下，仅偶经辅助排便始得一二枚干燥硬结之矢。询其平素体质，

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

家人言其人虽届高龄，身材虽瘦小，但素来强健，少有患病，年虽80，但劳作如常人。

诊断：中风闭证。肝阳上亢、血出颅内，升降失调、气机逆乱，阴阳乖桀、经络不通，遂致神机闭塞、脏腑失和、肢体失用。

治则：宜当醒脑开窍、通阳启闭，平肝息风、清热通便，调其升降、和其阴阳，疏通经络。

治疗经过：（戌时）先取复溜、间使，再取百会、上星、悬颅、内关、三阴交、丰隆、合谷、太冲、天枢、上巨虚、阳陵泉，以平补平泻和泻法为主，施捻转或提插手法，每15分钟行针一次，留针1小时。

12月9日复诊，家人诉经昨日针后约半小时许，自泻出大量极臭秽粪便，初得干结之便，旋继之以稀稠及溏便、其臭不堪。泻下已，则目开，口开，手足自舒，渐能闻人声，意识渐复。今晨间情形益佳，举家遂为之欢欣庆幸。查见气息已平，脘腹和软，脉象弦缓。继前法针之，1日1次。

10日，三诊，患者神识渐清，已可翻身、稍进流质饮食；昼寐夜寤，精神欠佳。针加中脘、气海。并予中药桃红四物汤加葛根、黄芩、制首乌、桑寄生、牛膝等每日服用以活血通络，清热益阴，补肾平肝，增强疗效。

14日，七诊，患者饮食大好，已可问对应答，扶助下能坐起，左侧肢体功能基本正常，唯右侧肢体活动乏力（下肢肌力3级，上肢肌力2级），头晕头昏、疲乏多寐。于酉时取：太溪、阴谷，百会、悬颅，中脘、气海，肩髃、曲池、合谷，足三里、解溪、三阴交；阳辅、阳陵泉；并速刺大椎、身柱、腰阳关（得气后捻转提插各约1分钟，即出针），每日1次，1周5次。

十二诊时，患者已可坐起，并能站立，扶助下可尝试行走，右手可以举过头顶。去丰隆，加承山（不留针）、照海、申脉等，又继续针刺治16次并服中药20余剂，血压基本复常，肢体功能恢复，生活完全可以自理而愈。

体会：中风为临床危急重症，自古为历代医家重视。如《素问.生气通天论》所说：“大怒则形气绝，而血菀于上，使人薄厥”（3）者即是。此例虽无大怒诱因，然高年阴虚，阳亢于上，与大怒肝阳暴张，其理相同；血随气逆，致脑窍闭塞，经络不通，气机紊乱，升降失调，三焦阻闭，危症蜂见，虽经西医种种治疗月余，危急之象，较之当初有过之而无不及。

治以开窍启闭（内关、百会、合谷、太冲）与息风通络（上星、悬颅、阳陵泉）、清热豁痰通便（天枢、上巨虚、丰隆）同施，并先取时穴复溜、间使以激发经气，并可清心滋肾、交通阴阳，兼伍诸穴，是以能逆转大气，使升降复而气血和调，脏腑通利、营卫畅达而神志清、手足舒，自是而脱离险境，再经针药结合调治而经脉经筋等则功能易于恢复也。

3. 胆道蛔虫

邓儿，男，5岁。1992年4月12日，医院外科邀请会诊。因急发右胁剧烈疼痛1天，经当地医院于以解痉、抗炎等治疗不效，转本院住外科病房1小时。经本院超声波检查，确诊为胆道蛔虫症。本院副院长、外科主治医师白某邀余会诊。患儿面容痛苦，以双手护右胁部，蜷卧于床，疼痛阵发加剧，剧则翻滚呼号，已经肌注、静滴解痉止痛诸药无效。诊得双手关脉弦数。

诊断：胆道蛔虫。脾虚湿热，虫入胆道，肝胆气闭，气机逆乱。

治疗：疏肝利胆、通络解痉，调理气机、和胃健脾。

未时（14:30），灵龟八法开临泣、外关。先取右临泣，轻刺入针；继针外关透支沟；再取阳陵泉，轻刺入后，遂轻捻转、提插诸穴之针，反复施术3-5分钟后，患儿遂渐渐安静，于是嘱其深呼吸，屏息鼓气，询问知其胁腹疼痛已不显。拟酌情留针30分钟至1小时。于留针25分钟许时，复觉胁痛，嘱其深呼吸，遂再予捻转提插阳陵泉、外关、临泣三穴，少顷痛再止而安，不多时，患儿因疲倦入睡，再留针40分钟起针，醒后予B超复查，胆道内已无蛔虫影征。遂与平胃散合四逆散加驱虫安蛔消导中药方善后。

体会：素体脾虚，饮食不洁；湿热生虫，耗伤气血；虫随肠道游走，钻入胆道，则致胆腑不利，肝胆气闭，胆汁淤阻，气机逆乱，发为剧痛，虫静则稍安，虫动则痛剧，良非一般解痉、止痛之药物所易缓解者。

针灸长于调理内脏功能，对胆道、尿路结石梗阻等急腹症疼痛，有即时之著效。针刺足少阳胆经穴，可缓解胆管痉挛，促进胆囊收缩、增加胆汁排泄；胆汁味苦，非蛔虫之所喜，故自行避让退出；胆囊收缩，胆汁汹涌而出，亦可冲击蛔虫外出，故效捷功伟，然其理平易。外关者，三焦之络，又八脉交会之穴，通于阳维，与临泣相应，善于调理三焦气机；胆虽奇恒之腑，总在腹中。当蛔虫入胆，肝胆气闭，升降失调，五脏六腑，皆受其累，三焦之气，与五脏六腑之气，息息相关，凡腹中急痛诸证，条畅三焦，极为要紧，治腹中诸证不可不知。

讨论

笔者在多年临床中，多次以针灸中医为主参与治疗诸如咽后壁脓肿(5)、癫痫持续状态、胆道蛔虫、胆结石绞痛、肾结石绞痛(6)、中风昏迷、重症鼻出血、高热持续不退、哮喘持续状态(7)、术后尿潴留、冠心病心律失常、心绞痛、急性意外伤损疼痛(8)等急症，屡获良效，体会到针灸善于调理气机、调整内脏功能，活血化瘀、通络止痛，有即时性效应，结合中药，治疗急症尤宜。

但临床应注意：1，坚持四诊合参、病证同辨,对病治疗与对症治疗相结合; 2,注意脏腑阴阳气血平衡和气机升降出入；3，治疗的补、泻、轻、重，应根据寒热虚实的多少轻重，各得其宜，是有效治疗急症的关键；4，结合应时开穴、酌

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

情应用适当强度的补泻手法或结合呼吸补泻、运动导引、动态针灸，或适当延长留针时间、增加行针频率、甚至1日针灸2次，总之当以病证体质实情为考量，不可因因循迁延而功亏一篑。

结语

中医学数千年临床实践中，对急症机理、证候和预后辨识有着独特而深刻的认识，在急症救治中积累了极为丰富、独具临床特色的实践经验，开创了很多卓有成效的诊断和治疗方法，值得我们在临床急症诊治中继承和发扬、进一步研究探讨，以提高急症诊治水平和疗效。

参考资料：

[1] 明. 杨继洲《针灸大成》，北京：人民卫生出版社，1963：38

[2] 袁胜.针刺为主抢救鼻出血重症案，《中国针灸》，2005; 25(10):695

[3] 清.张隐庵.《黄帝内经素问集注》，上海：上海科技出版社，1959：10

[4] 李景荣等.《备急千金要方校释》，北京：人民卫生出版社，1998：436

[5] 袁胜.里喉痈案.中国针灸.1999;19(3):164

[6] 袁炳胜.医案三则--辨病辨证体会，《英国中医药学会会刊》，2009; 16(2):34

[7] 袁胜.危重哮喘治验.华夏医药网：http://www.huaxia120.com/1.1.060719.8.htm

[8] 袁炳胜.针灸治疗意外所伤医案三则，《英国中医针灸杂志》，2013; 20(1):18

Clinical Experience on TCM Treatment of Emergency Cases

Bing Sheng Yuan

Herbs & Acupuncture, Rotherham UK

Abstract: Emergencies, such as coma, serious bleeding, hyperpyrexia, baryodynia, critical palpitation or asthma, will endanger health and even life if not treated immediately. In thousands of years of the Traditional Chinese Medicine (TCM) clinical practice, emergency research has always had much attention from the TCM doctors. Under conditions without modern physical and chemical inspection and clinical supporting treatment, the TCM doctors invented many first aid treatment skills such as resuscitations by external chest compression and the arm method of artificial respiration (cir AD221, Han Dynasty, Shang Han Za Bing Lun), and male urethral catheterization with Chinese shallots (cir AD652, Tang Dynasty, Bei Ji Qian Jin Yao Fang). Plenty of experience has also been accumulated in diagnosis and treatment for emergencies.

In over 20 years of my clinical experience，I have taken part in treatment of many different kind of emergencies successfully by using the traditional Chinese acupuncture and herbal medicine. I feel that the TCM is very important for emergency treatment. It is well worth further study to popularize the treatments in this field of medicine. Here I reported and discussed the process of treatments by the TCM acupuncture in three selected cases of epistaxis, coma and biliary tract ascariasis.

Key Words: TCM (Traditional Chinese Medicine), Acupuncture, Emergency, Epistaxis, Stroke coma, Biliary tract ascariasis, Treatment.

Introduction

Emergencies such as coma, serious bleeding, hyperpyrexia, baryodynia, critical palpitation and asthma, may be caused by unexpected physical, chemical or biological factors, or chronic illness which is suddenly aggravated. It will bring the patient unbearable physical and mental sufferings, seriously affect the physiological functions of the brain, heart, lung, kidney and other vital organs, or even endanger life if not treated immediately. During over 20 years of clinical practice, I took part in many different kinds of emergency treatment successfully using the traditional Chinese acupuncture and herbal medicine, and gained satisfactory results. Here I reported three selected cases of epistaxis (nose bleeding), (stroke) coma and biliary tract ascariasis treated with the TCM acupuncture for further discussion and reference.

Clinical Cases

Case one: Nose bleeding (Epistaxis)

Michael, 23 years old.

First visit on 14th November 2010, 8:00am, I saw him standing in the front of the antique fair foyer, with his face coved with blood, his nostrils stuffed with tissues, and blood continually coming from his mouth. He was given tissues to stop the bleeding, but was unable to. After inquiring of his health, I understood that he had the

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

history of nose bleeding, and it usually happened in cold and dry winters. Recently he also caught a cold with blocked nose and sore throat. This morning he walked half an hour in the cold wind, just after entering to the room, he felt a little hot and itchy in the nose, then suddenly started bleeding profusely, without stopping for more than 10 minutes. Besides nose bleeding, he also had chronic colitis and bleeding hemorrhoids.

Diagnosis: epistaxis (nose bleeding). The main reasons were both from outside and inside of the body. From inside, there was heat and dampness in the stomach and intestines; from outside, he was affected by the wind and cold. After walking in the cold and dry wind again, his blood circulation accelerated and his body became hot, competing with the cold and dry factors, thus resulting in epistaxis.

Treatment: At the moment of the emergency, the first step was to stop the bleeding. According to 'Acupoints Tian Fu and He Gu, the best for the nose bleeding'from 'Bai Zheng Fu' (1), I administered the treatment as follows. I had not brought acupuncture needles, so I placed my thumbs on the two acupoints on his left (because the blood was coming from his left nostril), held his arm and hand with my other fingers, then pressed evenly and forcefully and deep into the acupoints. Released for a second, and then pressed again. I repeated this skill several times. At the same time, I told him to relax, and breathe from his abdomen slowly and deeply, focusing on the bottom of his feet.

After 2-3 minutes, the nose bleeding was reduced and then gradually stopped. Treatment administered for another 3-5 minutes, I pressed the other 3 acupoints, ShangXing, TongTian and KongZui for 1-2 minutes, then pressed TianFu and HeGu again for 3-5 minutes. The blooding totally stopped. I told him not to take the cotton out of the nose, not to clean the nose and not to press the nose, thus preventing any further nose bleeding. The following day, he came to my clinic, and told me the nose bleeding had not happened again. I gave him 7 bags of herbal medicine, each including BaiMaoGen 50g，Han LianCao 50g， ShangYe 15g， LianQiao 12g， and ShengGanCao3g. He boiled each bag in water twice, and drank the liquid in the morning and evening every day. There was no recurrence for one year's follow-up.

My Experience: This young patient had strong blood and Qi circulation. He had chronic colitis and bleeding hemorrhoids before, as well as nose bleeding, thus we can know the dampness and the heat stayed in YangMing and TaiYin for long time. He caught a cold recently, and walked quickly in the chilly wind for half an hour, thus making the interior heat and exterior cold compete against each other in the lung meridian system. In term of TCM, the lung is on the top of the five Zang-organs, contacting with air, opening at the nose. The nose, like a door, connects the outside and inside, and therefore, was the first organ getting attacked, resulting in nose bleeding.

TianFu can help disperse the stasis of lung Qi; HeGu can eliminate the heat stagnant in YangMing meridian. YangMing meridian on the arm goes to the side of the nose, which is the opening of the lung, so pressing the two acupoints will help to stop bleeding in the nose. This was verified by ancient Chinese doctors, recorded in 'BaiZhengFu'. When treating a serious case of nose bleeding in 2005, I did acupuncture mainly on these two points as well (2). Acupuncture treatment is the practice of TCM theory. Over the past century, it has been argued that Chinese medicines are useful, but the TCM theory is not. This argument is meritless since the Chinese meridians are based on those theories. Thus without the theory there would be no acupuncture.

Case 2, Stroke Coma

Mrs. Chou, 80 years old, first presented on 8th December 1991.

Because of the sudden coma, she was sent to the Internal Medical Department in a western medical hospital. The diagnosis was cerebral hemorrhage with infarction and hypertensive encephalopathy of stage III. After emergency rescuing and the experts' consultation and treatment for one month, she was still in coma, without defecation and urination, and without eating and drinking for a long time. The doctors thought she was incurable. Due to her old age, surgery was also not recommended. Then she was sent home, maintaining life with intravenous infusion.

When I was invited to visit her, I checked her before treatment. She had tightly locked jaws, rough breathing, foul and hot breathing odour, deep red lips and tongue, thick yellow tongue coating, bloated, hard and hot abdomen to palpate. Both fists were clenched. Bent elbows and knees could not stretch with hyperactive tendon reflexes. Palms felt hot, with wiry-large (powerful) pulses, at all Cun, Guan and Chi sections in pulse taking by lifting, pressing and searching. Blood pressure was 182/106 mm Hg.

I was surprised. Her family told me that, since the onset, her catheterized urine was brown-yellow with no self-defecation even using anal laxatives once a week. Assisted defecation only saw one or two hard and dry stools. However, her family also told me she had been quite healthy. Although old in age and small in build, she had worked like normal people and rarely felt ill in her 80's.

Diagnose: Block pattern of Stroke.

Liver yang hyperactivity, intracranial bleeding, ascending -descending dysfunction, Qi movement disorder, yin and yang imbalance and meridian blockage, all of those leaded to the loss of mental activity, disharmony of Zang and Fu organs, and incapacitation of limbs.

Principle of treatment: induce resuscitation, unblock yang and remove blockage, pacify liver and extinguish wind, eliminate heat and open bowels, regulate ascending-descending of Qi, harmonies yin-yang and unblock meridians.

Treatment: (7pm to 9pm) first took FuLiu, JianShi, and then took BaiHui, ShangXing, XuanLu, NeiGuan, SanYinJiao, FengLong, HeGu, TaiChong, TianShu, ShangJuXu and YangLingQuan, mainly used the even reinforcing-reducing method and the reducing method by twisting or lifting-thrusting, and manipulated the needles once every 15 minutes while retaining the needles for one hour.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

On next day, 9th December, second visit. Her family said that about half an hour after she received acupuncture on the previous day, she expelled a lot of foul smelling stools. Started with dry and hard stools, they quickly turned into thin or thick and finally into the loose stools. The foul smell was unbearable. With the purgation done, her eyes and then her month opened, followed by her hands and feet relaxed. Gradually she became conscious and able to hear the sounds around. Her condition was getting even better this morning, and the whole family was joyful. On examination, her breathing was even and smooth, abdomen was soft, and pulses were wiry and moderate. The previous method of acupuncture was performed, once per day.

On 10th December, third visit. The patient was more conscious. She could turn over in bed and take a little liquid diet. She felt listless, sleeping in daytime but stayed awake in the night. For needling I added two more acupoints: ZhongWan and QiHai.

She took Tao Hong Si Wu decoction everyday plus acupuncture on GeGen, HuangQin, ZhiShouWu, SangJiSheng and NiuXi etc. to activate blood and unblock collateral, to clear heat and nourish yin, to reinforce kidney and nourish liver, and thus to enhance the efficacy.

On 14th December, 7th consultation. The patient's appetite was very good. She was coherent and could answer questions, and could sit up with help. Her left limbs functioned normally, and the right ones felt weak (the right lower limb could move and lift from the bed, and the right upper limb could moved on the bed). She felt dizzy, faint, fatigue and sleepy. At You time (酉时) (17:40), the following acupoints were taken with normal needling: TaiXi, YinGu, BaiHui, XuanZhong, ZhongWan, QiHai, JianYu, QuChi, HeGu, ZuSanLi, JieXi, SanYinJiao, YangFu, YangLingQuan; while at the acupoints of DaZhui, ShenZhu and YaoYangGuan, the rapid insertion method was used (after gaining Qi, twisted, lifted and thrust the needles each for about one minute, then took out the needles), once per day, 5 times per week.

On the 12th consultation, the patient could sit up and stand by herself, and with assistance, tried to walk. The right hand could go up over her head. For acupuncture I replaced FengLong point with ChengShan (without retaining of needles), ZhaoHai, and ShenMai, etc., and continued for 16 more sessions, combined with more than 20 doses of the traditional Chinese medicine. After those treatments, her blood pressure became normal and limb function was recovered. The patient was clinically cured and lived an independent life.

My Experience: Stroke is a severe emergency in clinic, and since the ancient times, physicians of all generations have paid much attention to it. For example, "Su Wen. Sheng Qi Tong Tian Lun" said, "Anger can be harmful to the qi of the body, stopping Yang-qi descending, and bring the blood to the brain, resulting in a sudden faint" (3). Although there was no incentive of angry in this case, the patient was old in age, deficient in yin but hyperactive in yang, which resembled fury and liver Yang hyperactivity. Bleeding due to the adverse flow of Qi led to brain obstruction, meridian blockage, Qi flow disorder, ascending-descending dysfunction, and triple burner occlusion, all of which then caused crisis. The crisis recurred aggressively, and, despite many kinds of western medical treatment being administered for more than one month, was no less than before.

The treatment included inducing resuscitation (NeiGuan, Baihui, HeGu, TaiChong), extinguishing wind and unblocking collateral (ShangXing, XuanLu, YangLingQuan), and clearing heat and phlegm and opening bowels (Tianshu, ShangJuXu, FengLong), all in the same time. But first of all, two timely acupoints FuLiu and JianShi were taken to stimulate the Qi of meridian, and also to clear heart and nourish kidney, to connect and adjust yin and yang, with the other acupoints. Those could refresh the foremost Qi of life, regulate and restore the ascending-descending system, harmonies Qi and blood and recover Zang-Fu organs function, and finally when both the nutrient and defence were smooth, the mind became clear, and hands and feet relaxed. Therefore the patient could get out of the crisis. To follow up, the combination of acupuncture and herbal medicines would help modulate the function of meridians and tendons, making recovery possible.

Case 3, Biliary Ascariasis

Boy Deng, 5 years old. First seen on 12th April 1992 for consultation in the hospital's surgical department. Complaining of severe pain in the right hypochondrium for one day, he was treated in the local hospital with antispasmodic and anti-inflammatory drugs, but failed to improve. He was then transferred to the hospital's surgical ward one hour before. After the ultrasound scan he was diagnosed with biliary ascariasis. Dr Bai, vice president of the hospital and a surgeon in the ward, invited me to the consultation. The boy had a very painful expression with both hands covered on the right side of the body curled in the bed. The pain was getting worse intermittently, and whenever it got worse he would cry and roll over in the bed. Both intramuscular and intravenous injection of antispasmodic and analgesic drugs failed to respond. Pulse checking found that Guan pulses of both sides were wiry and rapid.

Diagnosis: Biliary ascariasis. Weakness of spleen with damp-heat, ascaris entering the biliary duct, blockage of liver and gallbladder Qi, and disorder of Qi-movement.

Treatment: soothe liver and gallbladder, unblock collateral and relieve spasm, regulate Qi-movement, and harmonies stomach and invigorate spleen.

Selected the acupoints by LingGuiBaFa (or eight methods of sacred tortoise), it was 14:30pm (Wei Shi 未时), to open LinQi, WaiGuan. First taken the right LinQi, using light piercing, followed by needling through the points WaiGuan & ZhiGou. Then took YangLingQuan, and, after light piercing, lightly twisted, lifted and thrust the needles in all the points, and repeated for 3-5 minutes. The suffering child then gradually got quiet. He was told to take a deep breath and then hold it. Asked him and thus knew that the flank pain was not so severe. I left the appropriate needles for 30 minutes to one hour. But after 25 minutes, he felt the flank pain again. While asking him to take deep breathes I did twisting, lifting and thrusting

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

the needles of the above three points, and then stopped the pain shortly. The suffering child was tired and fell asleep. I left the needles for another 40 minutes. After waking up the boy had another B-mode ultrasound scan, showing that there was no biliary ascaris shadows any more.

The patient was then given PingWei powder plus SiNi powder and other herbal medicines to expel and quiet ascaris and help digest and evacuate.

Experience: the body was weak because of the weak spleen, eating unclean food and drinks; dampness and heat provided a good breeding ground for warms which in turn consumed and damaged the blood and Qi. The worms were wandering within the intestines, crawling into the bile duct, causing obstruction, liver and gallbladder Qi blockage, cholestasis and Qi movement disorder, all of which contributed to the pain. If the worms were inactive, the pain was less; if the warms were active, the pain increased. Indeed it was not easy for general antispasmodic or analgesic drugs to relieve the pain.

Acupuncture is good at regulating internal organ functions. For example, it has instant and remarkable effects on acute abdominal pains from the obstruction caused by biliary or kidney stones. In this case, acupuncture on the acupoints of gallbladder meridian, could help relieve biliary duct spasm, and promote gallbladder contraction, which expelled large amount of bile to drive the worms out of the biliary duct. So it is easy to understand why the effects were instant and obvious. Acupoint WaiGuan, belonging to the Triple Energizer meridian, is the crossing point of the Eight Extra Meridians, adept in regulating the Qi-Movement of the Triple Energizer. Therefore, WaiGuan is very useful for relieving emergent abdominal pains.

Discussion

During the 20 years of TCM clinical practice, I have mainly used acupuncture and Chinese medicine in many emergency treatment cases, such as retro-pharyngeal abscess(5), epileptic state, biliary colic, renal colic(6), stroke coma, severe epistaxis, hyperpyretic state, persistent asthmatic(7), post-operative uroschesis, arrhythmia or angina of coronary heart disease, and pain relief in acute injuries(8), etc., often with outstanding effectiveness. Acupuncture is good at regulating Qi-movement, modulating Zang-Fu organs functions, activating blood and resolving stasis, and unblocking collateral to stop pain with immediate effect. If combined with herbal medicine, it will have even better results.

In my experience, we should pay more attention to the following points:

1) We should adhere to the comprehensive analysis by synthesis of the four diagnostic methods, with differentiation on both the diseases and patterns, and combination of treatment for both the diseases and symptoms.

2) Pay more attention to the balancing of Zang-Fu organs, Yin and Yang, and Qi and blood, and also to the Qi movement, ascending and descending, and exiting and entering.

3) The key to the emergency treatment is that the use of reinforcing, reducing, forceful or gentle manipulations should base on the extent of pathogenic cold, heat, deficiency or excess.

4) Select the acupoints by time, use the appropriate reinforcing or reducing manipulation accordingly, or combine with breathing to reinforce or reduce, motion directed therapy，dynamic acupuncture, or extend the needle retaining time appropriately, perform more frequent needle manipulations, and even execute acupuncture twice a day to improve the results. All in all, the treatment should base on the thorough consideration of the whole conditions of the patient, or all the attempts may fail for procrastination.

Conclusion

In thousands of years of clinical practice the traditional Chinese medicine had developed unique and profound knowledge about the mechanism, syndrome and prognosis of the emergency, accumulated abundant experience of clinical characteristics in treatment, and established many effective diagnostic and treatment methods. It is worth inheriting, developing and further studying in the clinical emergency management, in order to improve the level and effect of emergency treatment.

References

[1] Ming Dynasty. Ji Zhou Yang, ‘Zhen Jiu Da Cheng’, the People's Health Publishing House, Beijing, 1963:38

[2] Sheng Yuan, Acupuncture-based rescue case of severe epistaxis, ‘Chinese Acupuncture & Moxibustion’. 2005; 25 (10): 695

[3] Qing Dynasty, Yin An Zhang, ‘Huang Di Nei Jing Su Wen Ji Zhu’, Shanghai: Shanghai Science and Technology Press, 1959:10

[4] Jing Rong Li and et al. Bei Ji Qian Jin Yao Fang, Beijing: the People's Health Publishing House of Beijing, 1998:436

[5] Sheng Yuan. Throat abscess inside the case. Chinese Acupuncture &Moxibustion.1999; 19 (3): 164

[6] Bing Sheng Yuan. Three Clinical Cases--clinical identified syndromes & diseases Experience. The Journal of The Association of Traditional Chinese Medicine.2009; 16 (2): 34

[7] Sheng Yuan, Critically asthma treatment experience. Hua Xia Medical Network: http://www.huaxia120.com/1.1.060719.8.htm

[8] Bing Sheng Yuan. Three cases of accident injury treatment by acupuncture, The Journal of The Association of Traditional Chinese Medicine and Acupuncture .2013; 20 (1): 18

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

多囊卵巢综合症及其所致不孕症的综合治疗

赵丽琴

（Fertility Care, Zhong Jing TCM, Sheffield）

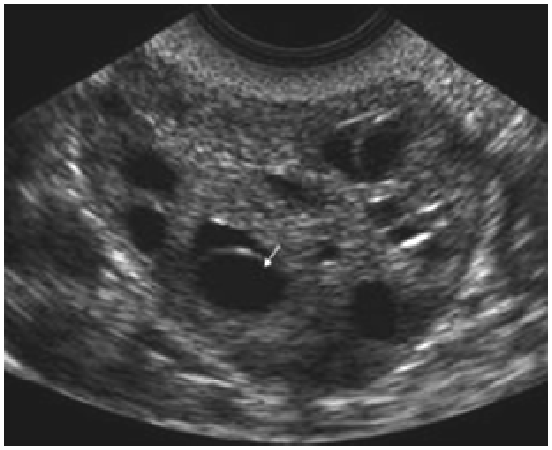
摘要：多囊卵巢综合症是临床上最常见的一种内分泌紊乱性妇科疾病，它不仅影响妇女的月经周期，而且常引起无排卵而导致不孕，甚或导致子宫癌、糖尿病及心脏病等，严重影响身体健康甚至生命。准确的早期诊断对有效地治疗多囊卵巢综合症非常关键，也可降低此类疾病的发生。本文将全面地讨论本病的中西医综合诊治，中医的病因病理、辨证论治和独特而有效的治疗方案，并通过具体病例来分析讨论。

关键词：多囊卵巢综合症，无排卵性不孕，排卵障碍，中医，西医，针灸，辨证论治。

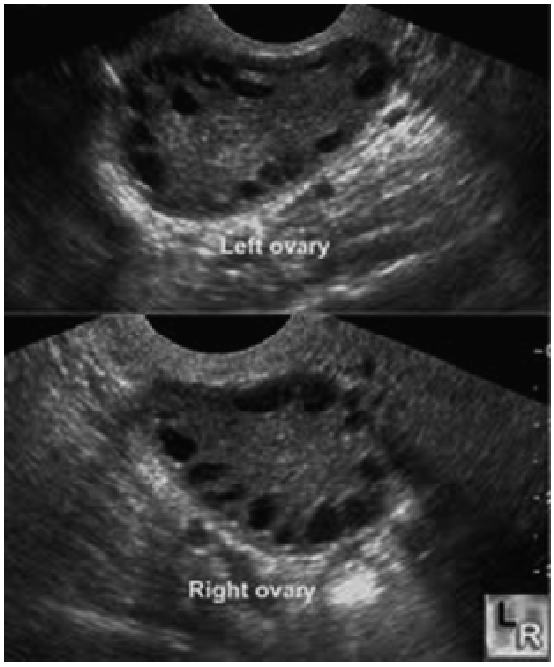
概述

西医对多囊卵巢综合症的定义有所争议。一般来讲是指排卵障碍，主要包括月经紊乱，肾上腺机能亢进和肥胖。本病可发生于育龄妇女的任何阶段[1]，但多发生于30岁以下妇女 [2]，大约有20-33%的英国妇女和5-10%的世界妇女患有此病[1,3,5]，是年轻妇女月经紊乱的最常见病因，也是导致无排卵及其所致不孕的常见病因，占无排卵性不孕的50-70%[4]。

由于新陈代谢功能和内分泌功能的失调，90%的多囊卵巢综合症的患者有月经稀少或闭经 [5]，且50-70%的患者有胰岛素抵抗，导致糖尿病、子宫癌、高血压、高胆固醇和心脏病等的发病率升高[6]，及时控制症状可以降低此类疾病的发生。



（B超图像—正常卵巢）



（B超图像-多囊卵巢综合症卵巢）

西医观点

1. 正常的自然排卵过程

正常妇女每月卵巢分泌20个始基卵泡，但只有一个卵泡发育为成熟卵子而最终排卵，卵子经输卵管输送到子宫与精子结合成为受精卵，继而着床受孕。此自然排卵过程的发生依赖于下丘脑-垂体-卵巢这一性腺轴的正常功能，下丘脑分泌促性腺激素释放激素 (GnRH)，刺激脑垂体释放卵泡刺激素 （FSH）和黄体生成素 (LH)；黄体生成素刺激小卵泡的生长发育，且协助卵泡刺激素促使卵子成熟最终排卵。

2. 多囊卵巢综合症及其所致不孕症的发病原因

此病发病原因至今尚不完全清楚。据统计，25%的患者与遗传有关[7]，内分泌功能紊乱和环境因素也许是另一发病原因。多数病人与高胰岛素血症及胰岛素抵抗有关[4]。高胰岛素血症导致性腺轴之间的正负反馈功能失调，继而引起垂体分泌FSH减少，LH增多，阻碍卵泡发育，卵泡停留在小卵泡阶段，无优势卵泡发育，故无成熟卵子及排卵。持续性的LH增多，使卵巢内小卵泡及肾上腺分泌大量雄激

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

素，而过高的雄激素又影响促性腺激素的分泌，导致FSH和LH比例失常，从而发生一系列变化形成多囊卵巢综合症。

3. 诊断要点

1) 临床表现

- 功能性子宫出血：大约有高达90%的多囊卵巢综合症病人有月经不调或闭经[4,5]。由于雌激素长期小量对子宫内膜的刺激，缺乏孕激素的对抗，使子宫内膜过度增生，发生功能性子宫出血，可表现为月经稀发伴经量多，或经期缩短伴经量稀少如泡沫，甚至闭经。
- 无排卵性不孕：大约74%，甚至高达94%的PCOS患者有无排卵性不孕[4,7]，即使排卵也较晚。由于卵泡发育异常，卵子质量差，子宫内膜不宜受精卵的着床，故不易受孕。
- 习惯性流产：由于卵子质量差及子宫内膜的过度刺激，即使成为受精卵，也很难正常着床致流产。
- 多毛症和痤疮：体内雄激素增多，可出现多毛和痤疮，据统计，约高达83%的病人有多毛症及囊肿性痤疮[4]。
- 肥胖：由于血中高雄激素刺激食欲中枢，引起贪食现象导致肥胖。大约50%的病人有肥胖症，体重指数大于25 [4]。

2) 辅助检查：

- 基础体温测定：表现为单相，月经后期体温无升高。
- B超显示双侧卵巢呈均匀性增大，为正常的2-4倍 [4]。
- 血化验：血清FSH基值偏低，LH和雄激素升高，LH/FSH比例大于3；雌二醇正常或稍高，其水平恒定不变，无排卵前后升高现象；促乳素升高。
- 腹腔镜：可呈现形态学和组织学上的明显变化，卵巢增大，包膜增厚，可明确诊断PCOS。

4. 西医治疗措施

1) 避孕药：可调经，降低雄激素水平，减少毛发过度增生，改善痤疮。适宜于妇女患有月经不调，经血量多，而尚不愿受孕者。但症状会在停药后复发，不适宜欲受孕者。

2) 促排卵药：克洛米芬是首选药，促排卵成功率为70-80%，但其妊娠率较低为30-40% [4] 。因其有对抗雌激素作用，导致宫颈分泌减少，宫颈粘液少而粘稠，不利于精子穿透。促卵泡刺激素如Gonal-F 或Manopur，可降低LH水平，缩小LH/FSH比例，升高E2水平，纠正病人生化失调，改善卵巢内激素环境。

3) 绒毛膜促性腺激素（HCG）：助卵子成熟而促排卵。

4) 糖尿病类药物：Metformin, Yasmin 或Provera，可控制胰岛素和血糖水平，降低雄激素水平，调经血。

5) 类固醇激素：如地塞米松可调节雄激素水平，控制多毛症。但长期服用有可能会导致肝脏受损和骨质疏松。

6) 控制体重：健康饮食和保持运动可帮助减肥，有效地利用胰岛素，降低血糖，从而调经。

7) 腹腔镜手术：在腹腔镜下通过激光或电凝进行卵巢楔形切除术，降低雄激素水平，增加FSH的分泌，促排卵，提高妊娠率。但其效果仅持续几个月，之后症状常会复发，且有可能致卵巢内疤痕组织形成。近些年亦有在阴道超声波引导下行卵泡穿刺术，获得较满意排卵率和妊娠率，且可避免手术操作引起的输卵管卵巢周围粘连。

8) 若上述均无效，则需做IVF 或IUI。但由于大剂量性激素药物的使用，患者发生卵巢过度刺激综合症(OHSS)的危险性较高，即使受孕，流产几率也较高。

中医观点

1. 病因病理

多囊卵巢综合症属中医之“闭经”、“月经不调”或“不孕”范畴，病因病机较为复杂。临床上多属虚实夹杂，多与脾、肾和肝脏有关。其主要病机为脾虚肾阳不足，水失健运，积聚于下焦-盆腔，致痰湿血瘀，卵巢囊肿。

1) 肾气虚，冲任失养：素禀肾气不足，或久病、房劳伤肾，或长期服用避孕药，以致肾精亏耗，阳气不足，水调失司，冲任失养，胞宫无血可下，致月经不调或闭经。《医学正传》曰：“月经全借肾水施化，肾水既乏，则经血日以干涸。”

2) 脾气虚，痰湿内阻：素体肥胖，痰湿内阻胞宫；或过食肥甘油腻及奶制品，或嗜烟酒，或体劳多虑，损伤脾气，脾失健运，水湿积聚成痰，阻滞于胞宫冲任，致月经延期，经血稀少，甚或闭经不孕。

3) 肝郁血瘀：长期精神紧张、忧郁或焦虑，七情内伤，致肝郁血瘀；或外感风寒，内伤生冷，血为寒凝而瘀，阻滞冲任，胞脉雍塞而闭经。若肝郁日久化热，或热邪耗伤阴血，也可致月经不调，经血量多夹瘀血块。

2. 辨证论治

中医强调治本，以补肾健脾、疏肝调经，化痰祛瘀为主。

1) 脾肾两虚，痰湿内阻

证候：经期延长，经量稀少或有泡沫，甚或闭经不孕，伴腰背痛，腹胀满，畏寒肢冷，疲倦，肥胖多毛。舌淡体胖有齿痕，苔白腻，脉沉细或濡细。

治则：温肾健脾，祛湿化痰

常用药：菟丝子、淫羊藿、熟地黄、山茱萸、桂枝、茯苓、苍术、半夏、香附、皂刺、浙贝、山楂

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

2) 肾阴不足，肝郁化火

证候：月经先后不定期，经量少或闭经不孕，经前紧张、忧郁、烦躁不安，头晕头痛，失眠盗汗。舌红苔少，脉弦细数。

治则：滋阴降火，疏肝调经

常用药：山药、山茱萸、牡丹皮、女贞子、旱莲草、枸杞子、当归、白芍、生地黄、麦冬、香附、柴胡、莞蔚子

3) 血瘀痰热，蕴阻胞宫

证候：严重月经不调，无任何规律，经行量少夹淤血，或崩漏，亦或闭经不孕，伴胸闷乳胀，腹胀痛，便秘，多毛痤疮，肥胖，口渴。舌暗红或紫红，边有瘀斑，苔白或黄腻，脉弦滑数。

治则：清热化痰，祛瘀通络

常用药：桃仁、丹参、赤芍、丹皮、川芎、香附、枳壳、夏枯草、皂刺、茯苓、海藻

3. 针灸方案

对病情复杂，多症并存者，中药配合针灸效果更好。

常用穴位：百会、天枢、归来、中极；艾灸关元、气海、神阙；电针肾俞、脾俞、次廖、志室

加减：

伴脾虚者加足三里、血海、丰隆、阴陵泉、三阴交；肾阳虚者加肾俞、大肠俞、命门、腰阳关、复溜、照海；肾阴不足者加肾俞、太溪、三阴交、内关；肝郁血瘀者加膈俞、肝俞、外关、合谷、三阴交、太冲、足临泣。

典型病例

病例一：多囊卵巢综合症伴多发性硬化症

Kate，34岁，公司董事长。

病史：自初潮即患月经不调，周期在30-70天之间无规律，经量少而稀薄，经后点滴出血10-14天，经前高度紧张，腰酸痛，两下肢刺痛麻木，疲惫不堪。试孕七年，曾做两次IUI和一次IVF，怀孕三次，其中两次均早期流产，一次怀孕成功生一女。盼望再生一子，但不愿再做IVF而放弃。经朋友介绍前来就诊于我。

辨证：脾肾两虚，夹肝郁痰湿

治疗与进展：针药并用，根据月经周期不同时段随时调整取穴用药。

第一周期：针药两周后经行，经期37天，经量仍稀少，经前紧张明显；

第二和第三周期：经期第14天排卵，28天周期，经量增多，经后点滴出血缩短到3-4天，无经前紧张等症；

第四周期：因买房搬家而紧张忙碌，疲倦不堪，情绪不稳，虽第14天排卵，但经期为34天，且经后点滴出血5天；

第五周期：第14天排卵，精神好，肢体麻痛消失。第35天妊娠化验为阳性。

调方后继续治疗至孕16周，孕期一切正常，足月产一健康男婴。

病例二：多囊卵巢综合症合并习惯性流产

Helen，33岁，大学老师。

病史：25岁时曾流产两次，26岁时自然怀孕生一女。之后服用避孕药五年，2002年1月停服避孕药后六个月未曾行经，自此月经紊乱，2005年一年内仅行经两次，经检查被诊断为多囊卵巢综合症。自2006年四月服克罗米芬九个月，于2006年11月怀孕，但又于孕六周时流产。经同事推荐前来就诊，时主症：精神紧张忧郁，焦虑不安，易疲倦，月经延后，经量稀少。舌淡苔薄，边有瘀点，脉沉细。

辨证：肾气不足，肝郁血瘀

治疗和进展：中药浓缩粉每周100克，配针灸每周一次，选穴据经期调整。

一诊（经期第七天）：八珍益母方合暖宫孕子方加减；

二诊（经期第14天）：疲倦减，精神较前放松。助孕方合桃红四物汤方加减；

三诊（经期第21天）：自觉有排卵痛，阴道有蛋清样分泌物，B超检查证实于第19天排卵。调经促孕方合苁蓉补肾方加减；

四诊（经期第28天）：感觉良好，调经补血方加减；

五诊（经期第35天）：自觉疲倦头晕，轻微恶心，妊娠化验阳性。

调方后继续治疗至孕12周，于2007年10月顺产一健康男婴。

病例三：多囊卵巢综合症

Fiona，37岁，歌手。

病史：试孕三年无效，曾于2006年被诊为多囊卵巢综合症。月经周期35-55天，经量甚少，阴道内从未排出过蛋清样分泌物，血化验和超声波检查证实无排卵。自幼食素，超量运动以保持身材（瘦小）。丈夫39岁，嗜酒，工作时间长，压力大，精子数低，活动率只有8%。2008年在准备开始IVF/ICSI治疗同时求诊于我，建议中医调理为先，暂缓IVF，但因其担心年龄越来越大，坚持要尽早做IVF，且只接受针灸。结果IVF药物引起了卵巢过度刺激综合症（OHSS），恶心，腹胀痛，胸闷气短，B超查有25个大小不等的卵泡，但只取出卵子九枚，六枚成为胚胎卵，最后仅有两个较好胚胎卵（2级和3级）被移植于子宫，但着床失败。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

IVF两周后又来复诊，决定接受我的建议，使用中医针灸争取自然怀孕。

辨证：肾精不足，冲任失养

治疗和进展：夫妻两人均服中药，妻子配用针灸，每周一次。

第一周期：第35日排卵，同时可见有少许蛋清样分泌物流出，周期51天，经量增。

第二周期：第25天排卵，明显蛋清样分泌物，基础体温相好转，周期39天，经量正常。

第三周期：第22天排卵，基础体温相改变明显，第33天血化验显示孕酮明显升高，第34天复诊时脉象细滑数，第40天始觉疲倦，乳房胀满，小腹隐痛，妊娠化验阳性，于2009年11月生一男婴。

一年后再次自然怀孕，自豪地成为两个孩子的母亲。

总结

PCOS是一个常见而复杂的妇科疾病，因为常出现为一系列豪不相关的症状，故称其为“综合症”。早期常被误诊，或长时间被忽视而未得到诊治，直到试孕失败方来就诊。根据本人临床观察，发现许多病人来诊时已曾服过促排卵药，或已做多次IUI/IVF而未成功，但从未针对其病因做过治疗。而中医治其本，可有效地改善症状，促使怀孕。兹总结关键几点如下：

1) 中医认为PCOS是一个虚实夹杂的病症，常侵犯脾、肾、肝三脏及冲任二脉。常见证型有：脾肾两虚，痰湿内阻；肾阴不足，肝郁化火；血瘀痰热，蕴阻胞宫。
2) 中医辨证要准确，治疗应注重健脾补肾，祛湿化痰，滋阴降火，疏肝调经，祛瘀通络。
3) 饮食调理、运动及控制体重对治疗PCOS也有帮助，可提高受孕几率。
4) 必要时可用中医针灸结合促排卵药，以加速治疗效果；对病情严重者，采用腹腔镜手术切除卵巢皮质下的小卵泡囊，可暂时缓解病情，但术后应结合中医针灸以预防或减少卵巢内疤痕组织形成，防止粘连，改善盆腔内血液循环。
5) 若同时合并有其它因素，如严重输卵管阻塞或男性不育症，可考虑IVF治疗。但需注意的是PCOS病人常出现对IVF药物反应不良，或分泌极少数量的卵子，且质量差；或产生卵巢过度刺激综合症，分泌过多但小而不成熟的卵泡，只有少数卵子能成为受精卵但质量差。因此，在IVF之前使用中医调理整体内分泌功能非常关键，使病人对IVF药物有最好的反应，从而提高IVF成功受孕率。
6) 一旦受孕成功，应继续中医治疗直至孕满三月，以固肾安胎，预防流产。

参考文献

[1] Wing, T. (2012), The Treatment of Ovarian Cysts with Traditional Chinese Medicine, 《英国中医药学会会刊》第19卷第2期.

[2] 曾庆琪主编《不孕不育症中医治疗》。南京：江苏科学技术出版社，2003年10月。

[3] Balen, A. MD, Rutherford, A.J (2007), Managing anovulatory infertility and polycystic ovary syndrome. British Medical Journal.

[4] 沈观印，黄克铭主编《不孕不育症》。北京：科学技术出版社，1999年8月。

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

[6] David, G. (2011), Acupuncture for the symptom of Anxiety in Polycystic Ovarian Syndrome, The Journal of The Association of Traditional Chinese Medicine.

[7] Wing, T. (2011), Ovarian Cysts and Polycystic Ovarian Syndrome. RCHM Post Graduate Lecture Series.

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 2014 年 2 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。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

浅谈梅花针疗法

薛秋龙

本人在几年的临床实践中，对梅花针的疗效颇为肯定。在英国，中医师使用梅花针的不多，多数诊所基本上不用，有些诊所连梅花针可能都没有。梅花针的出现时间并不长，在中医界它基本是一种无足轻重的治疗方法而被中医师所遗忘。现在本人就谈谈自己对梅花针的看法，与杏林同道共同探讨。

梅花针的发端

梅花针又称为皮肤针，发端于黄帝内经，《灵枢•官针第七》记载：“扬刺者，正内一，旁内四，而浮之，以治寒气之博大者也”。就是在病变部位正中刺一针，再在四周刺四针，都是浅刺，用来治疗寒邪所犯，而且寒气面积比较广但部位浅表的病症。《灵枢•官针第七》还记载了：“凡刺有五，以应五脏。一曰半刺，半刺者浅内而疾发针，无针伤肉，如拔毛状，以取皮气，此肺之应也”。就是浅刺入穴位后疾速出针，不伤肌肉，像拔毛一样。主要是疏泄皮肤浅表的邪气。肺主皮毛，故这是一种与肺相应的刺法。

《官针第七》记载了26种刺法，以上两种刺法最接近当今的梅花针。但近代的孙惠卿才是梅花针奠基者。他创立了初始的梅花针，当时称为保健针，1926始用于临床（王华，2006）。孙氏经过几十年的临床实践，于1954年成立了刺激神经疗法诊所，还授徒传艺， 并于1959年编写出版了《刺激神经疗法》一书。为此梅花针疗法正式开始传播（王华，2006）。

梅花针治疗效果的理论依据

梅花针疗法是以经络皮部论为依据的，它的治疗作用是通过刺激皮部和络脉来实现的（李苏民，王栋，2002），我们现在来看看黄帝内经对皮部的说法，《素问•皮部论》说：“皮部以经脉为纪者，诸经皆然”。这里首先说明了皮部是诸脉交错通行的必经之所。《素问•皮部论》又说：“凡十二经络脉者，皮之部也”。因此皮部除了是机体表皮和经脉所过之处外，应该还包含十二经的络脉、孙络和别络等。所以皮部也应该有行营卫，灌气血和防御外邪的作用。

《素问•皮部论》说：“是故百病之始生也，必先客于皮毛，邪中之则腠理开，开则入客络脉，留而不去，传入于腑，禀于肠胃”。袁青据此认为外邪入侵机体的路径依次是：皮毛—腠理—络脉—腑脏（袁青，2007）。《灵枢•经脉》中指出：“诸刺络脉者，必刺其结上甚血者，虽无结，急取之，以泻其邪，而出其血，留之发为痹也”。所以各种旨在皮肤刺激而达到治疗效果的，都是属于通过皮部治疗疾病的方法（袁青，2007）。梅花针的治疗如果伴随拔罐放血疗效比较好，达到出其血，去其邪。 根据皮部论的论述就不难解释有些所谓的研究，以针刺十二经穴位和针刺所谓无穴区作为对比研究，其实是一种谬误，发现两者都有效果，也就毫不稀奇了。

梅花针的临床应用

梅花针验之临床对好多疾病疗效显著，适应范围很广，尤以皮肤病，腰腿痛和斑秃用得比较多。其它还有头痛、胸胁痛、肌肤麻木等等。下面列举几个病例于供参考。

1．Mrs. Alexander，60岁，患不安腿综合征10年余。每以开会或和朋友聚会时双腿便不停摇摆，不得不起身活动一会方能缓解，晚上睡觉时也会发作，甚为懊恼。在朋友介绍下于2009年来就诊，我施以梅花针加拔罐出血治疗，选穴殷门、委中和承山。第一次治疗后即大为好转，第二次治疗后完全没有发作，一疗程六次完后停止治疗，3个月后随访没有复发。

2. 王太太, 58岁，2011年来诊。患左肩痛两周，肩关节活动正常，食指至尾指四个手指皆麻木，有颈痛史。在肩髃穴施以梅花针加拔罐出血治疗，一次治疗后则疼痛与麻木全消。第二次后就没再来治疗。两个月后因头痛来就诊，告知之前两次治疗后肩痛未再复发。

3. Nila， 女，43岁，患湿疹15年，2010年前来就诊，在四弯和小腿肚上可见深红色皮疹和抓痕，诉痒甚难以控制而抓挠。施以梅花针加拔火罐放血约一毫升，因想试验梅花针和拔罐的疗效所以没给草药。治疗一次以后则痒减颜色变淡，第二次治疗后瘙痒完全消失，原皮疹处有淡灰色的色素沉着和梅花针针痕，治疗三次后就没来复诊。一个月后再次回来，诉皮疹有反复，但较前轻。按前法治疗，再根据辨证给以中药治疗，治疗3周而愈。时有联系，告知原皮疹处有时会有点痒，偶有些许皮疹出现，但自己可以不把它当回事了。

4．Mike, 男，65岁， 右尾指麻木。感觉偏木，而迟钝，约半年。血糖正常。无颈痛。颈部X光显示无神经根压迫。单纯 施以梅花针治疗，敲击力度较重而快速，让患者有疼痛难忍之感。治疗5次后麻木消失，感觉恢复。

5．Gary，男，53岁，患银屑病3年， 2010年就诊，双下肢、腹部和背部散见淡红皮疹，脱屑，轻微痒。为了试验梅花针的疗效，没有用拔罐和中药。经两次治疗完全无效，患者拒绝再用梅花针治疗，而改用毫针和中药治疗。

结论

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

根据个人多年断续的临床观察，梅花针和拔罐结合的疗效会更好，而单纯用梅花针则对皮肤感觉异常之症疗效较好。第五个案例是个梅花针治疗失败的病案，如果加上拔罐也许效果会进步。还有对感觉异常的病症梅花针敲打的力度需要大些。一些疑难病症在其它治疗方法无效时，梅花针也是个不错的选择。

文献参考结论

[1] 李苏民，王栋（2002），梅花针配合拔火罐的临床应用举隅。陕西中医，23（11）：1021-1022

[2] 王华（2006），皮肤针治疗常见病。北京：中国医药科技出版社

[3] 袁青（2007），靳瑞针灸传真。北京：人民卫生出版社

英国中医针灸杂志
Journal of ChineseMedicine and Acupuncture

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 1) is **10th February 2014**.

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.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

针刺治疗戒烟28例疗效观察和针刺戒烟机制的探讨

郭小川

摘要：戒烟是我们在英国经常遇到的治疗问题，其有效性是毋庸置疑的。笔者治疗28例取得了很好的疗效，有效率达到８９.３％。本文探讨了戒烟治疗的方法，并且对其机制进行了一定的探索，提出心理暗示不是针灸疗法戒烟的主要原因，其机制为针灸导致的人体中枢神经系统的反应，从而引起人体内在包括中枢神经系统的相互作用，激活去甲肾上腺素 (NA)系统，多巴胺（DA）系统和阿片样多肽系统甚至更多的中枢系统产生兴奋和欣快感，对大脑吸烟成瘾区域产生欺骗或阻断替代，从而使戒烟达到一定的有效率。

关键词：戒烟，针刺，尼古丁和尼古丁受体变异，欣快感递质，尼古丁成瘾奖励效应回路机制

一般资料

治疗28例患者，治疗时间分别为6到15周，28例患者，男15，女13 ，年龄27到75周岁。烟龄为3到50年，每天分别为15到50支烟量。

治疗方法

选择穴位：印堂，太阳，四神聪，戒烟穴，神门，外关，风池，足三里，三阴交，太冲。

耳穴：内分泌，神门，肺。

选择半寸及一寸针每周治疗一次，根据患者的个体情况不同，即吸烟的时间长短，数量多少，和对针刺的敏感程度，对28 例患者予6到15周的治疗。手法使用平补平泄，以得气为度，不用强刺激，留针20-30分钟，头背部推拿15分钟。

耳穴以王不留行籽耳压穴位治疗三天。耳穴选择为内分泌，神门，肺等。

选择性使用中药加味逍遥丸，西瓜霜喷剂等。

评判标准：治疗疗程中和疗程结束后四周未复吸者为戒除，治疗疗程中和疗程结束后四周内减量为每天5支和5支以下者为明显好转治疗疗程中和疗程结束后四周内减量为每天5支以上和原烟量的50%和50%以下者为有效。

治疗疗程中和疗程结束后四周内减量为原烟量的50%以上者为无效。

治疗结果列表：

	戒除	明显好转	有效	无效
28	11	10	4	3

戒除率为３９。３％，明显好转率为７５％，有效率为８９。３％，无效率为１０。７％

治疗结果分析和讨论：英国针灸戒烟市场的形成得益于公众对吸烟有害健康的深刻认识，在寻求针灸疗法戒烟者中，大部分是由于对其健康的担心而来寻求帮助，戒除率为３９。３％，明显好转率为７５％的结果昭示针灸戒烟的有效性。

机理和分析探讨：

药物成瘾的机制尚未完全阐明，主要的假说包括阿片样多肽在内的生物活性物质递质受体学说,成瘾的机制之一就是成瘾药物能作用于神经系统的特定部位，引发一系列神经、受体、细胞内信号系统、效应器等复杂的微观调控系统的改变, 外源成瘾性药物作用于相应受体主要是使去甲肾上腺素 (NA)系统,多巴胺（DA）系统和阿片样多肽系统等兴奋产生欣快感，激活中枢奖励效应回路机制，造成对用药行为的高度诱惑力而至成瘾。

使吸烟者产生心理快感的主要因素是烟草中的生物碱尼古丁，它是成瘾性物质。烟成瘾者对烟草有强烈的渴求，其本质即药物依赖性。对烟草成瘾的研究近年有所进展34：烟草尼古丁进入中枢神经系统，在中枢神经系统的胆碱能神经元上存在尼古丁乙酰胆碱受体，烟草中的尼古丁与尼古丁乙酰胆碱受体（nicotinic acetylcholine receptors，简写为nAChRs）(3,4)相结合并可使其受体产生变异，激活乙酰胆碱受体系统，并可能通过中枢神经系统的相互作用，同时激活去甲肾上腺素 (NA)系统，多巴胺（DA）系统和阿片样多肽系统产生兴奋和欣快感，形成奖励机制回路，久而久之形成尼古丁依赖。一旦停止吸烟即发生戒断症状，渴望吸烟、焦虑不安、头晕、头痛、注意力不集中、食欲旺盛和心率下降、皮质醇和肾上腺素分泌变化等一系列精神、心理和生理改变。

针刺本身是对于机体的一种局部刺激，作用存在于通过针刺诱发的穴位局部的和非局部的机体反应之中，其中最重要的是机体非局部的反应。针灸基础研究证实，在针刺过程中，针刺信号是通过穴位深部的感受器及神经末梢的兴奋传

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

入中枢,可以产生全身性的、多系统性的(如：大脑皮层功能性变化，神经内分泌性反应，神经血管性反应等)的机理变化(1)。大量实验研究结果则显示：体表穴位的针刺信号可通过神经，体液生化物质的梯级传递抵达某些脑区。尤其是网状结构和中缝核群的神经元，可被穴位的针刺信号通过多突触转换所激活，并进一步投射到脑干网状结构、中脑中央灰质和丘脑内侧核团，进而抵达大脑基底神经节和边缘系统有关脑区。，可以产生中枢神经多系统的复杂生化变化，导致去甲肾上腺素,5-羟色胺,多巴胺, 阿片样多肽等生物活性物质的增加(2),它们广泛分布于中枢神经系统，与尼古丁与尼古丁乙酰胆碱受体结合后的脑区变化密切相关2。笔者认为其综合的结果是形成了某些欣快感递质如多巴胺，阿片样多肽等的分泌增加或占优势，并导致和其相关受体结合，对大脑吸烟成瘾区域产生欺骗或阻断替代，。同时针灸对尼古丁变异受体对尼古丁的致敏性也可能产生一些积极的，有利于消除成瘾性的影响，一定程度上阻断了尼古丁中枢奖励效应回路机制。当使用针灸产生部分或全部代偿时，人体就可减少对尼古丁的需要，减少或杜绝吸烟，从理论和实践两方面上说，针灸对戒烟是有明确疗效的。对吸食毒品者也同样如此，笔者在两例使用大麻的戒烟者身上也观察到吸食大麻减量的情况。

笔者认为心理暗示不是针灸疗法戒烟的主要原因，而是戒烟成功相当重要的组成部分，在戒烟中需特别注意对吸烟者的心理成瘾性进行矫正，在治疗中给予心理暗示是十分必要的，医生的劝诫对吸烟者的心理和行为具有重要影响。医生关于针灸有效性的陈述，和吸烟的后果和戒烟的好处的劝告，特别是结合吸烟者自身健康情况的严肃和多次的劝告可以在很大程度上增强吸烟者的决心和自觉性。如果吸烟者在戒烟过程中反复接受医生的进一步指导，则有望在更大程度上提高戒烟成功率。

头部按摩和背部的指压疗法，是针灸治疗的补充，兼有针灸治疗和心理安慰疗法综合功能。

中药使用的主要目的是调节人体内环境的阴阳平衡：加味逍遥丸，防风通圣丸，西瓜霜喷剂，西瓜霜润喉片等交替使用，调节情志，加速新陈代谢过程，清除体内尼古丁与尼古丁相关的自由基毒素等有积极的意义。

以上的综合治疗其核心是针刺疗法。而各环节的兼顾对临床保证疗效都有其一定的必要性。

参考文献

[1] 张香桐、季钟朴等《针灸针麻研究》，科学出版社，1986年。

[2] 韩济生《针刺镇痛原理》，上海科技教育出版社, 1999年。

[3] Andrew R. Tapper, et al., Science (5 November 2004). Nicotine Activation of α4* Receptors: Sufficient for Reward, Tolerance, and Sensitization

[4] R. C. Hogg and D. Bertrand, Science (5 November 2004). Nicotinic Acetylcholine Receptors as Drug Targets

杨氏手足五穴针刺法的临床应用

杨青林

摘要：杨氏手足五穴针刺法是家传的一种针刺疗法，取穴三阴交、地机、足三里、阳溪、偏历。进针0.5寸，留针30分钟。杨氏手足五穴针刺法简单易行，适用范围广，疗效好，病人乐于接受。

关键词：杨氏手足五穴针刺法，0.5寸

针灸时，如何取最少的穴位，得到更好的效果，需要临床医师不断地学习、实践和探索。本人学习家传杨氏手足五穴针刺法, 并经过三十多年的实践和临床应用，取得很好的效果。现将杨氏手足五穴针刺法介绍如下。

杨氏手足五穴针刺法

针刺穴位：三阴交，地机，足三里，阳溪，偏历。

取针1.0寸（0.25x25mm）毫针，针刺多采用浅刺0.5寸，腿部针尖朝向近端，手部尖朝向远端, 留针30分钟。

特点：取穴少，适应多种疾病，效果好。

功能与主治：杨氏手足五穴在治疗支气管哮喘、糖尿病、甲低、甲亢、高血压、强直性脊椎炎、多发性硬化、盆腔炎、急性腹膜炎、不孕症、子宫内膜异位症和皮肤病等疾病上都有很好的疗效。特举例如下：

（1） 支气管哮喘：

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

R024，女， 德国人，出生日期 1977年2月26日，首诊日期 2007年4月4日。

病人在1996年出现过敏症伴有鼻咽痒，眼睛痒，打喷嚏，流涕，口干，咳嗽，无痰。2000年除上述症状外，发作支气管哮喘，胸闷，气短，呼吸急促，有哮鸣音。以后每年4月到7月发作，服药不能控制症状，需要使用气雾剂才能控制。查体：舌尖红，苔黄，脉细数。处方：针杨氏手足五穴，服中药每天一剂。一周后哮喘完全控制，停用气雾剂，此后哮喘再未发过，花粉过敏症未发过。巩固治疗一年。无复发。

（2）糖尿病

O024，男，非洲人，出生日期1945年12月28日，首诊日期2009年9月19日。

从1996 起患糖尿病和服用药物如下：

阿卡玻糖（Acarbose tablet，50mg tid），格列奇特（gliclazide tablet，80mg，2bd）， 匹格列酮 和二甲双胍（Pioglitazone & metformin tablet, 15mg+850mg, 1bd）雷米普利（Ramipril capsule, 5mg, 1bd）。

针刺杨氏手足五穴每周一次和中药每天一付。

经过三个月的治疗，病人的血糖情况降至正常，去医院检查正常。

结果:

日期	治疗前	治疗后
30/09/2009	13.5 mmol/L （餐后30分钟）	5.6 mmol/L 正常 （餐后90分钟）
29/10/2009	8.1 mmol/L 正常 （餐后30分钟）	6.7 mmol/L 正常 （餐后90分钟）
11/11/2009	10.4 mmol/L正常 （餐后30分钟）	6.7 mmol/L 正常 （餐后90分钟）
25/11/2009	7.7 mmol/L 正常 （餐后30分钟）	7.4 mmol/L正常 （餐后90分钟）
10/12/2009	4.8mmol/L 正常 （空腹）	4.8 mmol/L正常 （空腹）

(3) 巴金森氏病

G024，女，英国人，出生日期 1962年4月21日，首诊日期 2007年4月21日。

患有巴金森氏综合症五年，服西药五年，2006年在医院住院一年，症状不能改善，医生建议做脑部手术，以缓解症状。本人拒绝手术，故而出院，请求中医帮助。面部肌肉、舌头、双手颤抖，不能持物，不能端水杯严重影响生活。口腔溃疡，有甲亢病史。舌淡紫，苔薄白，脉弱。针手足五穴，经络疏导法按摩。第一次治疗后手颤抖明显减轻，服中药，每天一付。三次后手颤抖完全消失，可以端起满杯水。舌头仍有颤抖但减轻很多。间断治疗一年。观察至今未发。

（4）急性盆腔炎：

M059，女，1977年1月31日生。 英国人。 盆腔感染3周。首诊日期2007年9月5日。

人流后，出现阴道出血不止，腹痛，在医院治疗，诊断为盆腔感染，在医院给与输液三周疗效不佳，仍有腹痛，不能正常行走，阴道流血不止。要求中医治疗。查:病人捧腹而行，表情痛苦，言语轻微，不敢大声说话，查: 舌稍红，苔黄白，脉数，全腹部压痛，下腹部有反跳痛，有少许肌紧张。诊断为流产后感染，盆腔炎。针手足五穴，和经络疏导按摩法后，病人能像正常人快步行走，可以蹦跳，腹部不痛。腹部无压痛，无反跳痛，无肌紧张。给中药七付和归脾丸一盒。第二次治疗后病人停止一切治疗，包括西医治疗和中医治疗。

（5）甲状腺功能低下：

L048，女，英国人，出生日期 1954年1月5日，首诊日期 2009年2月7日。

该病人2005年在医院确诊为“甲低”，每日服甲状腺素100MG，但颈部日渐增大影响呼吸，全身肿胀日渐严重，而且日渐肥胖，故来就诊。针刺手足五穴。治疗三次后病人觉得呼吸通畅，颈部无压迫感，全身肿胀明显减轻，四次治疗后全身肿胀全部消失。十二次治疗后减少10%的药物服用量。

（6）不孕症：

S060，女，英国人，出生日期 1968年5月4日，不孕症五年。 首诊日2008年6月26日。

病人未服避孕药五年未孕。经医院检查病人无排卵，体内的FSH和LH的激素水平异常，无法作IVF，故来此就诊。末次月经17/06/2008，持续3天，周期28天，无痛经，无血块，量中等。查体：舌淡红，苔薄白，脉缓弱。处方：针手足五穴治疗和中药每天一付。三个月后病人的体温曲线发生变化。五个月后双向体温曲线明显而且稳定。病人在医院检查FSH、LH结果正常。

（7）顽固性头痛

G012，男，德国人，出生日期1959年5月3日，头痛33年，首诊日期2007年4月7日。

从1973年开始出现头痛，从后头部至两侧头痛，有时出现头顶和两侧头痛，眉棱骨疼痛，时重时轻，下午加重至晚上9点左右，劳累乘飞机加重，咖啡因可减轻疼痛，怕光，伴有恶心，眩晕，每日都有头痛。曾在许多国家、中医医院、中医诊所治疗过，未见疗效。舌稍红，边有齿痕，芒刺，苔白，脉弦。针手足五穴，经络疏导按摩，和服中药，每日一付。第三次治疗后疼痛明显减轻。第四次治疗后，头痛症状消失，共治疗十次。观察三年无复发

（8）蛛网膜下腔出血及尿血

王女士，中国人，出生日期1972年7月9日，首诊日期 2013年6月11日。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

腰椎间盘突出患者。5月15日做腰椎间盘造影术。术后一小时出现双下肢麻木，疼痛，三小时后双下肢瘫痪。5月15日晚10点钟做MRI发现椎管内出血，从第八胸椎至骶椎有血液。5月18日病人出现头痛，呕吐，继而昏迷数小时。住院治疗25天，仍有双下肢瘫痪，胸部疼痛，头痛，肉眼血尿。6月11日晚和6月12日上午下午各针杨氏五穴一次，6月13日血尿停止。以后每天两次，针杨氏五穴和腰背俞穴各一次，6月16日病人下床缓慢行走，6月19日病人能做家务和下厨做饭。6月27日做ＭＲＩ显示椎管内血块大部已吸收。

讨论

1. 针疗的作用

打通经脉的阻塞，使经气畅通，气行血行，敷布全身，协调阴阳，使机体保持协调和相对的平衡。

2. 针刺前应注意的

《灵枢》（刺节真邪第七十五）：“用针者必先查其经络之虚实，切而循之，按而弹之，视其应动者，乃后取之而下之。”

《灵枢》（九针十二原第一）：“往者为逆，来者为顺，明知逆顺，正行无问。逆而夺之，恶得无虚，追而济之，恶得无实。迎之随之，以意合之，针道毕矣。”

张介宾《类经》注曰：“凡病邪久留不移者，必于四肢八溪之间有所结聚，故当节之会处索而刺之”。说明古人早已认识到穴位是与脏腑经络之气相通，并随之活动变化的反应点。机体在病理状态下，体表穴位具有反映病证的作用。

作者通过实践得出了一些经验，总结如下：

1) 用针之前，最重要的是要了解病人的病史，病症和基本的辩证，循经查之，得之经络的虚实，何处诸塞，何处虚损，以确定是补是泻。要注意在经络上出现的疼痛、凹陷、结节，温凉、滑涩、色泽、明暗。注意经络上的变化。

2) 从病变的边缘入针，不要有针感。 最好让病人没有太多的感觉。

3) 针刺入皮肤以后，稍稍推入一点儿，感觉有一个很小的阻力（就象针刺进橡皮的感觉），不需要达到正规的深度。如果没有阻力，需要调整一下。

4) 身体左边的病变是阳症，身体右边的病变是阴症。结节是阳症和有余，凹陷是阴症和不足。

3. 针刺手足五穴治病的原理及可以治疗的疾病

从理论上说，针刺杨氏手足五穴，可以治疗全身的疾病。

《灵枢》（始终第九）曰：“从腰以上者，手太阴阳明皆主之；从腰以下者，足太阴阳明皆主之。”

手足五穴针刺法的五个穴位就是取采用手太阴，手阳明和足太阴，足阳明经的五个穴位。手阳明的阳溪穴和手太阴的太渊穴仅隔着一个拇短伸肌，阳溪透太渊，手足五穴里偏历络和太阴，是太阴与手阳明的沟通，足三里是手阳明与足阳明胃经间的沟通和足阳明胃经与足太阴脾经间的沟通，三阴交是足太阴脾经与足少阴肾经和合足厥少阴肝经的沟通。地机是足太阴脾经的郄穴，使本经经气深聚的部位，

因此，针刺手足五穴交通了十二经脉的循行交接，从手太阴肺经---手阳明大肠经---足阳明胃经---足太阴脾经…足少阴肾经…足厥阴肝经---手太阴肺经，周而复始，使人体不断地得到精微物质而维持各脏腑组织器官的功能活动。

只要治疗得当，方法正确，即使是二十年的疾病也可以治疗，器官的功能是可以恢复的。

杨氏手足五穴针刺法简单易行，适应范围广，效果好，值得推广。

浅谈急性湿疹辩治

朱 沛

来英数年来，发现这里气候潮湿，风大雨多，再加上人们不注重均衡健康饮食，所以湿疹病人颇多。而前来应诊的湿疹患者，急性湿疹亦不在少数。湿疹急性发作，皮疹，红斑，全身分布，瘙痒剧烈难忍，伴液体渗出，结痂，严重影响正常生活和工作。笔者总结数年来临床诊治，发现虽同为急性湿疹发作，但临床证型却不尽相同。故总结如下，望能起到抛砖引玉的作用，供同道参考。

临床表现

本病发病快，多数有慢性湿疹病史，皮损表现多为对称性，可发于全身任何部位如面部，双耳，颈前，胸背，腹部，四肢等，或泛发全身，伴有皮疹，红斑或潮红，丘疹疱，水疱，脓疱，流滋，结痂并存，皮损多为多形性片状或弥漫性，边界不清，由于瘙痒抓挠可见水疱顶端抓破后渗液，糜烂或结痂。瘙痒剧烈，夜晚尤甚，严重影响患者睡眠。

鉴别诊断

1. 接触性皮炎

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

常有明显病因及接触史，皮损局限于接触部位，界线清，痒或有灼热感。去除病因后，痊愈快。

2. 神经性皮炎

皮损倾向于干燥，有典型的苔癣样变，无多形性损害，本病好发于颈侧，肘窝，腘窝、前臂、大腿、小腿及腰骶部等。 常成片出现，皮肤增厚，常不对称。

3. 手足癣（真菌感染）

皮疹边界清楚，上有细薄的鳞屑，多从单侧发病，从一个部位逐渐蔓延。

辩证治疗

1. 胃热炽盛，风湿内蕴

主证: 除上述临床表现外，皮疹或红斑色鲜红，伴有口渴，咽干舌燥，身热不扬，喜食冷饮，或有大便干，小便短赤，情绪可，睡眠差，舌质红绛（舌体中部为甚），无苔，脉滑数。

治则: 清热泻火，解毒祛湿止痒。

方药: 白虎汤合五味消毒饮，六一散。

石膏、知母、赤芍、丹皮、栀子、生地、蒲公英、连翘、金银花、滑石、甘草、当归、防风、白蒺藜、车前子

服用一至两周后，诸症均可见缓解，清热解毒药大多寒凉，久服易伤胃，故主症控制后可酌减用量或减去，又病久易耗伤阴血故宜酌情增加补血养血滋阴活血，健脾祛湿之品如丹参，川芎，麦冬，白芍，薏米，白术，土茯苓，萆薢等。

2. 心肝火旺，湿热内盛

主证: 除上述皮肤表现外，此类病人多表现为情绪急躁易怒，伴抑郁，口苦，口渴，嗜辛辣或饮酒，大便干，小便黄，睡眠差，舌尖边红，舌苔黄腻，脉弦滑数。

治则: 清泻肝火，清利湿热，祛风止痒。

方药: 龙胆泻肝汤合六一散加减。

龙胆草、柴胡、丹皮、栀子、苦参、黄芩、黄连、生地、当归、土茯苓、泽泻、滑石、甘草、防风、白蒺藜、车前子

主症控制后随症调整药物及剂量。

3. 脾虚湿盛，血虚风燥

主证: 除上述皮肤表现外，此类病人多有体型稍胖，慢性湿疹病史，急性发作，皮疹色暗，皮肤可见鳞屑，结痂与流滋并见，无有口渴，素喜食甜食，大便溏，情绪可，睡眠可或嗜睡，乏力，舌质红，体淡胖，边有齿痕，苔白腻或薄黄，脉滑缓。

治则: 健脾祛湿，养血活血，祛风止痒。

方药: 胃苓汤加减，萆薢分清饮合六一散加减。

萆薢、白术、茯苓、陈皮、厚朴、丹参、薏米、土茯苓、泽泻、猪苓、滑石、甘草、当归、防风、白蒺藜、车前子。

体会

各类证型处方用量均需在常用量的基础上根据症状轻重酌情调整。不同药物的增减同理。有是症，用是药。临证时经常会遇到证型不典型或不单一，或两种、三种证型同时出现，可根据主症灵活配伍。

急性湿疹伴有慢性病史治疗时，相对疗程稍长，通常约需 4 至 6 周可使病情完全控制。且症状缓解后，容易复发，迁延病久，易耗伤阴血，需注重养血、活血、益阴及健脾、祛湿相配合。

在草药，针灸治疗的同时，最好加用火罐治疗，急性期可用火罐拔出大量淡黄色液体或淡红色半固体粘液。应用消毒棉球清洁干净，避免感染。

治疗期间，禁食辛辣、海鲜、羊肉、饮酒以及黄油和奶酪等。以免诱发或加重病情。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Is acupuncture as effective as pharmacological management in migraine prophylaxis?

Apostolos Apostolou , Tianjun Wang

University of East London

Abstract

Aim: To assess whether acupuncture is an effective alternative to pharmacological management in the prophylaxis of migraine.

Rationale: Epidemiological studies suggest that migraine has a huge impact on the world population in terms of pain, side-effects and cost of loss productivity at work.

Methods: internet based research of relevant and recent randomized controlled trials and subsequent comparative analysis.

Results: Six relevant and recent papers were found to be published on migraine prophylaxis incorporating acupuncture treatment and drug control interventions. All reviewed papers varied considerably in study design and quality, making comparative analysis challenging. Nevertheless, a meta-analysis from the available quantitative data was performed and provided results that are concordant with the cumulative effect of acupuncture treatment. Furthermore, statistically significant increases in the percentage of responders and decreases in rescue medication suggested that acupuncture is an effective prophylaxis for migraine without the adverse events of standard pharmacological management.

Conclusion: There is evidence to suggest that acupuncture could be considered as a first line treatment for chronic migraineurs, particularly in patients who cannot tolerate standardized drug therapy. NICE guidelines may need to be updated. Forthcoming trials need to be redesigned to optimize the full potential of acupuncture in the treatment of migraine. .

1. Introduction

Conditions that have been linked to migraine were described in detail dating back to 3000BC from Babylonian writings. Papyrus scrolls from around 1550BC buried alongside a mummy in Thebes describe very similar symptoms to what we now regard as a migraine.Hippocrates in 460 BC described a shining light that was typically seen in one eye followed by severe pain that started on one side of the head and enveloped the whole head and down the neck.

Hua Tuo was a Chinese surgeon in the 2nd century who was given credit for the invention of anaesthetic drugs, he was also one of the first to take acupuncture needles to cure migraine. According to Traditional Chinese Medicine: migraine belong to the categories of "Tou Feng" (wind in the head) and "Pian Tou Tong" (pain of the half head) and were either caused by external pathogens or internal excess or deficiency, many of which related to the seven emotions and effecting the Liver.

A headache is a pain of any kind in or around the head. There are several types.

Common visual disturbances during migraine attacks include flashing or coloured lights. Nausea and/or vomiting may occur during an attack. Common prerequisites for a migraine include emotional strain, anxiety or around menstruation. Certain foods, like chocolate, may trigger off migraines and they usually occur between puberty and middle-life.

Attacks differ from person to person, but typically start with visual symptoms. In severe cases, pins and needles may occur or a weakness may arise on one part or sides of the body. These pre-symptoms can last for half an hour, then the pain will start on one side of the head. It will be severe and throbbing. Photophobia may also occur, plus pallor and sweating (Gascoigne, 2001).

Western pharmacological medication may come at a price concerning side effects from long and short term use. Pathologies include nausea, stomach upset, stomach ulcers, irregular or fast heart rate and seizures (Gascoigne, 2001). For the above reasons, this project needs to answer whether acupuncture can be deemed a safe alternative to prophylactic drugs.

Drug treatment for migraines is divided into two broad categories: acute (sudden onset) and prophylactic (to reduce frequency and intensity of recurrent attacks). For the purpose of this research project only prophylactic will be discussed. It is worth mentioning briefly about the drugs that are used for prophylactic. Drugs used are divided into six broad categories.

Acupuncture is part of an ancient system of Chinese medicine developed over 2000 years ago. Its core principle is the view of no separation between mind and body and that imbalances in one will generally lead to imbalances in the other (Birch et al., 2008). The primary concern of Western medicine is to isolate disease categories or agents of disease where identification of symptoms and causes are the main goal. Chinese medicine, however, considers all physiological and psychological presenting symptoms as well as external environmental factors so forming an overall pattern of disharmony from which a diagnosis and treatment plan can be devised (Kaptchuk et al., 2000).

Acupuncture has gained popularity in the Western hemisphere since the late seventies (Kaptchuk et al., 2000), and as a result of this growth and with the development of evidence-based medicine, there has been increasing demand for acupuncture and Chinese medicine in general to be able to demonstrate its efficacy and

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

effectiveness through the use of rigorous clinical trials in the form of randomised controlled experiments.

Acupuncture is considered a relatively safe therapy with few side effects (BMA 2004), whereas drug therapy has many possible side effects, especially when the patient takes them on a long-term basis.

Successful treatment of headaches and migraines relies on the expertise of the acupuncturist to identify and treat the both Ben and Biao, the affected Zangfu and associated channels.

The primary purpose of this research project was to assess whether acupuncture is an effective alternative to drug therapy as a prophylactic treatment for migraine headaches.

Acupuncture in the West is still not fully accepted, with much doubt, fear and unawareness from the public (MacPherson et al., 2008), because of this, further research is still needed to prove the efficacy and effectiveness of acupuncture as a safe alternative to drug therapy as a prophylactic treatment for migraine headache.

The reason as to why this question needs to be investigated is the fact that epidemiological studies report that migraine headaches have adverse effects on the human population in terms of pain, resources and costs, both personal and to the world national health systems.

2. METHODS

2.1 Identification and selection of studies to be reviewed

A broad search strategy was used in order to identify as many articles as possible. The following databases and sources were searched: PubMed, The Cochrane Central Register of Controlled Trials, The Journal of Chinese Medicine Archive, Allied and Complementary Medicine (AMED), Acubriefs, Acupuncture Research Resource Centre (ARRC).

The search terms used for the electronic databases were: acupuncture, migraine, prophylaxis, prophylactic migraine drugs, flunarizine, metoprolol.

In addition to systematic searches at the beginning of the research project, regular checks were carried out in PubMed in order to identify new studies by searching for migraine and acupuncture. Facco's study was identified in one of these regular checks.

2.2 Criteria for considering studies for this review

Randomized controlled trials were selected for this review, which is to say, controlled trials in which allocation to treatment groups (acupuncture and drug control) was randomized. Study participants had to be diagnosed with suffering from migraine for over one year. The acupuncture treatment involved needle insertion and the control intervention had to be prophylactic drug treatment, excluding acute treatment interventions.

Studies had to be less than 10 years old and had to be original research papers. In addition they had to provide results on outcome measures in which statistical analysis had been performed.

2.3 Data collection and analysis

Abstracts identified during the selection process were read and screened in order to identify candidate studies for inclusion. Full texts of shortlisted papers were obtained and screened in order to carry out the final selection.

Relevant general information was extracted from selected studies using an information extraction form. Information extracted included country, number of recruitment centres, blindness, treatment groups, inclusion of sham acupuncture, number of patients randomized, number of patients treated, number of patients analyzed, number of patients per treatment group, presence of aura, type of acupuncture treatment (standardized, individualized or semi-standardized), duration of acupuncture treatment, number of acupuncture sessions per week, total number of acupuncture sessions, acupuncturist training and expertise, drug treatment used, drug type, duration of prophylactic drug treatment, type of rescue medication allowed and whether usage was measured, use of headache diaries by patients, duration of baseline period, duration of follow-up period and measurement time points (in weeks and months).

Before quantitative data was extracted, as explained below, outcome measures studied were annotated in the information extraction form, including: proportion of responders, frequency of migraine attacks, migraine days, pain intensity, rescue medication, adverse events, physical and/or mental health questionnaires.

The precise time-points in which studies evaluated their chosen outcome measurements varied considerably. In order to allow for comparative analysis, time-points were grouped as follows: early time-points around 1-2 months after baseline (T1), mid time-points around 3 months after baseline (T2) and around 1 year after baseline (T3).

3. RESULTS

3.1 Comparative description of studies

Six randomised controlled trials that compared the efficacy of acupuncture prophylactic treatment to standard drug controlled interventions were reviewed. They were published between 2002 and 2013.

A total of 1,552 migraine patients participated in the reviewed studies. The mean number of patients in each trial was 259, with a median of 114. The smallest trial included 70 patients and the largest 990. Two trials originated from Germany, two from Italy, one from China and one from Taiwan.

All trials used parallel-group designs. Five trials had two groups (one acupuncture group and a control group) and one trial had three groups (verum acupuncture, sham acupuncture and standard drug treatment). A two-group trial followed a double-dummy design where the acupuncture group was also administered a placebo treatment and the control intervention included sham acupuncture and drug treatment; this design was the only design that allowed patients to be completely blinded to the type of treatment they were receiving. Therefore, two trials (Diener and Wang) used sham acupuncture in their control interventions.

Most trials included patients diagnosed as having

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

migraine with or without aura. One trial (Allais et al., 2002) was restricted to women with migraine without aura.

Acupuncture treatments were semi-standardized in four trials. They included both "basic" points and additional individualized points based on traditional Chinese syndrome diagnosis. Two trials used completely standardized acupuncture treatments.

The length of acupuncture treatment varied to a great extent ranging between 4 weeks and 24 weeks (from 1 month to nearly 6 months) with a median acupuncture treatment of 17 weeks (4 months). The total number of acupuncture sessions was also quite variable among studies, ranging from 10 to 32 sessions, with a median of 16 acupuncture sessions.

The length of control drug treatment also varied widely among studies, ranging from 4 weeks to 24 weeks (1 month to nearly 6 months), with a median of 12 weeks. Two studies compared acupuncture treatment with flunarizine (a calcium-channel blocker), two studies used anti-convulsants (valproic acid and topiramate) as standard prophylactic drug treatment, one study used a beta-blocker drug (metoprolol) and one study used a combination of beta-blockers, flunarizine and valproic acid.

Rescue medication for acute attacks was allowed in all studies. Frequency of rescue medication use was evaluated in all trials as an outcome measurement.

All studies used a headache diary kept by patients for measuring primary outcomes. Trials included a pre-treatment baseline period prior to randomization into the parallel treatment groups. Four out of six trials followed patients for 6 months or more after randomization.

The complex headache data on number of migraine days, frequency, percentage of responders, pain intensity and use of rescue medication were measured and presented in highly variable ways, making systematic extraction and comparison difficult.

Systematic analysis was further complicated by variable follow-up time-points, including 4, 6, 8, 12, 13, 24 and 26 weeks after randomization (Table 4). For comparative purposes time-points were grouped as early (4-8 weeks, 1-2 months), mid (12-13 weeks, 3 months) and late (24-26 weeks, 6 months) time-points.

3.2 Quantitative analysis of outcome measurements

Outcome measurement quantitative data was extracted from the six reviewed studies and represented to allow comparative analysis.

The number of responders was measured in four of the six studies reviewed: Diener, Streng, Wang and Yang. All four studies reported an increase in the amount of responders (3 months after baseline) in the group treated with acupuncture compared with control interventions. Two studies, Wang and Yang, found these differences to be statistically significant ($p=0.042$ and $p<0.01$, respectively).

Comparative data for the percentage of responders showed that the greatest difference between acupuncture and control groups was found in Yang's study. Yang's included the highest number of total acupuncture sessions (24). This was followed by Wang's, whose study provided 12 acupuncture sessions per patient, and also presented the second highest difference between acupuncture and control groups. Conversely, it was observed that Diener showed the smallest difference in the percentage of responders between acupuncture and control groups and was also the study with the least total number of acupuncture sessions provided.

A possible correlation between the percentage of responders and the length of treatment was therefore analyzed for this review. Interestingly, the percentage of responders at 3 months showed a very strong correlation ($R2=0.935$) with the total number of acupuncture sessions received. This data provides evidence that supports the widely held notion that the effects of acupuncture treatment are cumulative and therefore its effects related to the number of acupuncture sessions received. No evidence of correlation was found between the percentage of responders and the length of drug treatment ($R2=0.001$, data not shown).

Two of the six studies reviewed were designed with a control intervention that included sham acupuncture: Diener (sham control group) and Wang (double-dummy approach). Both studies investigated the percentage of responders and the number of migraine days per month as outcome measurements.

Statistically significant differences in the percentage of responders between acupuncture and control groups were found both in Diener's and Wang's studies. Differences in Diener's study were confined to the first time-point analyzed at around 2 months (T1), with differences not reaching significant values at time-points two and three (T2 and T3). No statistically significant differences between the verum and sham acupuncture groups were reported.

Wang's study showed statistically significant differences in the percentage of responders between the acupuncture and control group (that included sham acupuncture) at both time-points studied (T1 and T2, $p=0.043$ and $p=0.042$, respectively).

When the total number of migraine days was investigated, Diener only reported a significant difference between verum and sham groups at the third and last time-point analyzed (6 months). On the other hand, the reduction in the number of migraine days per month was highly statistically significant in Wang's study at both time-points analyzed ($p<0.01$).

Rescue medication for acute migraine attacks was used as an outcome measurement in all six studies reviewed; however, different variables were studied, including: number of analgesic doses taken per month, number of days per month when rescue medication has been used, number of participants taking rescue medication and percentage of participants taking rescue medication.

In order to obtain data that allows inter-study comparisons for this review, data related to the number/percentage of participants taking rescue medication was extracted from three studies (Diener, Wang and Yang) and converted into percentages of participants for comparisons. Two out of the three studies analyzed (Wang and Yang) revealed statistically significant

Linear regression analysis was used to investigate a

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

possible correlation between the percentage of participants taking rescue medication and the total number of acupuncture sessions received. This correlation was found to be moderately strong (R2=0.5455), again providing evidence that supports the cumulative nature of acupuncture treatment.

Five of the six clinical trials reviewed, all but Diener's, provided data in regards to adverse events reported by participants as a result of treatment received. All five studies reported significantly higher numbers of adverse events in participants that were taking prophylactic drugs. These ranged from 10% to 66%, with an average of 44% participants on drugs reporting adverse events compared to an average of 8% of participants receiving acupuncture complaining of adverse events (0-15%).

4. Discussion

A limitation of this project was the fact that only six relevant and recent papers had been published on migraine prophylaxis and therefore available for review. In addition, all six reviewed trials analysed a variety of different outcome measurements, such as pain intensity, responder rates, migraine days and rescue medication, at differing time points ranging from 4 to 26 weeks and sometimes using different quantitative variables. Furthermore, treatment courses also differed both for acupuncture and drugs in regards to length, number of acupuncture sessions or drug dose.

Their varying designs posed limitations for the systematic analysis and evaluation of their results, making comparisons of the six papers challenging. To improve these limitations, designs of future trials should be more homogeneous, designed in a similar fashion, so as to facilitate future comparative studies that can generate rigorous data to inform clinical practice.

This project provided a comparative study, both quantitatively and qualitatively, of the reviewed papers. A particular strength of this project was its meta-analysis of the available literature in a small scale. This project generated a new data set from the quantitative data extracted from the reviewed papers which allowed the study of the relationship between the number of acupuncture sessions and outcome measurements such as the percentages of responders and the rescue medication use. Results presented in this review showed evidence of strong correlations between the number of total acupuncture sessions administered and the increase in the percentage of responders, and also with the reduction of rescue medication use. Importantly, these results provide new evidence that supports the traditionally held view that acupuncture is cumulative and its effects increase with the number of treatments received.

In the two German trials (Diener et al., 2006) (Streng 2006) a large proportion of patients withdrew informed consent immediately after being allocated to the control (drug) group. Further along these trials additional patients also withdrew. This suggests that some patients that signed for the trial did so with the expectation or hope of being assigned to the acupuncture group, and withdrew if this was not the case. This may be a source of bias.

Interestingly, verum acupuncture did not prove to be superior to sham acupuncture in the reviewed study that used a sham control intervention. This observation is concordant with previous reports (Deng et al., 2007).

There may be three possible explanations: a) acupuncture may act as a potent placebo, b) sham acupuncture may produce direct neuro-physiological changes that may relieve several migraine symptoms and c) due to a lack of blinding, comparisons with routine care and prophylactic drug treatment may be biased (MacPherson et al., 2008).

The average effect of placebo interventions seems to be small (Chan et al., 2004); however, evidence exists that more complex placebos create larger effects (Kaptchuk et al., 2000). Evidence also exists that sham acupuncture has a greater effect than a placebo pill. Available evidence suggest important mechanism for placebo to work include expectations, conditioning, reduction in anxiety and social support (Benedetti, 2008). Acupuncture treatment involves repeated sessions, hands on treatment, empathy, and often, a very personal case history and an individualized diagnosis and treatment plan.

Sham acupuncture protocols involve needling in non-specific TCM points, but with the same frequency and the length as verum acupuncture (Diener et al., 2006) (Wang et al., 2011). Some researchers suggest that most neuro-physiological mechanisms involve in acupuncture do not have to have point specificity (Bäcker et al., 2004). Furthermore, the quality of acupuncture treatment in clinical trials is often disputed. Trials analysed for this review used standardized or semi-standardized needling protocols, which greatly differ from highly individualized routine care. Routine care may also include additional modalities such as Tui Na, cupping and electrotherapy. The challenges lie in designing and conducting clinical trials that suit the complexities of acupuncture treatments, especially when it comes to blinding and selection of control interventions.

Comparative results presented here, particularly in regards to rescue medication and reduction in migraine days, all point towards the fact that acupuncture provides effective prophylaxis for migraines.

Comparisons of prophylactic drugs versus acupuncture find fewer patients reporting adverse effects and a lower dropout rate in favour of all the acupuncture groups reviewed from the six trials. As public awareness increases in regards to the considerable side-effects of prophylactic drugs, acupuncture can only gain popularity over time.

From the National Institute of Clinical Excellence (NICE) guidelines (2012) sections 1.3.16-1.3.18 advise that after taking into consideration the persons preference, comorbidities, risk of adverse effects and the impact on their quality of life from migraines, that topiramate or propanolol can be taken. If neither are suitable of ineffective, a course of 10 sessions of acupuncture should be considered over a period of 5-8 weeks.

This recommendation is a massive leap forward for the credibility of acupuncture treating migraines and for the awareness of acupuncture to the general public. Up to ten sessions are recommended. Therefore one can expect that acupuncture has a cumulative effect and it would take, by recommendation from NICE, a minimum of ten sessions to show its efficacy and effectiveness over

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

treating migraines.

Several problems arise from this recommendation: a) topiramate and propanolol are still offered as first line treatment and acupuncture as a second recommendation and b) the lack of acupuncture involvement in the infrastructure of the NHS leads to many members of the public unable to afford acupuncture treatment.

In addition, many important issues remain unresolved. The real cost of implementing acupuncture clinics and employing acupuncturists within the infrastructure of the NHS should be evaluated. One successful example in South East London is the Gateway complementary therapy clinic within Lambeth Hospital, which has been running successfully for many years. This model could be replicated in other parts of the country within the infrastructure of the NHS. Optimal treatment length protocols need to be determined by improving study design, thereby allowing migraineurs minimum acupuncture sessions but still providing the maximum migraine-free period, therefore maximising the cost-effectiveness of acupuncture within the National Health System in the UK and potentially all public health systems around the world.

The fact that Europe alone spends 27 billion Euros a year on migraine research (Lekander et al., 2007) and proven research that drugs perform significantly worse than acupuncture when adverse events and side-effects are taken into consideration, should place acupuncture in the forefront of migraine prophylaxis.

5. Conclusion

Evidence presented in this review suggests that acupuncture is an effective treatment for chronic migraineurs, particularly in patients who cannot tolerate the vast array of implicated side-effects associated with standardized drug therapy.

NICE guidelines may need to be updated to incorporate acupuncture as a first line treatment on a par with the current pharmacological drugs such as topiramate and propanolol.

Designs of future trials should aim to be more homogeneous so as to facilitate future comparative studies that can generate rigorous data to inform clinical practice. In addition, future study design should aim to optimize the full potential of acupuncture in the treatment of migraines; they should aim at more closely replicating the individualized treatment provided in routine care environment, which also incorporates additional TCM modalities.

Corresponded Author:
Dr. Tianjun Wang (University of East London. T.wang@uel.ac.uk, 020 82234557)

References

Allais G, De Lorenzo C, Quirico PE, Airola G, Tolardo G, Mana O, Benedetto C. (2002). Acupuncture in the prophylactic treatment of migraine without aura: a comparison with flunarizine. Headache. 42 (9), 855-61.

Bäcker M, Hammes M, Sander D, Funke D, Deppe M, Tölle TR, Dobos GJ.. (2004). Changes of cerebrovascular response to visual stimulation in migraineurs after repetitive sessions of somatosensory stimulation (acupuncture): a pilot study.. Headache. 44 (1), 95-101.

Becker C, Brobert GP, Almqvist PM, Johansson S, Jick SS, Meier CR.. (2008). Migraine incidence, comorbidity and health resource utilization in the UK. Cephalalgia. 28 (1), 57-64

Benedetti F. (2008). Mechanisms of placebo and placebo-related effects across diseases and treatments. Annu Rev Pharmacol Toxicol. 48, 33-60.

Diener HC, Kronfeld K, Boewing G, Lungenhausen M, Maier C, Molsberger A, Tegenthoff M, Trampisch HJ, Zenz M, Meinert R; GERAC Migraine Study Group. (2006). Efficacy of acupuncture for the prophylaxis of migraine: a multicentre randomised controlled clinical trial.. Lancet Neurol. 5 (4), 310-6.

Gascoigne (2001). The Clinical Medicine Guide. A holistic perspective. UK: Jigme Press.

Kaptchuk TJ, Goldman P, Stone DA, Stason WB. (2000). Do medical devices have enhanced placebo effects?. J Clin Epidemiol. 53 (8), 786-92.

Kaptchuk TJ, Stason WB, Davis RB, Legedza AR, Schnyer RN, Kerr CE, Stone DA, Nam BH, Kirsch I, Goldman RH. (2006). Sham device v inert pill: randomised controlled tria of two placebo treatments.. BMJ. 332 (7538), 391-7.

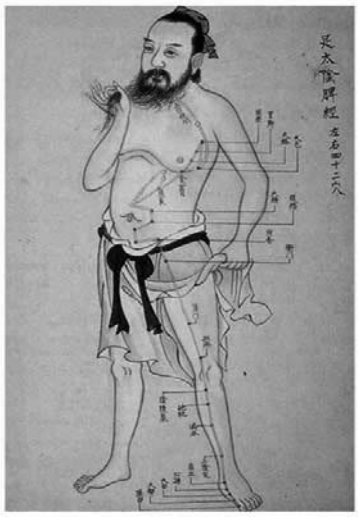
Kaptchuk TJ, Chen KJ, Song J. (2010). Recent clinical trials of acupuncture in the West: responses from the practitioners.. Chin J Integr Med. 16 (3), 197-203.

MacPherson H, Hammerschlag R, Lewith GT and Schnyer RN (2008). Acupuncture Research: Strategies for Establishing an Evidence Base. Philadelphia, USA: Churchill Livingstone Elsevier, Elsevier's Health Sciences. 112.

NICE clinical guideline 150 (2012), guidance.nice.org.uk/cg150.

Streng A, Linde K, Hoppe A, Pfaffenrath V, Hammes M, Wagenpfeil S, Weidenhammer W, Melchart D.. (2006). Effectiveness and tolerability of acupuncture compared with metoprolol in migraine prophylaxis.Headache1492-502.. 46 (10), 1492-502.

Wang LP, Zhang XZ, Guo J, Liu HL, Zhang Y, Liu CZ, Yi JH, Wang LP, Zhao JP, Li SS. (2011). Efficacy of acupuncture for migraine prophylaxis: a single-blinded, double-dummy, randomized controlled trial. Pain. 152 (8), 1864-71.



ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

针灸治疗颈源性头痛32例临床报告

张莉莎 郭振芳

(London)

摘要：本文观察针灸治疗颈性头痛的疗效，将32例患者选用天牖、颈夹脊、风池为主穴进行针灸治疗，结果痊愈18例，好转10例，无效4例，总有效率87.5%；并探讨了颈源性头疼的病因病机。结论：本法治疗颈性头痛方法简单，疗效较满意。

关键词：颈源性头痛，针灸治疗。

头痛是临床常见的症状，病程较长、反复发作，其分类分型繁多，病因更为复杂。虽然许多头痛起源于或位于颈、项、枕部 ,但颈椎或颈部的疾患引起的头痛常被人忽略。1983年美国医生Sjaastad首次报道（1），并正式提出了颈源性头痛的概念。该概念的提出，是头痛研究领域中的重大进展。本病属中医“太少两经头痛”范畴。自2008年以来笔者采用针灸治疗32例，现报道如下。

1．资料与方法

1.1 临床资料

32例颈源性头痛患者全部病例均以头痛为第一主诉，其中男10例，女22例；年龄最大75岁，最小19岁，平均31岁；病程最长者28年，最短3个月，平均5年。

1.2 方法

1.2.1诊断标准

本文所采用Sjaastad于1990年提出的颈源性头痛诊断标准（2）：

1) 间歇性或持续性头痛 (初起多呈单侧)，同时伴有同侧颈枕部或（及）肩部疼痛酸困、僵硬等症状；
2) 颈部肌肉紧张，压痛明显，C2横突压痛阳性，并向同侧头部放射；
3) X线片可见上位颈椎(C1～C2)移位，齿状突轴心偏移，生理性前凸消失、变直，甚至反张，颈椎骨质增生等征象；
4) 排除颅脑器质性疾病、五官科疾病、颈部肿瘤、结核等引起的头痛。

1.2.2纳入标准

符合上述诊断标准且符合以下条件：

1) 传染病及严重内脏病；
2) 自愿接受针灸治疗并能坚持治疗；
3) 患者可耐受较强刺激的针灸治疗。

1.2.3排除、剔除标准

1) 不符合颈源性头痛诊断标准；
2) 孕妇及伴有较严重的其它疾病，不适宜较强刺激针灸治疗；
3) 颈枕部皮肤条件不宜针灸治疗；
4) 不能按规定完成治疗。

2．治疗方法

主穴：天牖穴、颈夹脊、风池。配穴：伴肩痛者加肩井、肩髃、臑俞；伴手臂麻木者加小海、极泉；伴眩晕耳鸣者加听宫、听会；兼颞部疼痛者加太阳、率谷；额部疼痛者加印堂。

操作方法：患者取坐位或俯卧位，嘱全身放松，常规消毒后，用1寸毫针在所选穴位上针刺。

手法要求：天牖穴，用拇指触及天牖穴并深压至C2横突骨面，另一只手持针紧贴拇指甲快速刺入皮肤，缓慢进针至骨面，患者有明显的酸胀感，可放散至枕顶部，然后略提针沿骨边缘反复提插3—5次。C2横突邻近处有许多重要神经、血管，椎动脉在C2向外侧转折后上行，椎动脉孔向外侧开口，进针时易刺入。注意提插时不能深刺，出针时如有出血要多按压。风池穴，取穴时略偏外上，使针感沿头后外侧上行，部分患者可传导至前额或眼部。颈夹脊，以颈两侧局部有痛性结节、条索或压痛点处为穴更佳。以局部酸胀或向头部传导为度。年老体弱者刺激不可过强。留针30分钟，每周2次，6次1个疗程。共治疗3个疗程。

3 治疗效果

3.1 疗效判定标准（3）

痊愈：头痛消失。

好转：头痛减轻，发作时间缩短或周期延长。

无效：头痛症状等无变化。

3.2 治疗结果

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

痊愈18例，占56%；好转10例，占31%；无效4例，占13%。总有效率87.5%。

4 典型病例

（1） 患者，女性，66岁。头痛，伴眩晕，视物昏花反复发作5年，加重1年。开始大约每月发作1次，每次发作持续半小时至1小时，没有在意。以后每周发作，发作时间逐渐延长，可持续数小时，并且疼痛加重。以右侧枕顶部疼痛明显，严重时放散到太阳穴及前额。GP曾以神经性头痛、偏头疼给以止痛药，未效，并引起胃部疼痛。近1年来几乎每天发作，伴有眩晕和视物昏花。于2010年来诊。虽然患者未自述颈项部不适，但查体时颈部后伸及右旋欠佳，伴有疼痛。C2横突处有明显的压痛，疼痛放散到头右侧枕顶部。并C4、C5、C6、C7、T1右侧僵硬，可触及明显的痛性结节。斜方肌僵硬，天井穴明显压痛。选天牖、风池、颈夹脊穴，配以肩井穴。针刺后患者的头痛、眩晕即刻缓解，感觉头部轻松，视物亦清晰。每周针刺2次，3周后疼痛基本不发作。此后每周1次，再巩固3周，患者无自觉不适。半年后复诊，未见疼痛发作。

（2） 患者女，62岁。既往为教师，已退休。无慢性病史，无高血压心脏病及糖尿病。自述疼痛半年。为阵发性发作，主要为右颞及前额部疼痛。伴有眼胀，视物可。无恶心、呕吐。病初为每周发作一二次，持续几小时。后几乎每天发作，严重时需要抱头。曾在医院作脑MRI检查，未见异常。于2011年来诊。就诊时精神欠佳，由于头疼每日发作，情绪容易波动，睡眠欠佳。脉弦小数，舌质可，舌苔白。检查：颈部活动可，C2、C3、C4右侧压痛，C4、C5左侧压痛。均无放射痛。右侧C2横突处压痛明显，并向右侧耳后及右侧头顶部放射。检查时按压C2横突后，头部有轻松感。选天牖、风池、颈夹脊穴，配以鱼腰穴。每周针刺2次，2周后疼痛发作明显减少。5周后，无头痛发作。再每周1次，巩固3周，患者无自觉不适。3个月后复诊，未见头疼发作。

5 讨论

5.1 颈源性头疼的中医认识

在祖国医学文献中并无颈源性头痛病名的记载, 根据颈源性头痛的临床表现, 可将其归纳在“头项强”、“头项痛”、“颈项痛”、“颈项强”等条目下。最早对类似颈源性头痛症状的描述见于《内经》，《灵枢•经脉》（4）有: “膀胱足太阳之脉, 起于目内毗,. 是主筋所生病者: 痔疟狂癫疾, 头囟项痛。” 《素问•缪刺论》（5）有: “邪客于足太阳之络, 令人头项肩痛, 刺足小指爪甲上，” 《灵枢•经脉》（4）谓:“胆足少阳之脉,.下耳后, 循颈, 行手少阳之前, 至肩上。是主骨所生病者, 头痛颔痛, 目毗锐痛。”指出了少阳头痛之部位。《灵枢• 经脉》（4）谓: “三焦手少阳之脉, 循膺外上肩, 而交出足少阳之后； 其支者, 从膻中上出缺盆, 上项, 系耳后，是主气所生病, 耳后、肩、膺、肘、臂外皆痛,”等等是对类似颈源性头痛症状的最早描述。故颈源性头痛病属足太阳膀胱经及手足少阳经之脉，病因则多与风寒瘀有关。

颈源性头痛患者早期多为枕部、耳后部、耳下部不适感，以后转为闷胀或酸痛感，逐渐出现疼痛。疼痛的部位可扩展到前额、颞部、顶部、颈部。有的可同时出现同侧肩、背、上肢疼痛。疼痛可有缓解期。早期的疼痛多呈放射性，位置不定，阵发性发作。随着病程的进展，疼痛的程度逐渐加重，持续性存在，疼痛的位置比较固定。寒冷、劳累、饮酒、情绪激动可诱发疼痛加重。从颈源性头痛的症状分析，早期的症状与中医的风邪致病相似，易袭阳位，游走数变。随着病情的加重，久病入络，发为瘀血。表现为刺痛，痛有定处。正如 《素问•骨空论》（5）描述的风邪导致颈项疼痛: “大风颈项痛”，《素问•风论篇》（5）又曰: “风气循风府而上, 则为脑风” , 描述了风邪上袭人体阳位。《明医指掌•头风症》（6）指出了风寒邪气夹杂致病: “头风者, 本于风寒入于头脑髓也”。但风邪多易夹寒，故遇寒冷易发。《素问•奇病论》（5）云:“人有病头痛, 以数岁不已。此安得之? 名为何病? 岐伯曰: 当有所犯大寒, 内至骨髓, 髓者以脑为主, 脑逆故令头痛, 齿亦痛, 病名曰厥逆。”

病情发展，久病入络，发为刺痛。《治验回忆录•瘀血头痛》（7）案中说: “头为诸阳之会, 贼风久客, 瘀塞经遂, 与气相搏而为痛, 即古人病久入络之义。”指出了瘀血致头痛的缘由。王清任《医林改错•血府逐瘀汤所治之症目》（8）载有血府逐瘀汤治疗验案: “患头痛者, 无表证, 无里证, 无气虚、痰饮等证, 忽好忽犯, 百方无效, 用此一剂而愈。”验案很好证明了血瘀头痛病因的存在。

综上所述，根据中医理论，本病发于太少两经之脉，是为风（寒）邪所袭，久病入络而致。故选用颈夹脊穴沿足太阳之脉疏通经气，选用足少阳经之风池穴以疏风散寒。而天牖穴是手少阳三焦经的经穴，位于人体的颈侧部，乳突的后下方，胸锁乳突肌的后缘，天容穴与天柱穴的连线上，相当于第2颈椎横突的位置。天牖穴可疏调少阳经气，行气散瘀是治疗颈源性头痛的主穴。《千金方》（9）中记载，“天牖、主风眩头痛”。《灵枢•寒热病》（4）提到“暴聋气蒙，耳目不明，取天牖。”

5.2颈源性头痛的发病机理

颈源性头痛与颈部的神经、血管、韧带、筋膜等多种组织的病变密切相关，上述任何部位的病变、损伤或者受压皆可引起颈椎病的发作而引起头痛。就解剖特点而言，上3 对颈神经引起的颈源性头痛较为多见。C1的背支组成枕下神

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

经，支配寰枕关节，C2 的主要背支在通过C1～2关节侧面后成为枕大神经，此束感觉神 经与寰椎关节相关，支配顶枕区。C2和C3的腹支成为枕小神经与C2～3椎关节相关，支配侧枕部和顶部的感觉。三叉神经和上3对颈神经的传入纤维在颈上神经的脊髓背角集合，而临床研究发现这种集合恰是颈源性头痛同时出现在颈神经和三叉神经皮区的解剖学基础（10）。另外，颈椎关节突关节作为一种小平面的滑液关节，连接着上下两个椎骨，而每个椎骨各自的活动区域内有两个这样的小平面关节，它们的生理学功能就是防止脊椎的过度扭转（11）。当滑液关节存在退行性变、炎症或损伤时将使颈椎活动性减弱，颈部肌张力增加而在颈部活动时引发单侧的枕颞部疼痛（12），其生理学机理可能为三叉神经和颈部上3对脊神经对疼痛信号传入的集合，由此成为疼痛从颈部到头面部的三叉神经感觉感受区和脊髓副交感神经感觉纤维的传导径路（13）。

此外，颈交感神经节发出纤维与C2～6颈神经的相应脊膜支吻合形成窦椎神经，经椎间孔分布到椎管内和椎间孔周围组织，包括后纵韧带。而免疫组化研究证实不仅是后纵韧带而且椎间盘上分布有大量的感觉神经和交感神经纤维。顾韬（2008年）发现实验兔颈后纵韧带上大量的交感神经节后纤维主要呈互相交叉的网络状分布，且在椎间盘区的分布十分密集。在解剖学上已知窦椎神经进入椎管后在椎间盘区分别向上、向下发出上升支和下降支并向远处和深层延续成网（14）。在正常生理条件下交感神经和感受疼痛的感觉神经功能上不交叉，但是在神经损伤后两者不仅通过交感的芽生发生解剖上的藕联，而且通过交感递质的影响发生化学藕联。交感神经通过释放神经肽Y 等胺类递质使感觉神经释放更多的P物质而加剧疼痛刺激（14,15）。这些疼痛刺激，尤其是C1～3,通过颈上神经的脊髓背角与三叉神经聚会，使中枢误认为头痛。

根据颈源性头疼的病理机制，以上颈部为重点，提高颈部神经的耐受性为治疗目的，同时缓解颈部肌肉的痉挛，选用天牖穴、颈夹脊、风池为主穴，取得了较好的临床效果。

参考文献

[1] Inan N, Ates Y. Cervicogenic headache: pathophysiology, diagnostic criteria and treatment. Agri. 2005 Oct; 17(4):23-30.

[2] 李石良，韩峰，张辰宇。330例颈源性头痛临床特征回顾性分析，《中国骨伤》, 2010 (3):208~211.

[3] 国家中医药管理局，《中医病证诊断疗效标准》，南京: 南京大学出版社，1994.36-37

[4] 4．(唐)王冰《灵枢经》，辽宁科学技术出版社, 1997

[5] 5．(现代)何永, 马君, 何敬华整理《皇帝内经素问》，中国中医药出版社, 2006

[6] 6．(明)皇甫中原《明医指掌》，北京人民卫生出版社, 1982

[7] 7．(现代)赵守真《治验回忆录》，人民卫生出版社, 2008

[8] 8．(清)王清任《医林改错》，上海科学技术出版社, 1966

[9] 9．（唐）孙思邈《千金方》，人民卫生出版社， 1998

[10] 10. Busch V, Jakob W, Juergens T, et al. Functional connectivity between trigerainal and occipital nerves revealed by occipital nerve blockade and nociceptive blink reflexes．Cephalalgia，2006，26(1)：50—55．

[11] 11. Mehio AK，Shah SK．Alleviating head and neck pain． Otolaryngol Clin North Am. 2009, 42(1): 143-159

[12] 12. Van Duijn J，Van Duijn AJ，Nitsh W，et al. Orthopaedic manual physical therapy including thrust manipulation and exercise in the management of a patient with cervicogenic headache：a case report．J Man Manip Ther，2007，15(1)：10—24．

[13] 13. Biondi DM．Cervicogenie headache：a review of diagnostic and treatment strategies. J Am Osteopath ASSOC，2005，105 (4supp1)：1 6S～22S．

[14] 14. Piekartz H, Ludtke K. Effect of treatment of temporomandibular disorders (TMD) in patients with cervicogenic headache: a single-blind, randomized controlled study. Cranio. 2011 Jan; 29(1):43-56.

[15] 15. Antonaci F, Sjaastad O. Cervicogenic headache: a real headache. Curr Pain Headache Rep.2010 Apr; 11(2):149-55.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

辩证与辩病结合治疗男性不育症79例

张莉莎

(London)

摘要: 男性不育症是一种常见疾病，任何原因导致精子的发生，输送，以及精子和卵子结合障碍，均可以引起不育。笔者在英国治疗的男性不育患者中，以精液异常为多，在中医辨证与微观辨病相结合的基础上，用中药配合针灸治疗，获得良好的疗效，共总结79例，认为肾虚，瘀血和湿热是引起本病的主要病因，治疗时要以补肾为主，协调肾中阴阳水火，并在补肾同时根据病情配合活血化瘀或祛湿热之药，列举了六个成功病例，供同仁参考 。

关键词: 辩证与辨病，男性不育， 精液常规检查，精子数量， 精子活动率， 精液液化，畸形精子。

男性不育症是指育龄夫妇共同生活一年或两年以上，未采取任何避孕措施，由于男方生殖机能障碍导致女方不能怀孕（1），临床上男性不育占夫妇不孕总数的1/3以上，且有逐年增加的趋势。世界卫生组织宣布，男性不育症，癌症，心血管病将成为危害人类的三大疾病。由此看来，治疗男性不育将成为世界普遍重视的研究课题。

男性不育的病因是多方面的，对不育患者来讲，可能是多种因素的综合作用，因为任何原因导致精子的发生，精子输送，以及精子和卵子相结合发生障碍，均可引起不育，概括起来可分为三种：

1．男性的性功能障碍：包括阳痿，早泄，遗精，不射精等；

2．男性的精液异常：精子过少，精子活力低下，畸形精子过多，精液液化不良，精液的酸碱度异常，血精，无精子，死精子过多，以及抗精子抗体导致的免疫性不孕等。

3．男性的性腺炎症和其它疾病：慢性前列腺炎，睾丸炎，精囊炎，附睾结核，精管结核，睾丸萎缩，精索静脉曲张等。

笔者在英国作中医临床工作十二年，经治的男性不育患者，以精液异常者为多。在中医辨证与微观辨病相结合的基础上，运用中药加针灸施治，取得了良好的疗效，报道如下。

一般资料

79例患者均为在伦敦北部中医诊所收治，年龄最大50岁，最小25岁，不育病程在2-5年，多数为已婚患者，双方同居，配偶生殖功能正常，未避孕而女方未能受孕者。其中以精子密度低为主38例，精子活力低为主31例，其它10例，如畸形精子过多5例，精液液化不良3例，血精1例, 以及抗精子抗体阳性1例。但总而言之，精液化验多以一者异常为主，兼有其它。

临床表现

患者的症状因人而异，多数患者伴有不同程度的腰酸乏力，性功能紊乱，少数伴有排尿异常，少腹阴囊部坠胀不适，或伴有精神抑郁，记忆力减退等。有的患者曾患过男性性腺感染。

诊断标准

精液量：	2 ml-7 ml
精子密度：	20 x 106/ml 以上
活动率：	50% 以上
酸碱度（PH 值）：	7.2-7.8
液化时间：	少于60分钟
正常精子形态：	30% 以上

中医辩证分析

1 肾虚

中医认为不孕不育症均与肾脏关系最密切，因为肾为先天之本，肾主藏精，主生长发育和生殖，并开窍于前后二阴。其所藏的先天之精是生殖和发育的根本，所主的命门之火是促进生殖与发育的动力，所司的前阴功能直接主宰着外生殖器勃起与排精的功能。男性精子的生成有赖于肾阴的滋养和肾阳的温煦，《内经》云：“阳化气，阴成形”，肾阴的充盈源源不断地孕育化生着精子之体，肾阳的壮盛时时不停地激发维持着精子的活力，因此精子数目的多少受肾阴影响较大，而活动率的高低多由肾阳的盛衰所决定。

2 血瘀

男性不育病程较长,多为久病,“久病入络”，久病必有瘀。瘀血可以因情志不遂，肝气郁结，气滞血瘀，导致脉络不畅，影响了睾丸，精囊，附睾，输精管，及前列腺的血液循环，影响了精液数量，质量，精子活动力，影响了排精的畅通；瘀血也可以因为湿热之邪久恋化瘀，瘀阻精道，精道不通；瘀血还可因忍精不泄，败精郁结，导致了气机不利，血行受阻，精室失养，精道不畅。所以瘀血往往是在以往的慢性炎症，组织损伤基础上造成的血运不畅，局部组织失养。因此，瘀血是男性不育的另一个主要病理机制。

3 湿热

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

湿热是男性不育症中另一个常见病因，既可以从身体内自生，亦可以由性接触而从体外感染。体内自生者，有人因为长期饮酒而致，酒性助湿生热；也有人因为恣食辛辣和煎炸油腻食物，使脾胃运化不利，湿从中焦而生。从内生成的湿热易于流注下焦，恣扰精室；而外来湿热者从性接触感染了湿热毒邪，缠绵久留不去，蕴阻精道。临床症状大同小异，常见小便异常，小腹少腹胀痛，会阴部坠胀，还可见到尿后白浊，或血精，或精液稠厚，或液化不良，死精子多等。

根据临床观察，肾虚，瘀血，湿热，三者可单独为病，亦可相互夹杂。在大多数的男性不育症中，精液异常还主要由于肾虚所致，或肾阴虚，或肾阳虚，或肾阴阳两虚，治疗要精确辨证，灵活用药。

疗效标准

根据世界卫生组织WHO制定的标准为依据，痊愈：症状消失，精液常规分析正常，配偶受孕。有效：自觉症状消失或好转，精液常规化验有明显好转，但未达到正常标准，配偶未孕。无效：症状及精液常规分析均无改善。

结果

痊愈52例，有效21例，无效6例，总有效率在90%以上。治疗时间最短3个月，最长11个月。

典型病例

1．精子密度低

A 先生， 44岁，尼日利亚人，会计工作。2007年2月初诊

结婚3年，妻子未孕，双方在当地医院检查，妻子正常，男方精液化验，精液量：4.5 ml; 精子数量：3.5 x 106/ml，活动率 50%；液化时间：30分。患者平素常常乏力，脘腹胀满，矢气多，睡眠浅，夜尿多，性功能不足，常有早泄。高血压史4年，服西药控制。当日血压120/90mmHg. 舌尖红，脉弦细。

辩证分析：精子数量少是患者的主要问题，与肾虚有关，因为肾阴不足，不能提供足够的物质基础，使精子的生成发育受到影响，并导致性功能差频繁早泄。乏力，脘腹胀，矢气多为脾胃不和；血压高，脉弦细，又与阴虚肝旺有关。治疗应以补肾阴为主，兼以调肝和脾胃。

针刺取穴：肾俞，肝俞，脾俞，八髎，太溪，足三里，合谷，太冲为主，平补平泻法。

方药：熟地、山药、何首乌、枸杞子、五味子、黄精、菟丝子、仙灵脾、白术、茯苓、青陈皮、砂仁、炒麦芽 各10克，水煎服，日一剂，早晚分服。

针药并用，每周1次，患者接受3个多月的治疗后，乏力腹胀矢气缓解，睡眠好转，性功能增强，去医院复查精液：精子数33 x 10 6/ml，活动率55%。半年后其妻子怀孕。

2 精液量少

R 先生，34岁，犹太人，店员。 2012年1月17日初诊。

结婚4年未孕，其妻刚于2个月前作过IVF，未成功。双方均于IVF前检查，妻子一切正常，而发现本人精液异常，结果示：精液量 0.8 ml，精液粘稠，液化时间：60分；PH值：8.7； 精子数：4.5 x 10 6/ml, 活动率54%。

患者幼年因患有隐睾症作过睾丸手术，术后一切正常，睾丸局部无任何不适。但此后常常感到体力弱，乏力，怕冷，下肢发凉。成年后体魄外形健壮，四肢肌肉发达，但仍常觉腰膝酸软，气短乏力，不能胜任体力工作，现为店员，给货架上货时气不接续，故要求换作收银员，以减少活动量。婚后性功能弱，早泄较为严重。消化功能好，食欲佳，无脘痞腹胀，大便正常日一行，睡眠好，血压130/90mmHg. 舌偏淡，舌苔薄，脉尺弱。

辩证分析：精液量少，粘稠，精子数量低，均与肾阴虚有关，而畏寒，乏力，下肢冷，又表现出明显的阳气不足，精液的PH值高，性功能弱，早泄严重与肾阴阳两虚皆有关，而患者幼年时做过睾丸手术，局部气血受到损伤，也影响生精功能。故辩证为肾之阴阳两虚，兼有血瘀为其主要病机。治疗以补肾阴，温肾阳，佐以活血化瘀。

针刺：关元，气海，中极，曲骨，三阴交，足三里，血海，合谷，太冲，随症加减，平补平泻。

用药：桑寄生10克 续断10克 巴戟天10克 杜仲6克 菟丝子15克 桃仁6克 红花6克 当归10克 丹参10克 枸杞子15克 女贞子10克 生地15克 知母8克， 配中药浓缩粉，每次6克开水冲服，日2次。

服用2周后，畏寒乏力，下肢凉均减轻，性功能增强，早泄明显改善，血压120/80mmhg。连续治疗10周，复查精液常规，精液量1.4ml，精液粘稠，液化60分钟，精子数 13.5 x 106/ml，活动率53%，ph值8.4。坚持治疗7个月，体力增强，精液化验正常。

3 精子活力低下

J 先生，41岁，公司经理。2010年5月2日初诊。

患者晚婚，于39岁时结婚，婚后2年同居未孕。去医院检查精液常规发现，精子活力低下，活动率42%，数量正常。患者平素身体健康，性功能正常，无任何不适，偶尔于连续紧张工作后感到疲乏。否认高血压糖尿病史。

辩证分析：患者身体健康，性功能正常，是无症可辩，但从精液分析结果看，活动率低，是与肾中阳气不足有关，故温补肾阳为其治疗大法。

针刺取穴：以关元，中极，命门，肾俞为主，随症加减，针后加灸关元、命门、肾俞、足三里。

中药：熟地10克 山药10克 山茱萸10克 枸杞子10克 杜仲6克 巴戟天6克 覆盆子10克 菟丝子10克 仙灵脾10克，配中药粉早晚分服各6克。

患者连续治疗5个月后，其妻孕，并于第2年夏产一女，母子健康。

4 精子形态异常，畸形率高

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Marke 先生，36岁，波兰人，电脑工程师。2012年5月初诊。

婚后6年不育，妻子一切正常。患者平素性欲淡漠，腰酸乏力，怕冷，腹胀，阴囊湿冷，两侧少腹有轻微的疼痛，天气寒冷时少腹睾丸常有抽痛感，同房后疼痛加重，查其舌胖有齿痕，苔白，脉缓无力。去医院作精液化验，结果示，畸形精子83%，精液量1.8ml，精子数量16 x 106/ml，活动率32%。

辩证为寒湿停滞肝脉，肾之阴阳两虚。治疗以暖肝行气化湿为主，兼以温补肾之阴阳。

针刺：关元，中极，气海，水道，归来，三阴交，足三里，太冲，平补平泻，局部加神灯温小腹。

处方：干姜6克 川楝子10克 小茴香6克 橘核10克 吴茱萸4克 茯苓10克 薏苡仁15克 当归10克 桂枝6克 仙灵脾15克 枸杞子15克 山药10克。配中药浓缩粉，每日12克，分2次服。

治疗3个月后，性欲增高，腰酸乏力少腹痛缓解，复查精液常规，畸形率68%，精液量2.5ml，精子计数19 x 106/ml，活动率48%。又连续治疗3个月，其妻孕。

5 精液液化不全

Michael 先生，32岁，英国人。2008年2月2日初诊。

结婚3年未育，夫妻性生活正常，妻子月经规律，去医院检查无异常。患者平素小便黄赤，有时有灼热感和尿后余沥不禁，时见尿后白浊，小腹坠胀不舒，舌偏红苔黄腻，脉滑数。精液化验结果，量2ml，ph7.2，粘稠，液化时间60分钟，液化不完全，精子数量11.8x106/ml，活动率17%，白细胞（++）。

辩证分析：小便黄赤灼热和尿后余沥为下焦湿热所致，湿热蔓延至精室，使精郁不化，故精液粘稠，液化不完全；邪热煎熬阴精，阴精亏损，精子化生不足，故数量少；阴虚累及阳气，阳气受损，致使精子活动率减低。治疗以滋阴清利湿热为主，兼以活血化瘀，温阳益气。

针刺：关元，中极，水道，归来，阴陵泉，三阴交，合谷，太冲，平补平泻手法。

处方：生地15克 玄参10克 知母8克 白茅根15克 萆薢10克 车前子10克 茯苓15克 猪苓10克 菟蔚子10克 丹参15克 赤芍10克 生黄芪15克 桂枝8克

服药1个月，小便正常，小腹无胀满，又连服2个月，停药。半年后来告，其妻已孕。

6 血精

J 先生，48岁，伊朗人，办公室工作。2008年8月29日初诊。

患者于2周前同房后发现避孕套里鲜红色血精，量中等约3毫升。自觉无痛，周身亦无明显不适，仅觉同房后疲劳。 3天后同房又见血精。因心里担忧未同房一周，下周同房仍见血精。3次血精后担忧加重，故来诊。

患者自述向来身体健康，从不服用任何药物，也没有泌尿系感染病史。不抽烟而喜欢饮酒，每晚进餐时自饮一杯葡萄酒，或一小杯威士忌。细询问之，得知患者近一两个月工作不顺利，常与同事发生口角，心中郁闷烦躁，故饮酒量增多，并酒后同房。观其舌边红，苔黄腻，按之脉弦滑。

辩证分析：患者嗜酒，酒性助湿生热，加之口角后心中烦闷，肝气郁结化火，湿热肝火裹缬，下流肝脉，烁伤脉络，故生血精，舌边红苔黄腻，脉弦滑均为湿热之象。治疗以清利湿热，化瘀止血为法。

以中成药龙胆泻肝汤配合云南白药，给予14天量。二周后复诊，未同房，未知结果。查其舌苔薄白，脉和缓，继续给予两周药量。又半个月复诊，已同房2次，未见血精，停药，嘱其减少酒量。

讨论

1. 男子精液异常引起的不育在临床上较为多见，中药结合针灸治疗具有确切的疗效。因精子的生成从初始至成熟，大致需要72天时间，因此在诊疗初期，有必要告诉患者坚持治疗3个月以上，并在治疗3个月左右建议去看医生，预约精液常规检查以观察疗效。

2. 在临床辨证时，首先要结合全身症状，辩别肾中阴阳之虚实和湿邪瘀血之有无，同时还要根据精液常规进行微观辨病。在很多情况下，患者全身未见明显异常，无症可辨，只能从精液化验结果中分析疾病性质。故在开始治疗时，要求患者带来检查结果或去作精液常规检查，以提供参考数据，如精液量少及精子数量少者，多属肾阴不足；精子活动力差者，多属肾阳不足；精液不液化者，多见于阴虚夹湿或瘀血。精液ph值高低也反映了阴阳盛衰，一般来讲，ph值低者多与阴虚有关，ph值偏高多是阳虚所致。

3. 具体到用药配方时，必须兼顾阴阳之关系。由肾虚引起的不育，或责之于阳虚有寒，或责之于阴虚有热（2），在治疗时应当协调阴阳，既不能概用温补，以免灼燥阴精，亦不能滥用滋腻，以防遏制阳气。一般情况下阴阳并补，有所侧重，滋阴顾及阳气，壮阳不伤阴精（3），即前人所云，“善补阳者，必于阴中求阳，则阳得阴助而生化无穷；善补阴者，必于阳中求阴，则阴得阳升而源泉不竭”。对于少精子症，除选用黄精，熟地，首乌，枸杞子，山茱萸等滋补肾阴外，佐以菟丝子，覆盆子，仙灵脾等补阳之品。对于活动率低的弱精子症，选用菟丝子，仙灵脾，巴戟天，杜仲，牛膝，续断，覆盆子等温补肾阳之品同时，加用五味子，枸杞子，熟地，山药，山茱萸等补阴之药。

4. 在补肾基础上，根据证情配合活血化瘀及祛湿药物，可改善组织供血和循环，减少炎症反应及水肿，减少局部炎症的渗出，抵制纤维的增生，促进腺组织的软化和缩小，改善组织缺血，缺氧，使睾丸，前列腺，精索静脉丝的血液循环改善，生精细胞功能得到重新调节，促进精子的产生，活力提高（4）。

5. 结合针刺治疗，有助于增加局部血液循环，放松患者情绪，补充药物治疗的不足，收到很好的疗效。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

The application of Shenshu to tonify the mansion of the kidneys: acupuncture for chronic unilateral sciatica - a case study

A. Mason[1], P. Battersby[2] and A. Feyler[3]

[1]TCM Practitioner, Mandarin Clinic, Newcastle under Lyme, UK;
[2]Senior Lecturer in Chinese and Complementary Medicine, Glyndwr University, Wales, UK;
[3]Senior Lecturer in Chinese Medicine, Glyndwr University, Wales, UK.

Abstract: Low Back Pain affects 17 million people in the UK, subsequently costing the economy £10 billion each year. Sciatica is characterised by a burning sensation radiating down the sciatic nerve, producing unilateral pain. This case study aims to present a comprehensive analysis of scientific evidence, comparing Western and Chinese medicine treatment approaches for sciatica. A 55 year old woman presented with pain in her right buttock, instigating weakness in her right leg and discomfort in daily living. A four week treatment plan incorporating acupuncture was administered, resulting in reduced pain and increased mobility. .

Key Words: Acupuncture, Chinese Medicine, Back Pain, Sciatica.

Background

Low back pain is a common disorder which severely impacts on a person's quality of life and work performance (Bupa, 2010). The Health and Safety Executive (HSE) estimates that 4.5 million working days are lost yearly in the UK through back pain (HSE, 2011). Furthermore, Concannon and Bridgen (2011) inform that lower back pain prevails in 50-80% of adults, whilst Koes et al. (2007) reveal that 5-10% of those people will also experience sciatica. Originating from L4 to S3, the sciatic nerve is the longest and thickest nerve in the body, consisting of the tibial and common fibula nerve (Gillot, 2009). In 90% of cases, sciatica or lumbar radiculopathy is caused by herniation of an intervertebral disc at L5-S1 level (Patient UK, 2012). Furthermore, Stafford et al. (2007) outline that sciatica is a result of inflammatory, immunological and pressure-related processes. Inflammation occurs after phospholipase A2 (PLA2) and nitric oxide (NO) of the nucleus polposus leak into the epidural space, irritating the nerve root. In sciatica types, raised levels of antibodies to glycosphingolipids (GSLs) are indicative of immunological responses between nerve tissues and the exposed nucleus pulposus. Moreover, a high correlation between severity of disc disease and leg pain confirms the pressure theory of sciatica (Porchet et al., 2002).

Sciatica pain varies from mechanical back pain (Department for Work and Pensions, 2010). According to Tortora and Derrickson (2009) sciatica can produce a posterior presentation (from the posterior thigh along the postero-lateral aspect of the leg) or, an anterior presentation (along the anterior aspect of the thigh into the anterior leg). Pain might also radiate to the lateral aspect of the foot (in cases of S1 irritation) or to the dorsum of the foot and large toe (due to L5 irritation). Table 1, differentiates between back pain and sciatica patterns.

Pain endured for < 6 weeks is classified as acute, whilst pain presenting > 6 weeks is categorised as chronic (Baldry, 2005). Table 2, describes conventional treatment approaches for sciatica.

Dagenais and Haldeman (2012) acknowledge that a patient's response to treatment can also be affected by psychosocial factors, for example, psychological health and social well-being. Therapies such as Cognitive Behaviour Therapy (CBT) have demonstrated reduced levels of pain through relaxation techniques and adopting a positive attitude, although studies that suggest this are not conclusive (Otis, 2007). Moreover, research has revealed that acupuncture stimulates the production of endorphins and other neurohumoral factors, ultimately altering the way the brain and spinal cord processes pain (British Acupuncture Council, 2011).

Table 1 The difference between back pain and specific radiculopathy (Department of Work and Pensions, 2010)

MECHANICAL BACK PAIN	SCIATICA
Pain varies with activity	Pain tends to be more constant
	There is little variation with activity
Varied distribution for leg pain	Clear distribution of pain/other symptoms in the region of the leg supplied by a specific nerve root (Dermatome L4, L5, S1)
Back pain is worse than leg pain	Leg pain is worse than back pain
No neurological signs present	Muscle atrophy, loss of reflexes and specific sensory changes might be present
Sciatica presents as both sensory (pain, numbness, tingling, burning), and, or motor (muscle atrophy and loss of tendon reflexes) symptoms (Patient UK, 2012).	

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Table 2 Treatment of acute and chronic sciatic pain (Dagenais and Haldeman, 2012; NHS Choices, 2010; Patient UK, 2012; Waddell, 2004).

TREATMENT	DETAILS	ACUTE/ CHRONIC
MEDICATION /SELF-HELP	▪ Compression packs: hot and/or cold to relieve muscle spasm	Acute
	▪ Over-the-counter painkillers such as: aspirin, paracetamol or ibuprofen (includes gels, creams or lotions)	Acute/Chronic
	▪ Prescribed opiate-based pain relief such as: codeine or tramadol; muscle relaxants such as: diazepam; anti-depressant such as: amitriptyline or to treat the nerve pain - gabapentin.	Chronic
	▪ Epidural steroid injection in cases where other forms of medication have not worked	Chronic
EXERCISE	▪ Includes swimming, walking and gentle stretching. Exercise will help in the production of endorphins.	Acute/Chronic
	▪ Avoidance of lifting and prolonged sitting.	
	▪ Referral to physiotherapy for a tailor-made exercise plan	
SURGERY	Discectomy (removal of part of the herniated disc); fusion of the slipped vertebra or laminectomy (trimming of the arch of the vertebra in order to relieve the pressure on the nerve)	Chronic and when all else fails
OTHER	▪ Acupuncture	Acute/ Chronic
	▪ Physiotherapist	
	▪ Osteopathy	
	▪ Chiropractor	

Back pain in Chinese medicine, is characterised as dull, sharp, intermittent, burning or throbbing, and is either localised or a diffused pain (Bing and Hongcai, 2011). Pain is specifically defined as a complex symptom with a variety of causes, according to Xinnong (2007). Furthermore, negative emotions such as depression, anger, fear, anxiety and frustration not only generate pain (psychosomatic) but can also exacerbate pain that already exists (Hicks et al., 2004). The theory is confirmed by Ehrlich (2003) who informs that chronic back pain is often accompanied by a psychological overlay. Robertson (2008) reveals that two fundamental concepts are involved in the experience of pain; the channel system (Jing Luo); and the vital energy (Qi) that flows through the channel system. Pain therefore, reflects an imbalance in Qi flow in one or more of the channels (Bing and Hongcai, 2010). The syndrome of back pain is further classified as an excess (shi) or deficient (xu) condition (Maciocia, 2008). A sharp pain is indicative of the shi types produced by an external pathogen, for example, wind or cold, interior heat or cold condition, or stagnation of Qi and Blood. In contrast, the xu conditions manifest as a dull, aching pain, due to Qi and Blood deficiency. Additionally, the consumption of body fluids culminates in Yin deficiency, resulting in the malnourishment of the channels (Xinnong, 2007).

Patient Profile

The 55 year old female presented with a dull pain in her right buttock which she had endured intermittently for over fifteen years. Her occupation in a charity shop required her to stand for long periods of time, exacerbating her sciatica. Although the pain had been described as gradual onset, the patient reported experiencing excruciating bilateral pain a week previous to the acupuncture treatment. Bilateral leg pain is a red flag for back pain; however, it was established via questioning, that no saddle anaesthesia or bladder incontinence had occurred. Additionally, an experienced supervisor was present to verify that the situation did not warrant an emergency admission to a neurologist, especially as the patient had been referred to acupuncture by a qualified physiotherapist from a local pain clinic. Red flags in relation to sciatica are outlined in table 3.

Pain radiated the posterior aspect of the patient's right leg, terminating at the little toe (relating to the S1 dermatome). The patient reported a cold sensation in her low back. Rest alleviated the pain, whereas walking to work, lifting and bending precipitated painful spasms. The subject rated her pain as 8/10 on a Visual Analogue Scale. Weak knees had troubled her for a number of years, as had tinnitus. Sleep was reported as restless due to worrying about her problematic marriage; subsequently she feared the future and had become dispirited.

The tongue proper indicated a pale colour. Upon palpation of the pulse, it represented a deep, weak quality. The patient exhibited signs of Kidney Yang deficiency.

Table 3 presentation of general and specific red flags for sciatica (Greenhalgh and Selfe, 2006; Patient UK, 2012; Sizer et al., 2007)

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

GENERAL RED FLAGS	▪ Unexplained weight loss ▪ Failure to improve after 1 month of treatment ▪ Abdominal pain with changed bowel/bladder habit ▪ Gait deficits ▪ Unexplained referred pain ▪ Long term corticosteroid use ▪ > 50 years of age
SPECIFIC RED FLAGS	▪ Ability to locate pain to an extra-spinal point ▪ Constant progressive pain which does not vary with activity or position ▪ Severe night pain ▪ Saddle anaesthesia or paraesthesia ▪ Swelling or palpable mass along the sciatic nerve ▪ Bi-lateral pins and needles in the legs ▪ Muscle weakness/wasting ▪ Loss of tendon reflexes

Case Management

Hicks et al. (2004) affirm that deficiency types are synonymous with a decline in the Kidneys. Anatomically, the back is referred to as the house, or mansion of the Kidneys. Furthermore, Bing and Hongcai (2010) indicate that the Du channel and the Urinary Bladder channel of the foot-taiyang distribute the back area. The Kidneys dominate the bones, store Essence and generate Marrow. Consequently if the Kidneys become deficient due to cold, damp or trauma, back pain will transpire. Maciocia (2008) concurs that a deficient Kidney is the root or origin (Ben) of back pain, typically occurring in middle age when the Kidney Qi becomes weak. Acupuncture points were therefore chosen primarily according to the channels involved, in this instance the Bladder, which is paired with the Kidneys. The principle of treatment was to tonify the Kidneys and nourish the Essence by needling the back-shu point, Shenshu (Xue-min, 2007). According to Deadman and Al-Khafaji (2007), a shu point is where the Qi of the Zang Fu organs surface. Moreover, each of the shu points tonifies its corresponding organ. Shenshu (BL23) is the principal point which enhances the functions of the Kidneys, for example, strengthen and fortify the Yang, nourish Yin and assist Essence.

Table 4 Case Management of Four Week Treatment Plan

Tx1 – Tx4:

***Syndrome Differentiation*:** Back pain due to deficiency of Ki Yang, causing malnourishment of bones in lower back and hip.

***Principles of Treatment*:** Warm and Supplement the Kidneys; Strengthen Yang. Invigorate Qi.

Treatment Plan: Acquired verbal consent before taking pulses and observing the tongue. Ensured the patient's warmth and comfort: closed the window as she felt cold, 1 pillow, and 1 bolster. Prone position. Closed the blind before she undressed. Stayed with the patient throughout the treatment.

Considerations:

- Acquired written, signed consent before each treatment commenced.
- Respected the patient's modesty by appropriate use of towels.
- Explained which items of clothing to remove.
- Explained what moxibustion would entail.
- Needles were retained for 20 minutes.
- Ensured Health and Safety procedures when the patient departed the couch.

Acupuncture Points	*Actions*
BL23 – bilateral.	➢ Tonify the Kidneys. Fortifies Yang. Benefits Essence. Strengthens the lumbar region. Benefits the ears. ➢ Perpendicular-oblique insertion.
BL25 – bilateral.	➢ Strengthens the lumbar region and legs. Alleviates pain. ➢ Perpendicular insertion.
DU3	➢ Benefits the lumbar region and legs. ➢ Perpendicular insertion (caution).
BL40 – unilateral.	➢ He-sea and Earth point for Bladder Channel. Benefits lower back and knees. Good for sciatica. Alleviates pain.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

	➢ Perpendicular insertion.
BL60 – bilateral.	➢ Heavenly Star Point. Activates the Bladder Channel. Alleviates Pain. Relaxes sinews and strengthens lumbar spine. ➢ Perpendicular insertion. (Deadman and Al-Khafaji, 2007)
Health & Aftercare throughout the four week treatment plan	➢ Ensured Health & Safety was conformed to at all times: no obstacles initiating a trip or fall; couch the correct height for the patient and the practitioner.
Tx2	***Feedback and New Objectives:*** ➢ Only slight improvement in the pain levels. ➢ Tinnitus was reported as problematic whilst trying to sleep.

***Syndrome Differentiation*:** Back pain due to deficiency of Ki Yang, causing malnourishment of bones in lower back and hip.

***Principles of Treatment*:** Warm and Supplement the Kidneys; Strengthen Yang. Introduce local points.

***Acupuncture Points*:** BL23, BL25 and BL40 remained the same as the previous week.

***Additional Points included*:** BL30, BL36, BL37, GB34.

Acupuncture Points	***Actions***
BL30 – bilateral.	➢ Local point for the pain. Benefits lumbar region and legs. ➢ Perpendicular insertion.
BL36 – unilateral.	➢ Local point for the pain. Relaxes the sinews. Alleviates pain. Commonly used point for sciatica. ➢ Perpendicular insertion.
BL37 – unilateral.	➢ Benefits the lumbar spine. Alleviates pain. Commonly used when pain radiates down the Bladder channel. ➢ Perpendicular insertion.
GB34 – bilateral.	➢ Benefits the sinews and joints. Alleviates pain. ➢ Slightly oblique posterior insertion.
Tx3	***Feedback and New Objectives:*** ➢ Reported significant reduction in pain (<4/10). ➢ Felt very stiff and painful in the right hip. ➢ Apply indirect moxibustion to BL23. ➢ Reported feeling very fearful.

***Syndrome Differentiation*:** Back pain due to deficiency of Ki Yang, causing malnourishment of bones in lower back and hip.

***Principles of Treatment*:** Warm and Supplement the Kidneys; Strengthen Yang. Introduce Ashi point for the right hip.

***Acupuncture Points*:** BL23 (with indirect moxibustion), BL25, BL30, BL36, BL37 and GB34 remained the same as the previous week.

***Additional Points included*:** GB30, BL57 and Ki6.

Acupuncture Points	***Actions***
GB30 – unilateral.	➢ Heavenly Star point. Ashi Point. Benefits the hip and leg. Alleviates stiffness and pain. ➢ Perpendicular insertion.
BL57 – unilateral.	➢ Heavenly Star point. Alleviates pain. Relaxes the sinews. Commonly used for spasm and pain in sciatica. ➢ Perpendicular insertion.
Ki6 – bilateral.	➢ Calms the spirit, fear, nightmares. ➢ Oblique insertion.
Tx4	***Feedback and New Objectives:*** ➢ Reported that the pain had significantly reduced since the last treatment. ➢ Had a trip at work and fallen. ➢ Pain pattern changed due to trauma, now sharp in nature: Wandering Bi. More of a migrating pain. Chills and Fever. ➢ Pulse: wiry. ➢ Nourish the Kidneys and Liver. Disperse Stagnation.

***Syndrome Differentiation*:** Wandering Bi Syndrome (possibly due to cold at work and a fall).

***Principles of Treatment*:** Nourish Kidneys and Liver. Disperse Stagnation.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

***Acupuncture Points*:** BL23, BL25 remained the same as the previous week.

***Additional Points included*:** BL15, BL18, BL40, BL62.

Acupuncture Points	*Actions*
BL15 – bilateral.	➢ Back-shu for Heart. Calm the Heart – fall had frightened her. ➢ Oblique insertion.
BL18 – bilateral.	➢ Back-shu for the Liver. Spreads Liver Qi. Pacifies Wind. Benefits sinews and the spine and rigidity. ➢ Oblique insertion.
BL40 – unilateral.	➢ He-Sea and Earth point of the Bladder channel. Benefits the lumbar region and knees. Alleviates pain. Used in sciatica cases and painful obstruction. Good for injury by Cold, chills and fever. ➢ Perpendicular insertion.
BL62 – bilateral.	➢ Pacifies interior Wind. Calms the spirit. Alleviates pain. ➢ Oblique insertion. (Deadman and Al-Khafaji, 2007)

Reflection

According to Bishop et al. (2011) current systematic reviews advise acupuncture is effective in the treatment of low back pain. Moreover, their survey revealed that the majority of the studies included in their research used Shenshu for low back pain. The four week treatment plan successfully alleviated the symptoms of sciatica, before the patient incurred a fall. Sustaining the application of Shenshu throughout the treatment was vital for revitalising the Kidney Yang. Tunstall (2011) cites that Shenshu is often indicated in treatments for pain and cold in the lumbar regions. Furthermore, Maciocia (2008) highlights that the Kidneys are the root of Pre-Heaven Qi, as such, promoting the health of the Kidneys is fundamental to Chinese medicine. The treatment was refined in week three to incorporate a warming technique, by applying moxibustion to a needle inserted into Shenshu. Chen et al. (2009) conducted a small study of 30 sciatica subjects. There was a significant improvement in the subjects who received moxibustion. On reflection, moxibustion could have been applied earlier in the treatment regime to minimise her pain. Equally, it was felt that little attention had been afforded to the patient's emotional state. The patient was evidently struggling with a challenging marriage and constantly battling with pain at her workplace. The emotional aspect is just as important as resolving physical imbalances. Therefore, the patient might have benefitted from a treatment plan of longer duration (Ehrlich, 2003).

Additionally, it was interesting to reflect upon the possibility of a red flag in this scenario and emphasised the importance of signed consent. The support and advice from an experienced supervisor was reassuring, but in future practice, an acupuncturist might be working alone. Thus the need to build good networking skills is paramount, such as establishing the location of local physiotherapists and osteopaths. However, referring to an emergency department has to be the priority if an acupuncturist identifies or suspects a potential red flag.

Conclusion

Muscular skeletal conditions are leading causes of morbidity and disability, resulting in vast healthcare expenditure (Department of Work and Pensions, 2010). Low back pain can impact on a person's ability to carry out normal activities. Low back pain is regarded as a symptom rather than a medical diagnosis, as it can be caused by a variety of conditions. Specifically, sciatica is an array of symptoms including weakness, pain, and numbness alongside the sciatic nerve pathway (Bupa, 2010). Conventional approaches for treating sciatica incorporate either over-the-counter painkillers or prescribed opiate-based pain relief. If the pain persists, epidural steroid injections or surgery is administered (Dagenais and Halderman, 2012). In contrast, the Chinese medicine approach acknowledges that pain is classified as a shi or a xu condition (Maciocia, 2008). A 55 year old female patient presented with sciatica, where pain was the most prominent symptom. Painful spasms triggered functional limitations in mobility at work. A selection of acupuncture points based on local pain points and distal points along the Bladder meridian, successfully reduced sciatica pain. The treatment regime incorporated Shenshu to enhance the functions of the Kidneys (Deadman and Al-Khafaji, 2007).

Acknowledgements

I would like to thank the Research and Chinese Medicine tutors at Glyndwr University for giving me the opportunity to write this paper. Their experience and knowledge has inspired me when applying the multifaceted Traditional Chinese Medicine model to patients in my own clinic.

References

Baldry, P.E. (2005), Acupuncture, Trigger Points and Musculoskeletal Pain. 3rd ed. Philadelphia: Elsevier Churchill Livingstone.

Bing, Z. and Hongcai, W. (2011), Case Studies from the Medical Records of Leading Chinese Acupuncture Experts. London: Singing Dragon.

Bing Z. and Hongcai, W. (2010), Diagnostics of Traditional Chinese Medicine. London: Singing Dragon.

Bishop, F.L., Zamen, S. and Lewith, G.T. (2011), 'Acupuncture for Low Back Pain: A survey of Clinical Practice in the UK', Complementary Therapies in Medicine, vol.19, pp.144-148.

British Acupuncture Council, (2011), Acupuncture and Backpain. http://www.acupuncture.org.uk/index.php?option=com_K2&view=item&id=1127:back-pain&ITemid=106. [Electronically accessed 18th April, 2012.]

Bupa, (2010), Back Pain. http://www.bupa.co.uk/ individuals /health-information/directory/b/backpain.[Electronically accessed 18th April, 2012.]

Chen, M.R., Wang, P., Cheng, G., Guo, X., Wei, G.W. and Cheng, X.H. (2009), 'The Warming Acupuncture for Treatment of Sciatica in 30 Cases', Journal of Chinese Medicine. Vol.29, No.1, pp.50-53.

Concannon, M. and Bridgen, A. (2011), 'Lower Back Pain: a Need for Thorough Assessment', Practice Nursing, Vol.22, No.9, pp.458-463.

Dagenais, S. and Haldeman, S. (2012), Evidence-Based Management of Low Back Pain. United States: Elsevier Mosby.

Deadman, P. and Al-Khafaji, M. (2007), A Manual of Acupuncture. East Essex: Journal of Chinese Medicine Publications.

Department for Working and Pensions, (2010), What is Back Pain? http://www.dwp.gov.uk/publications/specialist-guides /medical-conditions/a-z-of-medical-conditions/back-pain/.[Electronically accessed 18th April, 2012.]

Ehrlich, E. (2003), Low Back Pain. http://www.who.int /bulletin/volumes/81/9/Ehrich.pdf. [Electronically accessed 24th March, 2012.]

Gillot, C. (2009), What is Sciatica? What Causes Sciatica? http://www.medicalnewstoday.com/articles/7619.php. [Electronically accessed 2nd March, 2011.]

Greenhalgh, S. and Selfe, J. (2006), Red Flags: A Guide To Identifying Serious Pathology Of The Spine. Philadelphia: Churchill Livingstone Elsevier.

Hicks, A., Hicks, J. and Mole, P. (2004), Five Element Constitutional Acupuncture. Philadelphia: Churchill Livingstone.

Health and Safety Executive, (2011), What is Back Pain and Musculoskeletal Disorders? http://www.hse.gov.uk/cleaning/ backpain.htm. [Electronically accessed 24th April, 2012.]

Koes, B.W., Van Tulder, M.W. and Peul, W.C. (2007), 'Diagnosis and Treatment of Sciatia', British Medical Journal, Vol.337, No.7607, pp.1313-1317.

NHS Choices, (2010), Sciatica – An Introduction. http://www.nhs.uk/conditions/Sciatica/Pages/Introduction.aspx. [Electronically accessed 18th February, 2012.]

Maciocia, G. (2008), The Practice of Chinese Medicine. 2nd ed. Philadelphia: Churchill Livingstone Elsevier.

Otis, J. (2007), Managing Chronic Pain – A Cognitive Behavioral Therapy Approach. USA: Oxford University Press.

Patient UK, (2012), Spinal Disc Problems (including Red Flag Signs). http://www.patient.co.uk/doctor/Spinal-Disc-Problems-(including-Red-Flags-Signs).htm. [Electronically accessed 24th April, 2012.]

Porchet, F., Wietlisbach, V., Burnand, B., Daeppen, K., Villemure, J.G. and Vader, J.P. (2002), 'Relationship between Severity of Lumbar Disc Disease and Disability Scores in Sciatic Patients', Neurosurgery, Vol.50, pp.1253-1259.

Robertson, J.D. (2008), Applied Channel Theory in Chinese Medicine. Seattle: Eastland Press, Inc.

Sizer, P.S., Brismee, J-M and Cook, C. (2007), 'Medical Screening for Red Flags in the Diagnosis and Management of Musculoskeletal Spine Pain', Pain Practice, Vol.7, Issue 1, pp.53-71.

Stafford, M.A., Peng, P. and Hill, D.A. (2007), 'Sciatica: a Review of History, Epidemiology, Pathogenesis, and the Role of Epidural Steroid Injection in Management', British Journal of Anaesthesia, Vol.99, Issue 4, pp.461-473.

Tortora, G.J. and Derrickson, B.H. (2009), Principles of Anatomy and Physiology, Volume 1. 12th ed. New Jersey: John Wiley and Sons, Inc.

Tunstall, M. (2011), 'Acupuncture for Acute Trauma-Related Low Back Pain Diagnosed as Qi stagnation and Blood Stasis with Yang Xu', Journal of the Acupuncture Association of Chartered Physiotherapists, Spring, pp.67-73.

Waddell, G. (2004), The Back Pain Revolution. 2nd ed. Philadelphia: Churchill Livingstone.

Xinnong, C. (2007), Chinese Acupuncture and Moxibustion. Revised ed. Beijing: Foreign Languages Press.

Xue-Min, S. (2007), Comprehensive Textbook of Acupuncture and Moxibustion. Beijing: People's Medical Publishing House.

Bibliography

Adams, M., Bogduk, N., Burton, K. and Dolan, P. (2006), The Biomechanics of Back Pain. 2nd ed. Philadelphia: Churchill Livingstone Elsevier.

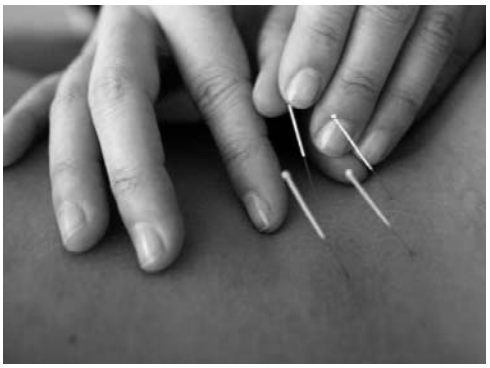
Ernst, E., Pittlett, M.H. and Wider, B. (2007), Complementary Therapies for Pain Management - An Evidence-Based Approach. Philadelphia: Elsevier Limited.

Legrand, E., Bouvard, B., Audran, M., Fournia, D. and Valat, J.P. (2007), 'Sciatica from Disk Herniation: Medical Treatment or Surgery?', Joint Bone Spine, Vol.74, pp.530-535.

Swezey, R.L. and Calin, A. (2003), Low back Pain. Oxford: Health Press Limited.

Tarulli, A.W. and Raynor, E.M. (2007), 'Lumbosacral Radiculopathy', Neurological Clinics, Vol.25, Issue 2, pp.387-405.

Anita Mason, BSc (Hons) is a Senior TCM Practitioner at Mandarin Clinic in Staffordshire, UK. She specialises in Medical Qigong Therapy and teaches the Medical Qigong Certificate and Diploma at the UK College of Medical Qigong. She studied Tuina, Acupuncture and Herbs at Glyndwr University and was awarded an ATCM Prize for Excellence for her studies in Traditional Chinese Medicine. She is committed to evidence-based and has recently written a Systematic Review on: The Efficacy and Safety of Acupuncture and Tuina for alleviating Symptoms in Adult Idiopathic Parkinson's Disease. She attends regular CPD courses in America. Contact: anita@mandarinclinic.co.uk



The Treatment of Postherpetic Pain with Acupuncture — Two case studies in the clinical application of Waveform

Alasdair B. Mearns, Ph.D, Lic Ac.

Private Clinic, Tain, Ross-Shire

Abstract: Postherpetic pain can occur after a Varcella Herpes Zoster infection. It causes mild to severe pain, to which modern allopathic treatments offer little relief. A 50% reduction of pain is considered a successful treatment. This study presents two cases of 100% pain reduction using acupuncture in combination with a point location technique known as Waveform. Point selection with Waveform is based upon the practitioner experiencing a sensation which indicates effective points.

Key Words: Acupuncture, Waveform, Shingles, Postherpetic Pain

Introduction

Shingles according to TCM[1]

Chinese Disease Categorization:

Herpes Zoster (She Dan) is referred to as 'chan yao huo dan', i.e. fire papules around the waist.

Disease Causes: External contraction of evil toxins, internal damage by the seven affects, unregulated eating and drinking, taxation fatigue, enduring disease and ageing.

Disease mechanisms:

1) Liver / Gallbladder damage engendering depressive heat.
2) Spleen Weakness with unregulated eating engendering damp.
3) Toxins with damp heat engender vesicles which obstruct the channels and network vessels causing pain. If the obstruction persists then qi stagnation and blood stasis will also be engendered.

Common Patterns:

1) Liver – Gallbladder Depressive Fire.
2) Spleen Dampness (internally smouldering).
3) Qi Stagnation and Blood Stasis.

Remarks:

It is sometimes proposed that if the upper area of the body is affected the lesions are owing to the heart and the liver. If the middle section of the body is affected, then the problem lies with the spleen and liver. If the lower abdomen or lower limbs are affected the problem lies with the kidney and liver. (Flaws and Sionneau, 262).

Shingles and Postherpetic Pain according to a Western Diagnosis[2]

Postherpetic Pain occurs in the sequalae of Varicella Herpes Zoster, Shingles infection. The pain can be severe and is the most common complication of shingles. It is not clear why some people who have shingles go on to develop postherpetic neuralgia.

The Varicella Zoster virus causes nerve damage and an imbalance between large and small fibres in the affected nerves. This alters chemicals that are released in the spinal cord and the higher connections in the brain. The brain may respond by altering the processing of the messages it receives and the signals it sends to the damaged nerves. This may cause and prolong the pain.

Risk factors known to increase the likelihood of developing postherpetic neuralgia include:

(1) age – the condition is more common in people who are over 60 years old
(2) a weakened immune system (the body's natural defence system)
(3) a more severe rash during shingles
(4) pain in an area of skin before the rash appears

Treatment Protocols for Postherpetic Pain:

Antidepressants (amitriptyline), anti-convulsants (gabapentin) and steroids (tramadol) are prescribed. However, it is thought that owing to extensive nerve damage that a 50% reduction of pain is considered a successful treatment. (El-Ansary, Maged)

The Treatment of Posttherpetic Pain by Acupuncture with Waveform

Case One:

Female: 48 years old.

The patient had a shingles episode diagnosed by her GP, following high doses of antibiotics for a chest infection. The lesions had disappeared but she presented with pain which ran from her right shoulder blade, under her right arm, and across her upper chest toward Ren17. The patient had been seen before, for tiredness, and

[1] Flaws, B., Sionneau, P. The Treatment of Modern Western Medical Diseases with Chinese Medicine: A textbook and clinical manual. Blue Poppy Press, 2001, pp 259 – 262. Also cf. http://www.jcm.co.uk/case-histories/case-history/acupuncture-treatment-of-post-herpetic-neuralgia-1241/ June19, 2013. For further information on TCM diagnostics please refer to, Meng, Fanyi (ed. English) et al. (2003).

[2] http://www.nhs.uk/Conditions/postherpetic-neuralgia/Pages/Causes.aspx April 22, 2013

therefore the following underlying conditions were known:

1) Kidney Deficiency, Yang predominant, but also some Yin Deficiency.
2) Spleen Deficiency
3) Blood Deficiency
4) Liver Qi Stagnation
5) Heat (skin rash)

Treatment

Owing to the severity of the pain, an empirical treatment was chosen to address the patient's discomfort. The painful area was scanned with regard to waveform sensations, and the following points were selected:

- Ren17
- 3 local points on upper right breast, very shallow needling
- Si 9, 10
- 7 local points in a line from the underarm to Bl 15
- Ear: Shen Men and Shoulder were also added.

Result

The patient reported an immediate and significant reduction in pain. When she returned for her next treatment the following week, she said the pain had reduced each day after treatment and was entirely gone by day 3. The patient was seen for 3 more treatments to address underlying conditions.

Case Two:

Female: 68 years old

This patient had been treated in the past for numerous complaints. Her home is nearly two hours away by car from the clinic so it is difficult to receive regular treatments. She was last seen in 2005, but she presented with postherpetic pain in November of 2012. She had shingles, as diagnosed by her GP, 3 months before. She said the blisters never broke the skin and, although the lesions had gone for the most part, severe pain had developed. It seemed to emanate from a point in her outer right mid abdomen and radiated into her right breast. The whole area was very sensitive to touch. She was also suffering from mouth ulcers. Treatment from her GP included painkillers and antivirals, which were not effective.

Her pattern diagnosis was:

1) Kidney Yin Deficiency
2) Spleen Deficiency
3) Blood Deficiency (He and Liv) and some Blood Stasis
4) Liver Qi Stagnation and heat

Treatment:

Session 1:

Principles and Treatment:

As with case one, the immediate problem, the pain was the primary focus, but underlying issues were also addressed, particularly anxiety. The following points were selected:

- Four gates (Liv 3, Li 4)
- 20 local points (waveform) from right side and lower half of her right breast, with very shallow needling.

Session 2:

Her pain was reduced significantly, but she was still very sore.

Principles and treatment:

- Course liver and clear heat: Liv 3, Li 4, St 44
- Local Points, right: (waveform) 2 points on sides, and 3 points lower half of breast.

Session 3:

Her pain was less, with a few good days and then bad ones. The area of pain was much reduced and was concentrated under her breast. The previous focus emanating from her right side had gone. Her mouth ulcers were healing well.

Principles and Treatment

- Course Liver and clear heat: Liv 3, Li 4, St 44
- Waveform: reduce Li 10 right
- Local (waveform): reduce 4 under right breast
- Tonify Metal: (indicated by pulses) tonified Lu 9 left and Lu 6 right (waveform).

Result

The patient later phoned to say that the pain had gone and she was back to work and feeling fine. I have since seen her outside of the clinic and she is still well. Owing to distance she hasn't had any further treatment for underlying issues.

Discussion

TCM provides a number of approaches for treating shingles itself. They include:

a. Treatment according to pathogenic factor.
b. Treatment according to the channels.
c. Treatment according to the local area.
d. Treatment using empirical points: such as Shiyan, on the big toe, bleeding, head and tail needling.
e. The use of electro-acupuncture.

The approach in the case studies presented here incorporates treatment of the pathogenic factors (Liver Qi Stagnation, heat), the channels (particularly the stomach channel owing to its association with the breast) and a selection of local points. No empirical point prescriptions were used.

Both patients were not in vigorous health and this would certainly be a factor in their Herpes outbreak in the first instance and also in the development of the postherpetic pain. What is notable is that both of them recovered so quickly, given the stubborn nature of the problem from an allopathic perspective.

Points were chosen according to the standard pattern diagnosis and were straight forward, but the local area needling with the use of Waveform is interesting. These points were selected because the practitioner felt a sensation when holding a needle near the point. The experience therefore was in the practitioner rather than the patient. These points changed from session to

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

session as the patient's experience of pain changed from session to session. The needles were left in place for about forty minutes except, of course, when tonifying.

Waveform techniques were also used to select points for tonification. The result in the second case, and also in many others, is that different points on the channel are needled on each side of the body rather than the usual needling of the same points on each side. Success of the selection is, of course, measured by an evaluation of pulses.

Although the cohort is too small to be statistically significant, the treatments were very successful and beyond the 50% reduction considered a success in allopathic medicine. In both cases the pain was reduced even after a single treatment, and it would appear that the assistance of Waveform in selecting local points was a definite factor in the success of the treatment, and deserves further investigation.

References

El-Ansary, Maged, (2013), Management of Postherpetic Neuralgia, http://www.iasp-pain.org/AM/Template.cfmSection=Guide_to_Pain_Management_in_Low_Resource_Settings & Template=/CM/ContentDisplay.cfm&ContentID=12187 June 19, 2013.

Flaws, B., Sionneau, P. (2001) The Treatment of Modern Western Medical Diseases with Chinese Medicine: A textbook and clinical manual. Blue Poppy Press.

http://www.nhs.uk/Conditions/postherpetic-neuralgia/Pages/Causes.aspx April 22, 2013.

http://www.jcm.co.uk/case-histories/case-history/acupuncture-treatment-of-post-herpetic-neuralgia-1241/ June19, 2013.

Meng, Fanyi (ed. English) et al. (2003), The Diagnostics of Chinese Medicine. Beijing University of Traditional Chinese Medicine. Academy Press (Xue Yuan).

Webster, Mike. http://www.waveformenergetics.com June 19, 2013.

谁之功效 — 典型中医临床治效的病案分析

江丹

目前，在讨论MHRA在今年年底有可能完全禁用无照草药制品草案（1）的时候，我想提出这几个真实的临床验案，让我们来分析判断中药在临床诊治中特殊的作用，与其不可取代的治疗价值。由于不孕症的疗效最明确，简洁， 易于判断，因而以几个不孕症的治效案例以明晰之。

病案一：不孕症（子宫内膜异位症），久针不效，加用中成药，孕四产三

Ms N Watkins, 初诊时36岁。月经规律，试孕三年未果，西医诊断为轻度子宫内膜异位症。听说针灸可能有效，在其友一西人针灸师处已规律针灸一年，仍未果，而就诊于余。由于较长时间的针灸，月经规律4-5/28-30天；少许经前紧张症，轻微痛经。就诊时逢周期第三周，舌质淡薄白苔，脉弦。

西医诊断：不孕症，子宫内膜异位症（轻型）。

中医辨证：肝气郁结，肾虚血瘀。

治疗原则：疏肝解郁，益肾暖宫。

针灸：百会，关元，气海，归来，阴谷，太溪，照海，足三里，三阴交，外关，足临泣，艾灸神阙。

中成药：加味逍遥丸，金匮肾气丸。

以上治疗，每周一针，按中医自然促孕法, 根据月经周期的不同时段，调整应用中成药（2）。来一次月经之后，其闭经受孕，足月之后，剖腹产一男婴。

两年之后，其再次就诊，业已在其友处接受规律性针灸半年余，再妊未果。在以上针灸的基础上，再次给予中成药辅助促孕，两月之后，成功受孕，足月之后剖腹产一女婴。三年之后，同样的经历，仍只用针灸与中成药，使其三个月之内再孕，再产一男婴。

今年三月，在其已有7岁，5岁，1岁9个月两子一女之后，再次来诊要求促孕治疗。同样，经针灸，中成药治疗两个月之后受孕，但于妊10周时流产。

分析：此女总是难于自然受孕，仅用针灸促孕，每疗程均在半年，甚至一年余，也不能奏效，而加用中药，也只是中成药的剂型，就可在两个月左右受孕。且多次试均得此效，可见治疗的效果是确切的。第四次，虽受孕成功，但由于患者年已43岁，超过了最佳受孕年龄，又已联生三子女，中医概念上的肾气虚更加明显， 如果及时应用中药汤药以保胎，还可能完成正常的妊娠。但是，该患者缺乏中医可能保胎的常识，未能够及时寻求治疗，而造成流产。

病案二：不孕症 （卵巢早衰），经由针灸，中成药，中草药治疗，自然受孕，孕二产二

Ms J Woodward，28岁，闭经两年。其16岁时因戒食减肥而至闭经，自此一直服雌激素类避孕药以保持规律的月经。直至两年前，婚后希孕，而停服避孕药，自此一直闭经至就诊。因本人为博士医学研究人员，开始时，对中药有一些偏见，故要求只接受针灸治疗。

就诊时刻下症：闭经，焦虑，忧郁，紧张，眠差，疲惫，四肢不温，舌质淡红薄白苔，脉弦细。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

西医诊断：不孕症，卵巢早衰 （就诊时雌激素<50, 提示更年水平）

中医辨证：肾阳虚衰，肝郁血瘀

治疗原则：温宫益肾，疏肝化瘀

针灸：百会，神庭，中极，气海，子宫，阴谷，太溪，照海，阴陵泉，三阴交，合谷，太冲，艾灸神阙。

以上穴位，每周一治，持约两个月，自感精神，气力明显好转。希望试中药治疗。

根据以上的治疗原则，根据病人的应允，先试用中成药建立正常的月经周期：

乌鸡白凤丸与血府逐瘀丸，前两个星期；

金匮肾气丸，柴胡疏肝丸，后两个星期；

每日晚间加服调经促孕丸一袋。

至此又两个月，虽无月经至，但是自测雌激素上升到65。她意识到中医可能有效，因而她表示愿意接受任何我认为适宜她的治疗。

从此，在每周一次的针灸治疗的基础上，其被给予了根据月经周期适当调整的中药汤剂治疗。主方如下：

艾叶10，仙茅10，阴阳藿10-30，熟地15，当归10，赤芍10，川芎10，枸杞子10，何首乌10，益母草10，香附10；

加紫石英15，桃仁10，红花10用于前两周；

加柴胡10，泽兰10，合欢皮10 用于后两周。

以上药水煎服，每日一剂，两次分服，每周六剂。两月之后，月经至。但每隔月一次月经，三次月经之后，自然受孕。足月顺产一女婴。半年哺乳之后，月经规律复至。一年之后，无助自然受孕，足月再产一子。

分析：此女为先天性不排卵，中医属于肾气虚，肾阳虚。因生性要强，青年时代一直努力学习，直至医学博士，故常年心里压力形成肝郁血瘀。虽一直应用雌激素类避孕药治疗，但是撤药之后，卵巢功能仍然未能恢复，而使闭经。此病症，只用针灸，，甚至加用了中成药，都显得治疗的力度不够。直至应用了汤药之后，才使得月经复至。虽尚未达到每月一至，却也使她成功受孕，产女；而经历的妊产过程使她的卵巢得到真正的调治，因而妊产之后，她的月经自然复至，旧病彻底治愈，使她得以自然，无助再次受孕。

病案三：不孕症（多囊卵巢综合症），经针灸师治疗半年未果，应用系统中医针药三个月而受孕

Ms H Forouzan，中东女士31岁，婚后10余年未孕，因此夫妇在族内备感压力，而全力求治，以希受孕。一年前，接受一次IVF, 未成功，其后在一针灸师处接受针灸，及少许中药半年余治疗未果，而求治于余。

就诊时，月经不规律5-6/ 32-90天， 月经时常在2-3月一至。如月经至，则几常无痛。妇科专家已作B-超及血检，诊断为：多囊卵巢综合症。就诊时刻下症：焦虑，压抑，善哭，末次月经为两个半月之前。两个月来，虽无经血至，但自感激素产生的周期性变化仍在，特别是情绪的异常反应。近一周，情绪的异常感觉尤为突出，甚至有少许下腹痛，头痛，入眠尤其不好。舌质瘦红少苔，脉弦细尺弱。

西医诊断：不孕症，多囊卵巢综合征

中医辨证：肝肾阴虚，肝郁血瘀

治疗原则：疏肝化瘀，滋育肾阴

针灸：艾灸神阙，针百会，神庭，外关，足临泣，神门； 关元，气海，归来，血海，阴谷，三阴交，照海，太溪。以上穴位，每周一诊。

中药：熟地30，女贞子10，旱连草10，何首乌15，枸杞子10，当归10，赤芍10， 川芎10，柴胡，川楝子10，枳壳10，白芍30，香附10；

加益母草10，合欢皮10，苦参10，于经前两周；

加紫石英15，桃仁10，红花10，于月经来之后两周。

以上药水煎服，每日一剂，每周六剂服。

其丈夫被给予柴胡疏肝丸与五子衍宗丸以助育。

以上药服近两周，月经至，以后月经每月一至；三个月成功受孕，足月顺产一女。

分析：此女月经迟至，间歇性闭经，虽针灸师已给予规律性针灸，甚至一些中药，但是仍然不能保证正常的月经周期，说明没能够给予她必要的治疗力度，也可能缺乏准确的辩证施治。其丈夫主动要求介入治疗，实践证明：对男方的辅助治疗，在加强，加速不孕症治疗的效果方面是有一定的积极意义的。

讨论

中医治疗的技术要点是给予每一个病患最适度的治疗方法。无论针灸，草药，以及大多数补充医学的治疗方法，相比西医化学药物，无或少有毒副作用是他们的优势，但是缺乏足够的治疗力度则是他们共有的劣势。因而，传统中医将是根据中医诊断的证候，综合选用各种疗法，使之达到最适宜的治疗力度。

1. 以上三例都曾经过足够时段的针灸治疗，为什么未能奏效？

应该说：单一针灸是可以治愈一些不孕症病患的，但多是比较轻的，非器质性病症。针灸的主要功效在于振奋，恢复人体的生理功能。但是真正的气血虚证，邪气淤滞，尤其是有些器质性的病变，针灸的治疗力度不够。久针的长时间弱刺激，还会产生局部反应迟钝的现象，而使人体停滞在偏低的平衡状态，因而病人会觉得一定的好转，但是达不到病症治疗的目的。所以，如果仅应用针灸，而没有期盼的疗效显现时，要即时增加必要的疗法，以保证疗效。

2. 中药补气血，调阴阳，可以提高脏器的功能，提高身体的平衡水平，因而，中药与针灸合用，可以有效地提高治疗

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

的力度，增加可治效的病症范围。而在各种剂型中选择最适宜的剂型种类是必要的。

中成药：简单易服，又比较便宜，目前中成药的种类比较多，容易选择到适宜对证的品种，适宜于常见的病症，与典型的证型；

中药浓缩粉：可以在传统主方的基础上灵活加减，方便处方，也方便服用，适用于慢性病症，复杂的，需长期在调整的状态下服药的病状；

中药汤剂：这是传统的中药剂型，也是至今仍然最为有效的剂型，可以选择主方灵活加减，也可以根据病状专门处方，病人每日煎煮，取其药汁内服，疗效比较确切，也比较快捷，适宜于比较严重，或比较复杂，或需要尽快见效的病症。

病例二的疗效，依次见证了中医的三个常见剂型，也明确地显现了各种剂型不同的治疗力度。

3.辩证准确是保证疗效的重要环节：有些病患在针灸的同时，已服了一些中药，为何也未能奏效？（例三）相比针灸穴位的选取，中药的正确选用，合理组方，更依赖对中医辨证是否精准，与组方技能掌握的是否正确。辩证模糊，选药，尤其组方就不容易精准；组方中，如果温凉补泻运用不当，还可能相互抵消其应有的疗效，甚至出现不良反应。一般来说：应用中药而出现不良反应，多是由于选药应用不当所致。由以上病例的分析与讨论可以看出，中药在治疗疾病，维持健康中所发挥着重要的，不可取代的作用，远不是单用针灸，或应用可获得执照的，单一草药制剂可以替代的。组方合用多种草药，是中医的技术精华，也是其能够成功治疗许多疾病与亚健康状态的根本要素。不明智地限制复方中药，将打击，甚至扼杀中医药，不利于这个带着人类文明，传承五千年的中华传统医药系统，有效地服务于西方人民。

参考文献

[1] MHRA, PROPOSAL TO END THE “SELL THROUGH” OF UNLICENSED PRODUCTS HERBAL MEDICINES, 9th July 2013, Ref HMSTCON13

[2] D Jiang, The effect of Chinese Medicine and Acupuncture on female fertility by inducing Artificial Ovarian Cycle, Chinese Medicine Journal of Association of TCM 2007, Issue32, P 6-11.

慢性咳嗽一例治验

朱 沛

笔者于2009年诊治一例慢性咳嗽患者，因其证型不是十分典型，故做一总结，与同仁共同复习回顾咳嗽这一章节。

病史：患者，女，28岁，华人，高级白领。一月前因感冒引起咳嗽，迁延不愈，其间未曾中断治疗用药。曾服用西药抗生素，中药川贝枇杷膏，止咳定喘丸等，并在一家知名品牌中医诊所服用汤药一月余，不但咳嗽未见明显好转，反而病势逐渐加重，伴有胸闷气短，微喘。经朋友介绍前来应诊，并声称这是最后一次尝试中药治疗，若一周之内再不见起色，准备放弃治疗，回国进一步检查诊治。

望诊：体形中等，精神稍倦怠，面色晄白，舌质淡，体瘦小，舌尖微红，舌苔薄白。

闻诊：语声低微，气短懒言，咳嗽短促，干咳无痰。

问诊：一月前感冒引起咳嗽，多方治疗，未见好转。至今咳嗽不断，午后开始加重，夜晚为甚，近日感胸闷气短，时有微喘。干咳无痰，无口干盗汗，无低热发烧，无咯血。自觉无乏力，寐差，易醒，饮食一般，二便正常。平素体健，未有任何慢性病史。

切诊：六脉均沉细，尺脉弱。

诊断：内伤咳嗽（肺肾阴虚伴脾肺气虚）。

治则：养阴润肺，益气止咳平喘。

方药：沙参麦冬汤加减。

北沙参15克，麦冬15克，玉竹12克，杏仁12克，黄芪15克，五味子20克，百合20克，百部12克，陈皮12克，款冬花15克，苏子15克，桔梗12克，半夏9克，桑白皮12克，枇杷叶12克，甘草9克。大枣三枚。

7剂，水煎服，一日一剂。

三剂后咳嗽明显减轻，胸闷缓解，七剂后时有咳嗽伴有气短。上方去桑白皮，半夏，款冬花，加党参30克，熟地9克，白术15克，黄芪加至30克，大枣6枚，续7剂。

两周后，患者打来电话兴奋告知，7剂后诸症全消，如常人，至今未有反复，十分感激。

讨论

咳嗽一证，辩证首分外感咳嗽及内伤咳嗽。外感咳嗽病程短，多属邪实，应辨清风寒，风热，风燥及外寒内热。内伤咳嗽病程稍长，多属邪实与气虚并见。当辨清痰湿，痰热，肝火及肺（肾）阴亏虚。治疗上除直接治肺外，需结合实际情况健脾，清肝，补肾。用药上注重调护正气。总则为外感忌敛宜散，内伤忌散宜敛；上述病例虽然从症状上不是十分典型，但从证型分类上诊断为气阴两虚型咳嗽并不困难。由于咳嗽迁延日久，由肺伤脾，病久及肾，而致气虚呼吸短促，肺肾摄纳失常。所以第二次调整处方加大健脾补气，佐以补肾而效如桴鼓。

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Case Study: Von Willebrands Disease with Urticaria Treated by Acupuncture

Lisa Gorden[1], Huijun Shen[2]

1. 2013 graduate from Acupuncture Programme, University of Lincoln

2. Senior lecturer and clinic supervisor, Acupuncture Programme, University of Lincoln

A 51 year old female patient named ML, self-employed, Clinic Registration No M220113L. On her initial visit on 22nd January 2013, ML presented main complaints as nose bleeding, skin itchiness and skin rash.

1. Von Willebrands Disease – 2-3 nosebleeds per week lasting 20-30 minutes
2. Unbearable itching around legs beneath the knee
3. When goes out for a walk gets rash around throat, chest, arms and buttocks

Present illness:

Nosebleeding for over 30 years - She has 2-3 nosebleeds per week now lasting 20-30 minutes. However when she was younger she had many nosebleeds per day which would last up to an hour each.
Itching - Her most problematic symptom currently however is an unbearable itching on her legs beneath her knee which comes and goes, is worse at night when she gets hot and is so severe that she has to wear gloves at night to prevent her making her skin bleed. It gets very red and mostly feels hot.
Rash - When ML goes out walking during the day she develops a red itchy rash which can spread outwards all over her body but especially round the around throat, chest, arms and buttock area. ML was diagnosed with Von Willebrands Disease and urticaria. Although she has some other conditions as well, ML would like the conditions above to be prioritised.

Tongue Diagnosis: Swollen sides**,** red and dark red body colour, slightly peeled and quivering, with thin white coat.
Pulse Diagnosis: empty in both front positions, thin and deep in the middle positions, very deep and weak in both rear position.

TCM pattern (syndrome) differentiation:

1. Main patterns: Spleen Yang Xu and Blood heat
2. Other patterns: Heart and Liver Blood Xu, Kidney Xu and Lung Qi Xu

Treatment Principles:

- Tonify and warm Spleen Yang
- Clear blood heat
- Nourish heart and liver Blood, calm shen
- Tonify Kidney and Lung
- Weekly treatments were given.

Acupoints prescription and Treatment:

- ST36 – tonifies Qi and is important to use in chronic conditions
- SP6 – Strengthens spleen, nourishes Kidney and Liver Yin, nourishes blood, tonifies kidneys, calms the mind

TREATMENT	POINTS USED
Initial consultation Treatment 1 (22/01/2013)	LIV3 LI4 ST36 KID3 DU20
Treatment 2 one week later	LIV8 SP6 LIV3 ST36 HT7 PC6 DU20 KID3 KID6 REN4 REN6
Treatment 3 one week later	LIV8 LIV3 SP6 ST36 REN4 REN6 KID3 DU20, Added BL11 SP10
Treatment 4 one week later	LIV8 LIV3 SP6 ST36 REN4 REN6 SP10 KID3 KID6 HT7 PC6 DU20 Added LI11 BL11 LU7
Treatment 5 two weeks later	LIV8 LIV3 SP6 ST36 REN4 REN6 SP10 KID3 KID6 HT7 DU20 PC6 LU7 Added BL67
Treatment 6 one week later	LIV8 SP6 ST36 SP10 KID3 KID6 HT7 PC6 LU7 BL67 Added LI11 Yin tang
Treatment 7 one week later	LIV8 SP6 ST36 SP10 LI11 HT7 PC6 DU20 BL67 Yin tang Added Anmian and ME-LE-34
Treatment 8 three weeks later	LIV8 SP6 ST36 SP10 LI11 HT7 PC6 DU20 BL67 Yin tang Anmian and ME-LE-34 Added Ren4
Treatment 9 one week later	LIV8 SP6 ST36 SP10 LI11 HT7 PC6 DU20 BL67 Yin tang Anmian and ME-LE-34 Added Ren4
Treatment 10 one week later	LIV8 SP6 ST36 SP10 LI11 HT7 PC6 DU20 BL67 Yin tang Anmian and ME-LE-34 Added KID3, KID6

- REN4 – Sea of Blood. Nourishes blood and yin and strengthens the kidneys. Benefits yuan qi. Roots the Mind (shen) and the Ethereal soul (hun) – insomnia
- REN6- Sea of Qi. Tonifies Qi and Yang deficiencies, dispels dampness and turbidity.
- KID3 – source point of the kidneys, supplements Kidney yin and clears deficiency heat
- KID6 – tonifies Kidney Yin
- KID7 – metal point of the kidneys, supplements Yin, clears deficiency heat and regulates sweating
- LI11 – clears heat
- LIV8 – nourishes liver blood
- SP10 – cools blood heat
- LIV3- spreads liver qi, nourishes liver blood and Yin (cools blood, benefits eyes)
- BL11- resolves wind
- LU7 – Luo point, spreads lung Qi, stimulates descending of lung Qi
- BL67 – brightens the eyes, nosebleeds, kidney weakness, expels wind, itching

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

- ME-LE-34- *One hundred insect burrows* Clears heat from blood to relieve itching
- HT7 - calms the mind and nourishes heart blood (insomnia)
- PC6 – calms the mind, invigorates blood, promotes sleep
- Anmian – extra point – promotes sleep
- Yin tang – calms the mind, nosebleeds, restlessness, agitation
- DU20 – clears the senses, calms the spirit, strengthens Spleen Yang, lifts Qi.

Addition of no more than 1-2 points per treatment allows an on-going assessment of which points have the most beneficial therapeutic effect.

Life Style Advice:

- Increase fluid intake as much as possible *especially water*.
- A Blood and Yin nourishing diet is recommended, i.e. seeds and beans, high quality protein, soups and stews. Pork, duck, millet, barley, tofu, string bean, black bean, blueberry, blackberry, seaweed are all useful additions to the diet. Iron and protein rich food, folic acid and Vitamin B12 and selenium may need to be supplemented
- Restrict or avoid bitter, sour, salty, pungent/hot foods, refined sugars, coffee, alcohol, chemical additives.
- Floradix is a liquid iron and vitamin formula containing organic iron (II) from ferrous gluconate, vitamins B2, B6 and B12. Very useful for blood deficiency.
- Appropriate relaxation techniques advised and exercise, yoga and meditation encouraged.
- A gluten free diet may also assist in the management of hyperthyroid conditions especially d/t evidence of gluten intolerance and Spleen Qi deficiency.
- A bedtime routine should be encouraged even in patients with sleep disturbance. The use of a relaxing bath with suitable essential oils and a relaxation audio tape may also be helpful.

Analysis:

1). Aetiology

The cause of the imbalance is a lifetime of serious blood loss/haemorrhaging. This has caused significant emotional difficulties especially around menstruation during her adolescence. As Von Willebrands was not diagnosed until ML was 37 years of age the serious and chronic nature of this condition cannot be under estimated. This condition is exacerbated by having a meat free diet, chronic dehydration and unresolved emotional issues. Other conditions have developed due to this imbalance, such as frozen shoulder, stiff low back, chronic insomnia and hypothyroidism.

2). Pathology

The above conditions have created a mixed condition that is interior, deficient/excess, hot/cold, yin/yang. Due to the complex nature of the patient's presenting symptoms, the priority for treatment will be to treat the blood and therefore treat the spirit.

Chronic illness and haemorrhage has put a tremendous strain on the Spleen causing Spleen Yang deficiency with signs of fatigue, cold, bloating, weakness, weight gain. As the Spleen is not functioning effectively and not producing enough Blood, this has led to both Heart and Liver Blood Xu resulting in insomnia, poor memory, dull complexion, floaters, short sighted, brittle nails; and also Spleen not controlling Blood shown by the nosebleeds and haemorrhaging. The excess sadness/difficulties in her life have led to Lung Qi xu contributing to her emotional state, dislike of cold, poor immunity, skin problems.

Due to the protracted nature of the disease, this has created Blood and Yin Xu with empty Heat shown by the itching, red skin and rash.

Blood not nourishing tendons and sinews may also have contributed to her problematic shoulder.

Depleted Kidney Jing due to excessive Blood loss, chronic illness and no sleep has contributed to Kidney Yin deficiency with signs of dark urine, thirst, low back pain, deep pulse and red tongue.

Spleen Yang Xu, protracted disease, age and emotional strain has resulted in Kidney Yang Xu, shown by aversion to cold, lassitude, low self-esteem.

3). Differentiation:

Due to the chronic nature of this condition, multiple Zang Fu organs have therefore been affected in this case as follows:

SYNDROME PATTERNS	SIGNS AND SYMPTOMS	TREATMENT PRINCIPLE
Spleen Pathology	Weight gain/change in body shape, Abdominal distension, Fatigue, Protracted chronic disease damages Spleen Qi leading to Spleen Yang Xu Fatigue, weakness, cold, deep pulse. Fail to confining blood in vessels causing bleeding	*Tonify and Warm Spleen Yang*
Blood Pathology	Blood heat-Red rashes, Severe itching, Comes and goes, Worse for heat. Also heat scorching vessels to cause bleeding	*Clear heat and Cool the blood*
	Blood deficiency- Fragile nails and hair, impaired vision, haemorrhage, chronic disease, worry, insomnia	*Nourish the blood*
Kidney pathology	Protracted chronic disease, Chronic Spleen Yang Xu, Emotional stress and strain, Aversion to cold, Low back ache, Lassitude, low self-esteem, Almost imperceptible pulse	*Tonify Kidney*
Heart Pathology	Insomnia, Poor circulation, Dejection/sadness/fear weakens heart qi and blood, Poor memory, Fatigue/weakness, Chronic illness weakens/over-consumes heart Qi and blood	*Tonify blood, nourish Heart blood, Calm shen*
Lung pathology	Itchy skin, Skin rashes, Physical and mental exhaustion, Dislike of the cold, Low immune response, Cries easily – grief and sadness, Weak, empty pulse	*Tonify Lung Qi*

Treatments and Result:

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Treatment 1
ML was very tearful, eyes dull, felt hopeless with her condition improving as had been to several Western Medical consultants without any success in alleviating her symptoms.

Treatment 2
An immediate improvement was noted – only one nosebleed in the last week lasting 15 minutes, no bruising from the acupuncture, itching still severe especially at night. Rash still appears when ML walks during daytime.

Treatment 3
No nosebleeds, itching at night lessened. No change in day time rash which comes and goes.

Treatment 4
Overall appearance and demeanour brighter, smiling more, no crying, talking has slowed down and appears less agitated. Pulses less deep in rear positions, no nosebleeds, severity of itching considerably less, mild itching at night. ML has taken suggested dietary advice (to build blood, nourish Yin and reduce bread) and is also supplementing with Floradix. Less 'floaters' in visual field and orange eyelid colour reduced.
ML feels very positive about the treatments, and the holistic approach to her health. She feels 'held' during her treatments and in the positive changes that are taking place.

Treatment 5
There were 2 weeks between treatments and ML's nosebleeds returned. She had 4 in one week for half an hour each. Itching increased in intensity. It appears therefore that it is vital to have weekly treatments for the time being. Emotionally, she reported that she feels less 'scattered' and that she is 'coming back to herself'. The big 'lump' of grief around her chest and throat feels like it has started to shift and she now feels safe and ready to look at her sadness.
.
Treatment 6
One week later, and ML is delighted to report that she has not had a nosebleed and experienced no itching at all for the first time in 2 ½ years. Also her sleep has improved and she slept for a 4 hour stretch and 'even had a dream' which suggests that she went into REM sleep for the first time in many years. ML has also started to feel increasingly more balanced emotionally. Feels calmer, not 'going at 100 miles an hour' and not as vulnerable and tearful.

Treatment 7
Again no nosebleeds reported, no itching at night. Not as cold in bed, continuing with attention to good diet and Floradix, and emotionally more positive. Improved pulses. Day time rash however occurs especially when walks in the cold outdoors.

Treatment 8
Three weeks between treatments due to Easter break. ML reported no nosebleeds for one week post treatment, then had 3 nosebleeds per day for 5 minutes only. However great improvement with skin. No itching at night and rash which appeared over body when walking during the day has resolved. Does not feel as cold at night. Feels more settled, not talking as fast and much less tearful. Insomnia still problematic.

Treatment 9
One week later, no nosebleeds, no itching at night, no rash when walking during the day. Feels more settled, not talking as fast, does not appear as 'scattered', not tearful, skin looks brighter, eyelids pale yellow (not orange as before). Still not sleeping well. Two hours per night. As a young child ML had insomnia and has only slept minimally 2-4 hours a night throughout her life.

Treatment 10
One week later, no nosebleeds, no itching at night, no daytime rash. Pulses less deep. Kidney pulses now perceptible. Demeanour is brighter overall, skin and eyes brighter, behaviour less adrenaline fuelled, calmer. Sleeping more deeply but still no longer than 2-4 hours, however ML's health continues to improve.

Discussion:

Von Willebrand disease (VWD) is a common hereditary coagulation abnormality described in humans**. It** is a bleeding disorder caused by a defect or deficiency of a blood clotting protein, called von Willebrand Factor. The disease is estimated to occur in 1% to 2% of the population. The disease was first described in 1926 by a Finnish physician Erik von Willebrand.

Von Willebrand Factor is a protein critical to the initial stages of blood clotting. This glue-like protein, produced by the cells that line the blood vessel walls, interacts with platelets in blood to form a plug which prevents the blood from flowing at the site of injury. People with von Willebrand Disease are unable to make this plug because they do not have enough von Willebrand Factor or their factor is abnormal. Usually, people with VWD bruise easily, have recurrent nosebleeds, or bleed after tooth extraction, tonsillectomy or other surgery. Recurrent nosebleeds are also a hallmark of VWD. Women can have increased menstrual bleeding.

Researchers have identified many variations of the disease, but most fall into the following classifications:

- Type I: The most common and mildest form of VWD. Levels of von Willebrand factor are lower than normal.
- Type II: The von Willebrand factor itself has an abnormality. Depending on the abnormality, they may be classified as Type IIa or Type IIb.
- Type III: This is severe von Willebrand disease. These people may have a total absence of von Willebrand factor or less than 10%.
- Pseudo (or platelet-type) von Willebrand disease: This disorder resembles Type IIb von Willebrand disease, but the defects appear to be in the platelets, rather than the von Willebrand factor.

VWD is a genetic disease that can be inherited from either parent. It affects males and females equally. A man or woman with VWD has a 50% chance of passing the gene on to his or her child. There are no racial or ethnic associations with the disorder. A family history of a bleeding disorder is the primary risk factor.

Diagnosis of von Willebrand Disease can be difficult. Blood tests can be performed to determine the amount, structure and function of von Willebrand Factor. Since levels can vary, sometimes tests may need to be repeated.

In western medicine treatment, desmopressin (DDAVP) is used for VWD Type I and Type Iia. But DDAVP is contraindicated in VWD Type IIb because of the risk of aggravated thrombocytopenia and thrombotic complications. It is ineffective in VWD Type III. Blood transfusion or infusion of platelet concentrates can be given in some cases as needed. The antifibrinolytic agents Epsilon amino caproic acid and Tranexamic acid are useful adjuncts in the management of VWD complicated by clinical hemorrhage.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Although in TCM there is no description of VWD, the two main causes for haemorrhage are deemed as Heat in blood and Spleen Deficiency. Heat bakes and damages the blood vessels to cause blood flow outside the vessels, Spleen is too weak to confine the blood flowing in the vessels causing overflow. In this case, Blood heat and Spleen deficiency are two main patterns, both hemorrhagic causes co-exist to cause chronic nosebleeds for so many years. Acupuncture on ST36, SP6, Ren4 and Ren6 etc to tonify Spleen so it becomes strong enough to confine blood, needling LI11, SP10 and ME-LE-34- helps to clear heat from blood, and once blood becomes cooler, it will not scorch vessels any more so bleeding stops.

The patient also had urticaria causing skin itchiness and rashes. This allergic dermatological condition may have no connection with VWD in western medicine, but in TCM both are much to do with heat and Spleen issues. Enduring Spleen deficiency has led to Lung Qi weakness hence defensive Qi also become deficient, so the patient is susceptible to wind invasion; with constitutional blood heat pattern, wind invasion is often transferred to heat. Both wind heat from exterior and blood heat from interior mingle in the body and flare up on the skin. So for urticaria, Spleen deficiency and blood heat are primary while wind heat invasion is secondary. The patients also has other secondary patterns such as Kidney (resulted in from Spleen deficiency) deficiency and Heart shen disturbance (by heat in blood). They are also treated simultaneously with good results.

References

- Laffan M, Brown SA, Collins PW, *et al.* (2004). "The diagnosis of von Willebrand disease: a guideline from the UK Haemophilia Centre Doctors' Organization". *Haemophilia* **10** (3): 199–217.
- Maclean, W; Lyttleton, J (2002) *Clinical Handbook of Internal Medicine. Volume 2. Spleen & Stomach* Pangolin Press: Australia
- Maclean, W; Lyttleton, J (2010) *Clinical Handbook of Internal Medicine. Volume 3. Qi Blood Fluid Channels* Pangolin Press: Australia
- Maciocia, G (2004) *Diagnosis in Chinese Medicine. A comprehensive guide* London: Elsevier
- Maciocia, G (2005) *The foundations of Chinese Medicine Second Edition*. London: Elsevier
- Mannucci PM; Mannucci, Pier Mannuccio (2004). "Treatment of von Willebrand's Disease". *N. Engl. J. Med.* **351** (7): 683–94.
- Sadler JE (1998). "Biochemistry and genetics of von Willebrand factor". *Annu. Rev. Biochem.* **67**: 395–424.

The influence of the 'Great Eliminator' in the treatment of idiopathic constipation: a case study

A. Mason[1], P. Battersby[2] and A. Feyler[3]

[1]TCM Practitioner, Mandarin Clinic, Newcastle under Lyme, UK;

[2]Senior Lecturer in Chinese and Complementary Medicine, Glyndwr University, Wales, UK;

[3]Senior Lecturer in Chinese Medicine, Glyndwr University, Wales, UK.

Abstract: An Constipation, which affects more than 1 in 5 of the population, is characterised by abdominal discomfort, flatulence, loss of appetite, and a foul tasting mouth. The aim of this case study is to provide an in-depth analysis of scientific evidence, comparing Western and Chinese medicine treatment methods for constipation. A 21 year old female presented with symptoms of abdominal bloating, headaches and tiredness. Faecal evacuation had been problematic for over 10 years; consequently daily living had become uncomfortable. A four week treatment regime incorporating acupuncture was administered, resulting in increased peristaltic movement and the ability to fully evacuate faeces..

Key Words: Acupuncture, Chinese Medicine, Constipation

Background

According to Lembo et al., (2010) constipation is one of the highest morbidity factors in the developed world. In the UK alone, 14 million prescriptions are written each year for laxatives, subsequently costing the National Health Service £60 million (National Institute of Health, 2010). The prevalence of constipation increases with age and is more frequently reported in female patients (Gallegos-Oroszo, 2011). Talley et al., (2010) describe constipation as a symptom rather than a disease which can range from being mild to severely debilitating. Both Robinson (2007) and Kumar and Clarke (2009) share a consensus definition that constipation can include: having infrequent stools (<3/week); the need for excessive straining (>25% of the time), or a sense of incomplete defecation. Propulsion of the faeces in the large intestine occurs as a result of three actions: peristalsis, haustral churning and mass peristalsis (Talley et al., 2010). The ascending and transverse colon assist mainly in the chemical digestion of food residues and water absorption. However, the descending colon forms the link to the rectum where faeces are stored in readiness of defecation: a reflex triggered by rectal distension and voluntary control of the external anal sphincter (Kumar and Clarke, 2009). Sporadic or strenuous defecation is therefore due to the impaired motility of the intestines (Travis et al., 2005). According to Wong et al., (2002), two classifications of constipation exist: idiopathic constipation (unknown cause) and real constipation (known cause). Idiopathic constipation either

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

reduces the transit time or, produces dry, hard faeces due to excessive water absorption. The causes of real constipation are outlined in Table 1.

The assessment of constipation has to include comprehensive history taking, observation, abdominal palpation and rectal examination, as it is crucial in understanding the cause. Treatment therefore, depends on the underlying cause and can range from increasing fibre and fluid to exploring stress relieving techniques. If the problem persists, laxatives are prescribed, outlined in Table 2, although many carry adverse side effects (Talley et al., 2010).

Both Western and Chinese medicine systems concur that constipation pertains to the large intestine. Bing and Hongcai (2011) affirm from a Chinese medicine perspective, the foremost reason for constipation is due to the decreased transmission function along the large intestine. Aetiological factors include an excess of cold food for example, which may block the Spleen function of transportation. In turn, the contraction of the intestines decelerates the peristaltic movement. Equally, over indulgence of hot foods dries the stool making excretion more difficult due to an accumulation in the large intestine (Xinnong, 2005). Emotional stress contributes to constipation, as anger causes Liver Qi stagnation which obstructs the smooth flow of Qi. Excess mental activity such as over thinking depletes the Spleen; in turn diminishing the Qi required for the transportation of food. Excess physical activity can deplete Qi resulting in dryness; on the contrary a sedentary lifestyle weakens Spleen Qi. This deficient syndrome fails to provide the Qi to move the stools which become sluggish resulting in constipation (Maciocia, 2008).

Table 1 Common Causes of Real Constipation:

- Inadequate fibre and fluid intake.
- Sedentary living.
- Medication.
- Pregnancy.
- Medical Conditions: for example, Diabetes Mellitus; Multiple Sclerosis.
- Mechanical problems: Disorders of the anal sphincter muscles, pelvic floor weakness, stress factors or even muscle and nerve disease can cause defecation disorders where there is difficulty initiating evacuation.
- Stress and Anxiety.

Table 2 –

Prescribed Laxatives	Action of Medication
Bulk-Forming Laxatives	➢ *Ispaghula Husk* – Fibrelief, Fybogel, Isogel, Ispagel Orange, Regulan. Caution: maintain fluid intake to avoid intestinal obstruction. Side effects include: flatulence, hypersensitivity, abdominal distension. ➢ *Methylcellulose* – Celevac, Sterculia. Action: these laxatives absorb water in the intestine making the stool softer.
Stimulant Laxatives	➢ *Bisacodyl* – Dantron, Docusate Sodium, Glycerol, Glycerol Suppositories. Contra-indications: acute inflammatory bowel disease, dehydration. Side effects include: local irritation, griping. ➢ *Senna* – Manevac, Senokot. ➢ *Sodium Picosulfate* – Dulcolax. Action: creates a rhythmic muscle contraction in the intestines.
Faecal Softeners	➢ *Arachis Oil* – Arachis Oil Enema. ➢ *Liquid Paraffin*. Caution: avoid prolonged use. Side effects: anal seepage of paraffin causing anal irritation. Action: moistens the stool thus preventing dehydration.
Osmotic Laxative	➢ *Lactulose* – Macrogols, Laxido, Movicol. Contra-indication: intestinal obstruction. Side effects: cramps, flatulence. ➢ *Magnesium Salts* – Magnesium Hydroxide, Magnesium Sulphate, Magnesium Hydroxide with Liquid Paraffin. Caution: elderly and debilitated patients. Side effects: colic. ➢ *Phosphates* – Carlalax. Caution: renal impairment, uncontrolled hypertension. Side effects: local irritation. Action: causes fluids to flow through the colon. Neale (2009).

Patient Profile

The patient's chief complaint was constipation which she had endured for over 10 years. Empathetic questioning during the initial consultation established whether a red flag was prevalent. Red flags in relation to constipation include abrupt and prolonged changes in bowel habit, weight loss, nausea, and vomiting. Rectal bleeding and a family history of bowel cancer would need urgent attention, primarily through endoscopy and possibly surgical intervention (Robinson, 2007). Extensive tests had been undertaken by her G.P. with a resultant idiopathic outcome. Apart from being prescribed an osmotic laxative (Movicol) which precipitates fluids through the colon, no medical intervention had been necessary (Neale, 2009). Reasonable energy levels were reported: 7/10 on the Visual Analogue Scale. The patient's 8 hour per night sleep pattern was adequate, although she constantly felt tired upon waking. Emotionally, she was stressed due to being in the final year of a degree, and regularly experienced a frontal headache. Her appetite was normal as two nutritious meals were consumed

daily, however breakfast was frequently omitted. Fluid intake, which is of paramount importance when constipated, was reported as minimal. Bowel movement occurred every 4 - 5 days, with scanty dry stools, accompanied by abdominal bloating and a feeling of incomplete evacuation. Urination sustained normal capacity, which appeared dark yellow in colour. The tongue proper was red with heat spots: the pulse was rapid and deep upon palpation. The main pathogen indicated was therefore, Heat accumulating in the large intestine due to Stress.

Case Management

Zhang et al., (2009) imply that chronic cases of constipation are caused by mental and psychological factors. The patient's clinical manifestations such as, dry, 'pebble-like' stools and infrequent defecation indicated Heat according to Maciocia (2008). Whilst Xinnong (2005) corroborates that a red tongue proper with yellow coating is also typical of a Heat pathogen, especially if red heat spots are present. The subsequent accumulation of Heat in the intestines consumes the fluids, thereby disturbing the normal function of the large intestine. Jinsheng (2006) equates the intestinal tract to that of a river's course; a boat sailing in the river being the stool. The analogy is drawn whereby; the boat needs the combination of water, the auto-motive impulse of the boat and the smooth flow of water to successfully sail. Constipation, due to Heat, perceived as an Excess condition according to Jinsheng (2006), is likened to a boat sailing in a dry river. Lee et al., (2010) specify that four predominant constipation patterns exist in Chinese medicine: heat, cold, Qi and deficiency types - see table 3.

Table 3

Heat Constipation Fullness in intestines. Pain. Bad breath. Thirst. T – red, yellow coating. P – full. ***Clear Heat. Induce bowel movement.** **Sedate Yangming** – LI4, LI11, ST37, ST25, SP14. Thirst – Ren 24, PC8.	**Qi Constipation** Unfinished feeling. Bitty stools. Bloated. Belching. **T** – white coat. **P** – wiry. ***Regulate Qi to induce bowel movement.** **Sedate Ren, foot Jueyin** – Ren 12 & ST25. Ren6 – moves intestines. LV 2 & BL34. Hypochondriac pain – LV14, SJ6. Bloating – SP15.	**SP/KI Yang Cold Constipation** Fatigue. Coldness. Dizzy. Tinnitus. Clear urine. **T** – pale, white moist coat. **P** – deep. *Warm SP and KI Yang. **Tonify, Moxa – Foot Shaoyin & Taiyin** – Ren6, KI6, BL23, BL20 & SP6, ST25. Excess coldness – DU4, BL40. Anal Prolapse – DU1, DU20.	**Deficiency Constipation** Lack of Qi & Blood can lead to LU Qi deficiency. Lack of energy to push. Sweating. Fatigue. T – pale with white coat. P – thin, weak. ***Strengthen SP; nourish Qi** to induce bowel movement. Tonify, Moxa – BL20, BL21, SP6, ST36, Ren4, BL25 & ST25, KI7 & LI4. Palpitations – PC6.	**Yin/Blood Deficiency Constipation** Chronic. Rabbit stools. Yin deficiency signs. Dryness. ***Moisten dryness. Nourish Yin**. Foot Shaoyin – KI3, KI6, BL20, SP6, ST36, BL25 & ST25. Insomnia, palpitations – HT7, LV2, LV3.
(Lee *et al*., 2010)				

Heat in the intestines, according to Dowie (2009), necessitates a reducing method of treatment to eliminate the Excess whilst moistening the intestines. The treatment principle was therefore to clear Heat, circulate Qi and moisten the intestines. In view of the theory of channels in Chinese medicine, LI11 and LI4 were predominantly employed throughout the four week treatment regime as both acupuncture points pertain to the Metal Element. According to Gumenick (2011), patients with a metal imbalance seem unable to eliminate toxins. LI4, classified as 'The Great Eliminator' is a Yuan-Source point of the large intestine. Clinically, Yuan-Source points can significantly influence diseases of the Zang Fu by treating with root cause, especially if internally combined with the Luo connecting point, LU7. In addition, LI11, the Earth point of the large intestine was utilised to create a stabilising quality to the elimination process (Zhaogang et al., 2003).

Table 4: Tx 1 – Tx 4

Tx 1:

Syndrome Differentiation: Constipation: Heat in the Large Intestine due to stress. Loss of peristaltic action.

Principles of Treatment: Clear Heat. Circulate Qi. Moisten the Intestines.

Treatment Plan: Ensured the patient's warmth and comfort; 1 pillow; 1 bolster. Supine position. Stayed with the patient throughout the treatment. Duration of treatment – 1 hour.

Considerations:

- Respected the patient's modesty by appropriate use of towels.
- Explained which items of clothes to remove.
- Explained where the needles would be inserted and the sensations associated with De-Qi.
- Acquired signed consent with relevant date before treatment.
- Needles retained for 20 minutes.

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Acupuncture Points	Actions
LI11	➢ Clears Heat. Cools pathogenic Heat. Activates channel.
LI4	➢ Main point for Accumulation of Heat. Activates the channel.
LU7	➢ Luo-connecting point of Lung channel and related large intestine. Promotes descending function. Clears intestines.
ST37	➢ Lower He-sea point for large intestine. Regulates the intestines, transforms stagnation.
KI3	➢ Anchors Qi, clears Heat. Good point for difficult defecation.
LV3	➢ Spreads and smooths Liver Qi. (Deadman and Khafaji, 2007)
Health & Safety/Aftercare throughout the four week treatment plan	➢ Ensured Health & Safety was conformed to at all times: no obstacles initiating a trip or fall; couch correct height; adequate ventilation. ➢ Enquired whether patient was pregnant as LI4 is contra-indicated in pregnancy. ➢ Drink plenty of water. ➢ Ensured patient leaves the couch safely after treatment.
Tx 2	***Feedback and new objectives:*** ➢ Successful faecal evacuation within one hour of treatment. ➢ Extreme thirst.

Syndrome Differentiation: Constipation: Heat in the large intestine due to stress. Loss of peristaltic action. Thirst due to Kidney Yin Deficiency.

Principles of Treatment: Disperse & Cool Heat. Circulate Qi. Moisten the intestines. Nourish Kidneys.

Acupuncture Points: LI11, LI4. LU7, ST37, LV3 remained the same as the previous week. KI6 replaced KI3.

Acupuncture Points	Actions
KI6	➢ Clears Heat. Nourishes Kidney Yin – thirst, dry mouth.
Tx 3	***Feedback and new objectives:*** ➢ Successful daily faecal evacuation since last treatment. ➢ Does not feel that she is 'fully evacuating'. ➢ Binge eating. ➢ Worry.

Syndrome Differentiation: Constipation. SP Qi Deficiency. LV Blood Deficiency. Lung Qi Deficiency. Peristaltic action weakened.

Principles of Treatment: Circulate Qi. Tonify SP Qi. Nourish LV Blood. Tonify LU Qi.

Acupuncture Points: LI4, LU7, ST37 and LV3 remained the same as the previous week. Additional points included were: ST25, SP10, LV8 and SP6.

Acupuncture Points	*Actions*
ST25	➢ Front Mu point for the large intestine. Regulates Qi and Blood. Eliminates stagnation.
SP10	➢ Invigorates Blood. Disperses stasis.
LV8	➢ Nourishes Blood and Yin.
SP6	➢ Invigorates Blood. Nourishes Spleen and Stomach. Contra-indicated in pregnancy.
Tx 4	***Feedback and new objectives:*** ➢ Successful 'full faecal evacuation' daily since last treatment. ➢ Binge eating. ➢ No more thirst. ➢ Tearful. ➢ Worry.

Syndrome Differentiation: Stress and poor diet causing SP Qi deficiency, LV Blood deficiency. Constipation due to Qi and Blood deficiency.

Principles of Treatment: Tonify SP Qi. Nourish LV Blood.

Acupuncture Points: LI4, LU7, ST25, ST37, SP10, SP6, and LV3 remained the same as the previous week. SJ6 replaced LV8.

SJ6	➢ Jing-River point. Regulates Qi. Moves the stool. Clears Heat and activates the meridian. (Deadman and Khafaji, 2007)

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Reflection

Bing and Hongcai (2011) bestow that constipation is an uncomplicated condition to treat in clinical practice. Practitioners are constantly encouraged to use reflective practice to reflect upon the skills used to maintain competence (Neville, 2009). In week three the practitioner recognised that the pattern had changed to a deficiency type. Refining the treatment plan at this point proved helpful as the patient reported "full evacuation" as a result of introducing Spleen points. A treatment plan should change depending on what the patient experiences and the practitioner needs to be mindful of such subtleties. In week three, the patient reported 'binge' eating as she had suddenly become worried about the mounting volume of university work. The Western diet predominantly consists of wheat, sweets and dairy products; all believed by Chinese Medicine, to be damp forming. In retrospect, a food diary could have been suggested and would have been useful to illustrate her over consumption of certain foods (Gagné, 2008).

Excessive thinking and worry damages the Spleen. Stress depresses the Liver precipitating Qi stagnation which ultimately obstructs the free flow of Qi. More advice could have been suggested with regard to relaxation and exercise techniques; T'ai Chi or Qigong (with a qualified teacher), would benefit a patient who is constipated due to Qi stagnation as it is known to increase peristaltic movement (Johnson, 2002). Robertson (2008) reiterates that dietary and lifestyle changes are just as important to a patient's health as deliberating a correct acupuncture prescription. From a motivational standpoint, ear press seeds could have been attached to the ear points of the lung and large intestine (Romoli, 2009). This methodology would have given the patient the opportunity to participate in her own healing process. Upon recognition of deficiency-constipation in the third week, the treatment plan could have been further refined by introducing moxibustion. Documented evidence exists where moxibustion is effective for treating constipation especially when applied to Ren 6 which enhances and strengthens the Qi (Jinsheng, 2006). Conversely, various authors report the following findings in the treatment of constipation:-

Author	Description	Outcome
Lee *et al*., 2010 Systematic Review	➢ 522 relevant studies. ➢ Moxibustion combined with acupuncture. ➢ LI4 was included in the acupoint selection.	It was concluded that methodological rigor was insufficient.
Zhaogang *et al*., 2003 RCT	➢ 188 patients. ➢ Point selection included LI4. ➢ 6 sessions. ➢ Needles were retained 15 – 20 minutes.	No recurrence of constipation after the 6 sessions.
Jinsheng, 2006 Case study	➢ 65 year old male. ➢ Moxibustion and acupuncture combined. ➢ LI4 was used throughout to regulate the function of the large intestine. ➢ SP6 used to promote the foundation of Qi and Blood ultimately reinforcing the motive force. ➢ 20 treatments.	No recurrence after 20 treatments.
Shaoguang, 2001 Case Study	➢ 36 patients treated with electro-acupuncture. ➢ SJ6 predominantly used throughout the programme. ➢ 8 – 10 sessions were administered.	Out of 36 cases, 27 showed no recurrence.

Conclusion

14 million prescriptions are written annually for laxatives to alleviate the symptoms of constipation, many of which carry adverse side effects (National Institute of Health, 2010). Idiopathic constipation is debilitating for individuals as symptoms include infrequent defecation, excessive straining or incomplete defecation. Both Western and Eastern medicine systems conform to the concept that constipation occurs as a result of a reduced transmission function along the large intestine (Travis et al., 2005). A four week acupuncture treatment plan offered a safe, effective outcome to an individual who had endured idiopathic constipation for over ten years. LI4 (great eliminator) was utilised throughout with immediate effect as defecation occurred after the first treatment. Full evacuation was reported upon completion of the fourth treatment. Current research reasserts that acupuncture is a safe, effective treatment regime for the management of idiopathic constipation.

References

Bing, Z. and Hongcai, W. (2011), Case Studies from the Medical Records of Leading Chinese Acupuncture Experts. London: Singing Dragon Publishers.

Deadman, P. and Al-Khafaji, M. (2007), A Manual of Acupuncture. East Sussex: Journal of Chinese Medicine Publications.

Dowie, S. (2009), Acupuncture – An aid to Differential Diagnosis. Philadelphia: Churchill Livingston Elsevier.

Gagné, S. (2008), Food Energetics: the Spiritual, Emotional and Nutritional Power of What We Eat. Vermont: Healing Arts Press.

Gallegos-Orozco, J., Foxx-Orenstein, A., Sterler, S. and Stoa, J. (2011), 'Chronic Constipation in the Elderly', The American Journal of Gastro-Enterology, Vol. 107, pp.18 - 25.

Gumenick, N. (2011), The Spirit of the Points: The Large Intestine Meridian. http://acupuncturetoday.com/mpacms/at/column.php?c_id=131 [Electronically accessed December 2011]

Jinsheng, H. (2006), 'Acupuncture Treatment of Constipation', Journal of Traditional Chinese Medicine, Vol.26, No.4, pp.310-313.

Johnson, J. (2002), Chinese Medical Qigong Therapy:

ATCM, 314 Premier House, 112 Station Road, Edgware, London, HA8 7BJ
Tel/Fax: 020 8951 3030, Email: info@atcm.co.uk Website: www.atcm.co.uk

Prescription Exercises and Meditations. California: The International Institute of Medical Qigong Publishers.

Kumar, P. and Clarke, M. (2009), Clinical Medicine. 6th ed. Philadelphia: Saunders Elsevier.

Lee, M., Chol, T.Y., Park, J. and Ernst, E. (2010), 'Effects of moxibustion for constipation treatment: a systematic review for randomised controlled trials', Chinese Medicine Journal, Vol.5, No.28.

Lembo, A., Kurtz, C., Mac Dougall, J., Lavins, B.J., Currie, M., Fitch, D. Jeglinski, B. and Johnston, J. (2010), 'Efficacy of Linaclotide for Patients with Chronic Constipation', Gastroenterology, Vol.138, Issue 3, pp. 886 – 895.

Maciocia, G. (2008), The Practice of Chinese Medicine. 2nd ed. Philadelphia: Churchill Livingstone.

National Institute of Health (2010), Constipation. http://digestive.niddk.nih.gov/ddiseases/pubs/constipation/ [Electronically accessed November, 2011]

Neale, M.J. (2009), Medical Pharmacology at a Glance. 6th ed. UK: Wiley-Blackwell.

Neville, L. (2009), Interpersonal Skills for the People Professions. Devon: Reflect Press Ltd.

Robertson, J.D. (2008), Applied Channel Theory In Chinese Medicine. Washington: Eastland Press Inc.

Robinson, B. (2007), Biomedicine: A Textbook for Practitioners of Acupuncture and Oriental Medicine. United States: Blue Poppy Press.

Romoli, M. (2009), Auricular Acupuncture Diagnosis. Philadelphia: Churchill Livingstone Elsevier.

Shaoguang, W. (2001), 'Electroacupuncture Treatment For Constipation Due to Spasmodic Syndrome of the Pelvic Floor – A Report of 36 Cases', Journal of Traditional Chinese Medicine, Vol. 21, No. 3, pp. 205 – 206.

Talley, N.J., Kane, S.V. and Wallace, M.B. (2010), Small and Large Intestine and Pancreas. Oxford: Blackwell Publishing Ltd.

Travis, S.P., Ahmad, T., Collier, J. and Steinhart, A. H. (2005), Gastroenterology. Oxford: Blackwell Publications.

Wong, J., Murray, L., Hussaini, H. and Dalton, H. (2002), Gastroenterology. Oxford: BIOS Scientific Publishers Ltd.

Xinnong, C. (2005), Chinese Acupuncture and Moxibustion. Revised ed. Bejing: Foreign Languages Press.

Zhang, L., Zhu, M., Liu, Q. and Lei, Y. (2009), 'The Clinical Experiences of Dr. Cai Gan in Treating Chronic Constipation', Journal of Chinese Medicine, Vol. 29, No.3, pp.205-208.

Zhaogang, Z., Hongbo, L., Chen, L., Guangwu, W. and Chenggao, K. (2003), 'Acupuncture Treatment of Habitual Constipation', Journal of Traditional Chinese Medicine, Vol. 23, No. 2, pp. 133.

Bibliography

Marieb, N. and Hoehn, K. (2010), Human Anatomy & Physiology. 8th ed. San Francisco: Pearson Benjamin Cummings.

McKenney, J.A. (2008), 'The Physiological Use of Water in Constipation', American Journal of Digestive Diseases, Vol.13, No.3, pp.78-80.

Müller-Lissner, S.A., Kamm, M.A., Scarpignato, C. and Wald, A. (2005), 'Myths and Misconceptions about Constipation', The American Journal of Gastroenterology, Vol.100, pp.232-242; doi:101111.

Wood, G.K. (2006), The Complete Guide to Digestive Health. United States: Frank Cawood and Associates.

Anita Mason, BSc (Hons) is a Senior TCM Practitioner at Mandarin Clinic in Staffordshire, UK. She specialises in Medical Qigong Therapy and teaches the Medical Qigong Certificate and Diploma at the UK College of Medical Qigong. She studied Tuina, Acupuncture and Herbs at Glyndwr University and was awarded an ATCM Prize for Excellence for her studies in Traditional Chinese Medicine. She is committed to evidence-based and has recently written a Systematic Review on: The Efficacy and Safety of Acupuncture and Tuina for alleviating Symptoms in Adult Idiopathic Parkinson's Disease. She attends regular CPD courses in America. Contact: anita@mandarinclinic.co.uk

ATCM OFFICE HAS MOVED TO A NEW ADDRESS

The office building in which ATCM office has located for 5 years is going to be converted to a residential building very soon. As a consequence, ATCM office has recently moved to a new office building. The new location is not far from the current one but much closer to Edgware tube station.

The new office address is shown as below:

ATCM
314 Premier House
112 Station Road
Edgware
london
HA8 7BJ

Please note all posts to ATCM office from 1st October 2013 should be sent to the new address shown above.

ATCM's telephone/fax number, email address, and website remain the same.

ATCM 于 2013 年 10 月 1 日搬迁办公室

由于 ATCM 所在的办公楼即将动工改建成居住楼，ATCM 办公室于 2013 年 10 月 1 日正式搬往新的办公地址，新办公楼离 EDGWARE 地铁站更近一些，便于会员有需要时来访。新办公室的地址如下：

ATCM
314 Premier House
112 Station Road
Edgware
London
HA8 7BJ

请会员于 10 月 1 日起将所有的信件寄往以上的新地址。

此外 ATCM 办公室电话/传真（0208 951 3030），邮箱（info@atcm.co.uk），以及网址(www.atcm.co.uk) 将保持不变。

HENAN UNIVERSITY OF TRADITIONAL CHINESE MEDICINE

河南中医学院

Founded in 1958, Henan University of Traditional Chinese Medicine was located in Zhengzhou the capital city of Henan province with over 18000 students. It consists of 16 schools (departments or centers), 3 affiliated hospitals (all at provincial level), 125 clinical bases, 59 research institutes, 24 priority disciplines and 6 key specialties nominated by the State Administration of TCM. The university has established friendly relationship with over 50 educational, research, and medical institutions worldwide.

The School of International Education offers Bachelor's (RMB26000/year), Master's (RMB32000/year), Doctoral programs (RMB35000/year) as well as Chinese Language programs (RMB7000/semester) and short-term trainings. It was awarded by the China Association of Higher Education for excellence in international education. It was the only TCM university competing in the final of "China Exploration 2013" a sports and cultural competition for international students in China.

河南中医学院始建于 1958 年，位于河南省会郑州市。下辖 16 个院（部、中心），3 所直属附属医院（均为省级医院）和 125 个临床教学基地，59 个研究所。学校有国家中医药管理局重点学科 24 个、重点专科 6 个，在校生 18000 多人。学校与国外 50 多个教育、科研和医疗机构建立了联合办学、技术合作等长期友好关系。

河南中医学院国际教育学院负责留学本科生（RMB26000/年）、硕士研究生（RMB32000/年）、博士研究生（RMB35000/年）、汉语生（RMB7000/学期）和进修生的教学。曾被中国教育部高等教育学会评为"来华留学生教育管理先进集体"。2013 年在中国教育部主办的 "留动中国——在华留学生阳光运动文化之旅" 活动中，河南中医学院为晋级全国总决赛的唯一一所中医药院校。

Henan ----*a vast museum of natural and historical beauty*

- ☆ Being the cradle of Chinese civilization, 3 out of 7 ancient capitals in China were located in Henan;
- ☆ 3 properties were enlisted as the World Cultural Heritage:
  - ◆ Yin Ruins—where oracle bone inscriptions were excavated;
  - ◆ Songshan Mountain—origin of Shaolin kungfu;
  - ◆ Longmen Grottoes—where ***Hetu*** and ***Luoshu*** (The River Chart and the Inscription of the Luo) came into being;
- ☆ Henan is the roots of Chinese medicine and birthplace of ZHANG ZHONGJING the writer of the *Treatise on Febrile and Miscellaneous Diseases*;
- ☆ Henan is where Taijiquan originated.

Contact Information

School of International Education, Henan University of Traditional Chinese Medicine

Address: 1 Jinshui Rd, Zhengzhou, Henan, 450008, P. R. China

Tel: +86-371-65962930 +86-371-65978696

Fax: +86-371-65962930 Email: henantcm@gmail.com Website: http://www.henantcm.org