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地址 Address: ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ

电话 Tel: 0044 (0)20 8457 2560　　电子邮件 Email: info@atcm.co.uk

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缅怀针灸泰斗程莘农和贺普仁

２０１５年５月和８月，中国著名针灸大师程莘农，贺普仁相继离世。

中国中医科学院名誉首席研究员，首届国医大师，中国工程院院士程莘农教授于５月９日在珠海逝世，终年９４岁。国医大师，三通法创始人，国家级名老中医贺普仁教授于８月２２日在北京辞世，享年９０岁。两位大师同为联合国教科文组织人类非物质文化遗产中医针灸代表性传承人，他们毕生为弘扬和发展针灸事业作出了巨大的贡献。本刊在此发表两位大师的亲传弟子的文章，缅怀程教授和贺教授的不朽生平和崇高治学精神。

缅怀程老 弘扬针灸

韩煜 伦敦

我的导师程莘农教授于2015年5月9日永远地离开了我们。程老是中国著名的针灸专家，中国工程院院士，从医数六十余年，医人无数，育人万千，德高望重，享誉天下。我于1987年从师程老三年 攻读“针灸临床与教学”专业硕士研究生，并于毕业后留在程老担任主任的北京国际针灸培训中心工作多年，亲耳聆听程老的教诲，受益于程老的面授亲传。 现在深切怀念恩师之际，除了悲哀，还有感恩之心与奋进之志，只有更加努力地学习与实践程老所授，并使之弘养光大，才是我们这些后辈应尽之责，才是对导师最好的纪念。

程老于 1956 年就担任南京中医药大学针灸教研组长，1957年调任北京中医药大学任针灸教研组组长，同时又兼任大学附属东直门医院针灸科的副主任，于1976年又在中国中医研究院针灸经络研究所从事临床与教学、科研工作，直到晚年。

程老从医60多年，积累了丰富的教学，临床与科研的经验，程老一生著述颇多。 若概括程老学术思想的精华，当用理，法、方、穴、术这几个字。虽然这仍有以偏概全之嫌， 但这是我的深切体会。

一、理 ----- 发扬传统中医理论，重视中医经络学说

理论可以指导实践，理是传统的中医理论及原理之意。程老自幼熟读经书，15岁多就离开家乡求学于江南温病派名医陆慕韩 继续读习中医理论及用于临床，中医理论的根底非常深厚。在汗牛充栋，翰如烟海的中医理论宝库中，程老推崇缘于《灵枢》《素问》及《难经》的传统中医理论，主张在正宗传统的中医理论指导下，认识人体的生理及病理，概括疾病的变化规律。他不主张搞玄而又玄的学术，坚持用中医的整体观念，辨证论治的基本方法来指导平日的针灸临床与教学工作。

在丰富的中医理论中程老极其重视经络理论 强调经络具有运行气血， 贯通内外，连系肢体和关节的作用，程老认为经络辩证的临床运用，可以概括病变时的规律，以病归经络，以经知脏腑，从而提高诊断准确性及临床疗效。比如程老取足三里穴治疗心脏疾病，心慌气短，即根据”胃之大络，名曰虚里，位于左乳下，其动应衣”的理论。另取肺经孔最穴治疗便秘，亦是根据肺和大肠经脉相连”肺经起于大肠，还循胃口，上膈属肺---"故取肺经穴孔最以治便秘肠疾；所以明了经络的走行和主治以及内外联系 则可以观一点而知全体，用这种整体观念的思维以指导临床实践， 就能够收到良好疗效。

二、法 ---- 针灸大法， 经络为重

法为治疗大法，针灸大法，确立治疗法则.。中医看病主要以辨证论治为指导原则，而治疗法则是联系辨证和治疗的枢纽，根据中医基本理论，了解病因的外感、内伤及不内外因，了解脏腑、经络及气血营卫的不同病所及不同病理变化,辩出疾病的寒热温凉气血虚实，就为立法提供了充分的依据。

程老认为中医及针灸治疗法则虽然都要基于八纲辩证为基本法则 ， 但经络理论的指导意义更为重要。根据经络的连络作用，更利于对整体观念的运用，因而解释了为什么不是头痛只是医头，脚痛只是医脚，程老强调古人是很重视经络理论的，认为经络理论为中医理论的基础及针灸学术的核心，这可以从（灵枢）（素问）中很多对经络针灸的论述中就可以看出，以经络循行指导下的临床应用 ，对于指导现今的临床也仍然很有意义。如用内关穴治疗心悸，用太冲穴治疗巅顶头痛，合谷穴治疗鼻塞等等，都是与经络的连系密不可分的。

确立针灸治疗法则，即针灸大法，对于指导临床治疗提

供指导原则和依据，古人在《灵枢 经脉篇曰”为此诸病，盛则泻之，虚则补之，热则疾之，寒则留之，陷下则灸之”又曰”不盛不虚，以经取之”所以熟悉经络的走行主治，在正确辨证的基础上施以正确的治法，进而指导临床选取适**合的穴位，施以恰当的針刺手法，才能取得良好**疗效。

三、方 -- 既重视针术针法，也注重组成穴配方

方法针术对于取得疗效具有举足轻重作用，程老注重针灸方法，首先程老认为如古人所训针者要求手如握虎 **状如伏弓 如**临深渊如履薄冰 **。医者手上小小寸**针 **持之要用真气力** ， 这样才能起沉疴 调阴阳，行气血。程老手上针连年轻人都拔不去 **可知程老指力很**强。程老每天诊治很多难医之病患 **或者是已**经在别处久治不效的病患 ，**程老都**轻松应对。

程老认为用针如用药 **在**辩证立法的前提下也要组穴配方。如我分析程老門诊病人中 60 岁以上的患者，总结出对于这些老年患者，尽管病情复杂 ， **或病程**较长，多使用健脾疏肝补肾之法相配合，用足三里，太冲，三阴交，太溪等穴与其他穴位配合使用，以提高疗效。这是根据老年人的生理病理特点，辩证常见脾气虚 **肝血虚**肾气亏而总结出的经验。如治疗老年人因风寒湿所致肩关节痛痹之时 ， **程老局部取穴的同**时常配合足三里穴，以助阳明气血运行 ， **扶正祛邪同步。**

如同中药之有经方，程老推崇古人针灸的穴位配合应，如俞募配穴，原络配穴，五输穴等等的应用 ， **程老亦得心**应手 **。从而达到**针灸能寒能热，能补能泻， **能治慢性病 也能治**疗急病。

四. 穴 —— 用穴精准，掌握特性

穴位是气血输注进出之地。针药同理 **穴位就象中药 ， 也有不同穴性 程老曾**说百会位于巅顶 **可以提升阳气 其性就像升麻 治**疗清阳不升的眩晕头痛；**位于**脐下三寸的关元 **具有**补元气 **益气血作用恰似黄芪 ，曲池穴能清泻肺胃之**热 **作用就象黄芩....程老**认为熟知穴性，掌握穴位的共性和特性 **以及准确取穴 正确运用**补泻运气等针刺手法 **才能收到良好效果**。

程老对穴位运用有选穴精准的特点 **比如曾跟着程老治**疗一位 20 **多**岁男，患久治不愈的荨麻疹病人，反复发病已八个多月，我们取了风池 ， **曲池，三阴交，太冲，心**俞等穴后 **程老告知一定要加上血海** ， **因**为治风先治血，血行风自灭，对于来去如风，时現时隐的荨麻疹之具的风性多变特性 **具有化**龙点睛之效，**用后果然病人很快有了好**转。

五. 术 ---- 针术简便，气随人意

针灸之不同于中药是因其有很强操作性。穴位位于体表却通过经络内连脏腑，由外及内达到气血深藏之部。所以不同针刺手法在浅表与在深层对肌体刺激的强度和深度是不一样的，对气血调节作用也是不同的。通过不同的针刺手法，进而使”寒者热之，热者寒之，虚者补之，实者泻之”落实到实处，通过针术将理法方穴融会一体。所以程老独创了”程式三才”这种简便实用的操作手法，可利气速达。另外程老运针讲求指实腕虚，气随人意，他经常演示给外国学员看如何持针”如用握虎之力”，**若想从程老手中将所持毫**针夺走是不容易的。而医者用针调气，使气随人意程老亦经常用外关穴而演示给外国学员，通过调整针刺角度深度及针尖方向而使经气或下达手，或上传肘臂，对程老都是易如反掌之术。

程老每天治疗很多病人，他每天早上六、七点钟上班，他轻灵快捷地进针，”三才”手法得气，一气呵成，即快又准，临床疗效非常好。据说有一日程老因过于劳累而自己晕倒，与程老一起工作的年轻的黄医生情急中给程老针刺诒疗，程老醒过来后问”是谁给我扎的针呀?，”**膻中穴**针尖应该向下，可以降逆”程老对针术的精研也可見一斑。

综上所述，我试图用理，**法、方、穴、**术这几个字来总结导师程老的学术特点，对于程老这样的针灸泰斗，程老对中医针灸的贡献是巨大的，远不止我所介绍的这点儿。我离开与程老一起工作了十几年的北京国际针灸培训中心也二十年了，非常欣慰地看到程老的后人正在积极努力地为传扬程老的学术思想而前行着，做为程老亲授的研究生的我，只有不断地努力，把传承并发扬针灸事业做为终生的责任，才是对先师最好的怀念。

韩煜医师与程莘农教授，摄于２０１５年３月 The Author Dr Yu Han with Prof Cheng Xinnong in March 2015

追随贺老的日子

作者：盛丽

今天 8 月 22 号日英国早上 6 点，看到在澳洲的贺老韩国弟子姜声厚打来的三个未接电话，急忙问之，告贺老去世。惊悉噩耗，又难以确认，后经证实，贺老因急性心梗，病逝于北京时间 11 点 23 分。山河垂泪，天地含悲。贺老是我一生的恩师，他给与我的无以伦比，永远铭记在心。

一 初次认识贺老

89 年面临研究生论文的最后答辩阶段，我的导师程莘农教授让我去贺老家请贺老作为我的论文答辩委员会主任。和所有的学生一样怀着忐忑不安的心情，我如约走进琉璃厂的一个北京四合院。南房客厅兼书房，和蔼可亲的贺老热情招待我，坐在太师椅上，环顾四周，印象最深的就是这么多书呀，三四个书柜里面上面前面都放着堆着各种古籍，屋内还有一个大大的写字台，上面放着宣纸笔墨砚台，随时为主人徽墨书法做准备，顿时心里充满了敬重之情。贺老请我喝茶吃水果，和我聊论文，并爽快地答应了我的请求，我最后愉快地离开贺老家。在程莘农教授的三年帮助指导下，经贺老和杨甲三等教授的考核，终于顺利地结束了三年的研究生生活。

二 学徒三年

89 年毕业后分到北京中医医院针灸科，正值北京中医管理局为继承名老中医的学术思想和经验，选拔培养老中医的学术继承人。那时候作为第一个分配到针灸科的研究生，又有当院长的同学推荐，名单放在贺老的面前，之前通过论文答辩，贺老已经认识了我，非常幸运地贺老选择了我和崔芮作为他的学术继承人即徒弟。

记得我们当时很兴奋，和贺老商量既然是徒弟，怎么也应该有一个拜师仪式。我们当时选中西单的鸿宾楼，邀请了李院长和孙书记一共六人参加了我们的仪式，三鞠躬代替了屈膝磕头，自此我们有了师傅了。此后 10 年我见证了无数次的私塾弟子拜师会，虽然我们的拜师仪式规模最小，但我心里认为只有我们的拜师仪式最为纯真最为感人。

作为徒弟的三年时间里享受到科里所有的特权，我们不用向其他医生那样每年轮流去病房去急诊工作，不用值夜班。

贺老那时每周出 2 次半天门诊，我们作为他的助手，帮助先问诊，然后贺老看病人，望闻问切后写舌脉及针灸穴位处方，诊床躺满了十余个病人后，贺老来到病人身旁，我们端着盘子站在旁边，静静地看着贺老给病人治疗，针刺或针加灸，根据病情或加刺血拔罐，或加火针点刺。学徒后期，贺老放手让我们针刺患者的下肢穴位。因贺老在中国临床针灸届的泰斗地位，国内外众多患者慕名而来，疑难病症患者众多。内外妇儿皮科各种病症，经过贺老的治疗均得到治愈和好转。看一眼贺老治疗小孩脑瘫，治疗白斑症，治疗癫痫证等等，你会体会到针灸的神韵，作为针灸医生的自豪，帮助病人解决痛苦的快乐。

针灸科原位于北池子大街北口的宣仁庙内，独门独院，古色古香，宫廷建筑。上午小院喧哗，医生兢兢业业，病人来来往往。下午只有一名值班医生治疗病人，小院明显清静许多。
在小院的诊室里，一次贺老和我们谈起如何从理论上提高对针灸三通法的认识，谈起诸多病症皆因不通引起，提出病多气滞，法用三通的原则。教导我们不仅在临床上有所作为，更应该多学习，多读古籍，读古医案。于是在贺老指导并担任主编下，我们在学徒末期编写了《针灸歌赋的临床应用》，记得当时，我们把清明时期的医案以及常用的针灸歌赋按疾病分门别类，写出学多的卡片纸条，用 400 字的稿纸工整的写出书稿，多次到公主坟的出版社见编辑，听取意见加以修改。92 年科技出版社正式出版。99 年我在南京开针灸学术会议，听到数位同仁聊天时，一位医生极力推荐这本书，认为很有临床使用价值。我心里暗自窃喜。

看贺老针灸施术，是一种享受。银针在他的手指末端，飞来飞去。他运用的不是一般指法，是含有内在功力的手法。他常告诫我们针灸医生应该练指力练功夫，一次贺老在他家给我们表演他的功夫，近 2 米高沉重的武术器械，他一手提起，旋转挥舞不费吹灰之力。难怪贺老又是八卦掌协会的高手。可惜我们两个徒弟连半点功夫都没有学会。

贺老在生活上平易近人，把徒弟作为家人看待。每年春节，贺老会在他家的小院大摆宴席，在小院里支起灶台，请专业厨师掌勺，邀请所有的徒弟到家里和家人共进午餐，小院摆设 5~6 桌，徒弟一桌，热热闹闹，共度新春。90 年代初，我第一次吃鲍鱼就是在贺老家吃的。

三年后，我们出徒了。北京中医管理局还开了隆重的结业仪式，发证书照合影。但我们还是一直给贺老当助手。

三 贺老的高招

90 年代初，我一直作为贺老的徒弟助手在医院里跟随贺老出门诊，他针治病人的情节历历在目。

虽然有很多的透针刺法，但足部内外踝下的丘墟和照海，想想踝关节多个硬帮帮的骨头，就知道很少有医师将他们连在一起。我们常见贺老手持三寸银针，身体微微弯曲，将患者脚掌直立，用毫针先刺到外踝丘墟的皮下，

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再通过骨骼之间的缝隙，最后直接刺到照海的皮下，皮肤被针顶起而不刺破，手法纯熟，一气呵成。主要适用于肝胆疾病。

提起治疗坐骨神经痛，必然想到膀胱经和胆经穴位。但最有效的穴位是胃经的伏兔穴，没错，就一个穴位。但如何取穴很有讲究。患者一定要曲膝跪坐，在该穴上三寸毫针垂直进入二寸，提插捻转，尽可能让患者往后坐，上身直立，留真 5 到 15 分种后取针，效果立现，太神奇了。贺老说此方法来源于明代古书《针灸大成》，“膝上六寸起肉，正跪坐而取之”。真功夫就在古籍里，看你是否静下心来去读它。

看过贺老的放血疗法吗？绝对印象深刻。比如治疗严重的脉管炎，患者下肢紫暗，甚至破溃。我们首先要找一些旧报纸放在地下，椅子放在中央，患者坐在椅子上，将裤腿卷至膝上。常规消毒，将火针烧红，目光移到患处，稳准快地把火针刺进患处拔出，只见暗黑淤血似小喷泉一样喷射出来，射程远近不同，我们看着等着，时不时挪动报纸以免血溅地上，慢慢压力越来越小，射程由远到近，血色由紫变红，逐渐自己停止，然后清洁局部血迹，治疗完成，出血量 100 到 200 毫升左右。有人会说这多原始。但疗效高于一切，去腐才能生新。患者立即会感到下肢轻松疼痛消失，皮肤有破溃的可以逐渐愈合。当然糖尿病血液病患者不建议使用。

火针的使用是贺老最主要的高招，虽然内经早有论述，但多数医师很少见到也很少使用。想想火针的材料就很微妙，既要耐高温又需要一定的柔韧性，还需要像毫针一样粗细便于临床使用，只有钨锰合金的材料才符合所有要求。

临床上我们常发现只有应用了火针，才能使疑难顽固的病症快速缓解及治愈。颈项疼痛是常见病症，对中老年患者而言也是顽固的容易复发的疾病，我们都会毫针华佗夹脊以及三焦小肠经循经取穴，还会刺络放血拔罐，但有些病人他还感觉局部僵硬不适，贺老会用火针快速点刺局部 4 下左右，针到病除。疗效就是这么快，病人立马感觉轻松。火针的针感远比毫针强烈而且持久，不信你可以亲身体验一下哈。

国医大师贺普仁教授追悼仪式定于北京时间 8 月 26 日上午十时至十二时在八宝山举行。愿用短文寄以无限的思念。

四 继承推广

贺老毕生的针灸学术思想和临床经验汇聚在他所创立的针灸三通法中，他最希望的是把这个宝贵体系流传下来，指导医师提高疗效。

91 年贺老首先创建了三通法研究会，记得开筹备会议时贺老亲自主持，贺老家人学者教授 20 余人参加，大家出谋划策，群策群力希望在临床，出版，授课三方面来推广。

九三年左右我们参加了贺老第一个诊所的成立，位于北京丰台区丽泽桥附近，一处普通的平房小院，贺老家人学生弟子 20 余人，贺老首先讲话，然后大红绸布花朵挂在白底黑子牌子上，众人抬着挂在门口，大家合影留念，伴随着一串串鞭炮响声， 简单热闹的开业仪式就算结束了。最迫不及待的是患者，纷纷涌入，争占床位，贺老就开始治疗病人。那时贺老一周 2 次亲自到这里出门诊，其余时间贺老家人管理，贺老儿女都在贺老的教育影响下成为出色的针灸医师。诊所开业即火，患者盈门，病人来自五湖四海。有时候我需要办事见贺老到诊所找他。进入房间只见人烟雾缭绕（艾灸引起）人头攒动，患者里三层外三层地包围着贺老。那时候就这样，虽然有病历本在排队，大家都担心被加塞，都要围着看着似乎才放心。贺老总是在忙，没有休息从不喝水，一干就是 5 个小时。因道路扩建，这家诊所搬到马家堡附近，目前仍然在为患者服务。

随后为庆祝贺老行医 50 周年暨三通法研究会的成立在北京人民大会堂举行了隆重的纪念仪式。非常隆重，91~92 年间第一次看见老中医的会议在这里举行。非常正式，甚至邀请到人大副委员长王光英等高级领导参加；非常气派，会议占用一个厅，午餐占用另一个大厅，餐厅满满地摆设 40 到 50 桌的座位；非常好吃，能品尝到人民大会堂的美味佳肴，那味道能差吗？非常轰动，大会邀请了许多新闻媒体和名老中医的参加，我的导师程莘农教授和杨甲三教授也亲临会场。贺老的病人著名播音员葛兰夏青也来了，夏青作为患者发言，我很荣幸地作为贺老弟子发言。现在想起往事，还是很自豪的。92 到 94 年间我参加了许多的授课活动，主题就是介绍贺老的火针疗法，最常去的是中医研究院针灸研究所，他们常年举办全国针灸医师培训提高班，讲完课后略加火针的演示，学员来自全国各地。没有想到，十多年后在英国的中医学术会上，有一个女医师还认出了我，记得当年我的讲课。

97 到 98 年间在贺老指导下，组织了特种针法研究会，征稿审稿出论文集，在泰山医学院和张家界分别举办了学术交流会，我发言的主题介绍针灸三通法。

北京中医管理局对针灸三通法也很重视，科研立项，经费支持。我们从理论临床文献全方位深入研究，最后课题顺利完成获得科研奖项。

给随贺老门诊多年，我们收集了大量的病历，94 年开始我和崔芮帮助贺老整理编写了针灸三通法的第一步专著，因为 95 年我被公派出国，大量的出版后期工作由崔芮完成。95 年 12 月中国医药科技出版社出版了《贺氏针灸三通法》。

97 年我回国后，一天贺老和我说山东科技出版社的编辑要谈出版事宜。真的很佩服这个叫夏魁周的年轻编辑，他很认真执着诚恳，多次到北京谈修改催进度，帮助解决绘图的问题，我们终于在 98 年完成了汇聚贺老丰富临床经验的专著《三棱针疗法图解》，《毫针疗法图解》和《火针疗法图解》。这套书很畅销，多次印刷。N 年后我逛北京西单图书大厦，这套书还在架上。

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五 贺老的弟子们

贺老有多少弟子呐？没有统计，谁也不知道，因为太多太多。

弟子一般分两类: 公派弟子 私塾弟子

公派弟子 ：为继承老中医的经验，政府和老中医一起指定本科室的医生，他们一般每周 2 到 3 天跟随老中医出门诊，至少 2 到 3 年的时间。这期间主要工作整理老师的临床经验，结束的时候至少要有论文，最后政府组织专家考核，通过后颁发类似奖状的老中医学术继承人的证书。89 年北京市开继承工作之先河，我和崔芮成为贺老的公派弟子。2 年后，国家中医管理局推广北京的做法，我们针灸科的王京喜，徐春阳为第一届，张小霞，程海英为第二届的公派弟子，再以后不仅本院内，外地外院的也可以参加国家继承项目，比如天津老中医的博士李岩也是贺老的公派弟子。还应该包括贺老培养的 3 名研究生。

不好统计的是私塾弟子，只要你有向贺老学习的愿望就可以了。贺老没有任何过高的门槛，他愿意满足医生学习的愿望，传授他的宝贵经验。贺老对私塾弟子没有任何要求。只要你有心，造诣完全在个人。

贺老常会告诉我，某个医生想拜师，你帮助安排一下。医生会和我直接联系，因贺老住和平门附近，通常会安排在北京烤鸭店，找一个包间，挂上红色横幅，写上自己和贺老的名子，请几位医师的朋友和其它老中医作为见证人。我常作为司仪主持仪式，弟子先介绍自己的情况，贺老讲话，然后向贺老三鞠躬，见证人说恭喜鼓励的话，大家在红幅下合影留念，最后美味佳肴结束。私塾弟子不分年龄，不分职业，不分国籍，不分学历。成功的私塾弟子遍及国内外。

勤奋诚恳的私塾弟子最容易成功。例如韩国人姜声厚在韩国大学学习汉语，金熙哲学习法律。对中医的爱好，他们双双退学来到北京中医药大学从本科读起，是北中医韩流的先驱。他们为更好学习针灸，请我做私人老师额外辅导，坚持数年。最后我把他们引荐给贺老，96 年他们正式成为贺老的弟子。很勤奋的姜声厚又向中日妇科的许老，西苑男科的王琦老师学习。因韩国不认可中国的学历，经过数年的奋斗，他目前已经在悉尼安营扎寨多年，靠中医针灸过着幸福的生活，在悉尼的韩人区享有名望。学霸的金熙哲在北中医读完本科，读硕士，值到博士毕业。听说目前在美国行医。厚道的姜声厚不忘感恩，每 2 到 3 年亲自到北京看望贺老，最后一次是 2012 年 8 月在建国门贺老家，贺老非常高兴弟子们的看望，问弟子的工作生活，答疑解难。那时的贺老因病行动不便，我们推着坐着轮椅的贺老从建国门走到永安里附近的那家小馆，心情久久难以平静。

贺老对我的载培难以忘怀，带我出席各种学术会议。记得一年牡丹花开的季节，贺老带我和崔芮出席洛阳的学术会议，休息日时我们一起下饭馆吃鸳鸯火锅，和与会的针灸文献专家王雪苔教授一起参观洛阳的古迹，他们边走边说着故迹的往事，我们傻傻地听着这些典故，真正体会到什么是学识渊博。

我和崔芮还很意外地收到过贺老送的礼物。九十年代初一次贺老从香港开会回来，特意把我和崔芮叫来，打开一个塑料口袋，一看里面有就几件夏天穿的短袖衣服，贺老说你们一人挑一件送你们的，我们自然很高兴，我选的是蓝底白红相间的格子短袖衣服，崔芮选的我忘了，这件衣服一直保留着。前天在英国的贺老弟子张医生微信贴出拜师相片，看见相片里的我穿的正是贺老送的那件衣服，一下我想了这件礼物。

99 年我参加在南京举办的针灸学术会议，主持会议的专家和我说，“你就是盛丽呀，贺老常夸你。”会上正值中国针灸学会各分会理事换届选举，我被告知我已经成为新一届的临床分会的理事，和实验针灸分会的理事，拿着两个大红的为期 5 年的聘书，我心里完全明白是贺老的极力推荐。

99 年 6 月我走了，来到了英伦。几年后崔芮到了瑞士，我们经常趁着圣诞节休假在北京相聚，一起看望我们的老师。最后一次是 13 年在北京中医医院的贺老病房里，我们三人愉快地聊天，最后提议合影，贺老坐前我和崔芮站后，没有想到这次合影被永远定格。我最后一次看贺老是去年的 12 月，感叹时间飞逝，岁月无情…。

六 最后的专著

为纪念贺老行医 70 周年，贺老一直想有一部专著能够全面深入地反应他的学术思想，理论体系和临床经验。我们也认为应该有一部具备新思想新形式新突破新意义的精品著作。于是写作小组在建国门的贺老家成立了。贺畅是小组的领军人物，她是北京电视台的主任编辑，具中文中医针灸心理学知识背景，又是贺老的女儿是贺老最亲近的人，贺老怎么想怎么做她会最先感知。成员还有杨光主任医师，他是中研院针灸文献研究生，毕业后从事针灸临床，又加入贺老的弟子行列，熟知针灸三通法，身兼多种技能的他，半天针灸门诊量超过百人次，令人赞叹，针灸超人也！编写顾问黄龙祥研究员，中国中医科学院首席科学家，多次参加我们的编写会议，发表独到的见解，贡献个人写真腧穴图谱，保证了这部著作的高水平和高质量。09 年末到 13 年中期，因家庭因素我常居北京，贺老找到了我，和医中翘楚合作也是我的幸运。

编写时期，贺老的家成为编辑部，贺老从书目大纲书写体裁均亲自参与，文章内容文章细节均一一过目。它反映了是贺老的真实理论和经验。一但商量到饭点时，香喷喷的饺子或饭菜就会端到桌前，多美呀！不仅有精神上的还有舌尖上的享受。

从本书章节内容你会看到新形式新内容新精华。全书分叙论，法示篇，法用篇，医外篇。叙论你会深入从理论上了解三通法的演变过程 ;法示篇教你学会应用三通法；法用篇告诉你贺老常用的各 70 个针灸穴位和处方，还

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有国内外弟子们的精选临床医案。医外篇揭示贺老的医功。

例如上肢的臂臑穴，贺老常用它治疗眼病，耳前的听宫穴是治疗颈椎病的常用要穴。治疗癫痫的固定处方是大椎和腰奇，看看都是不带水分的干货呀！

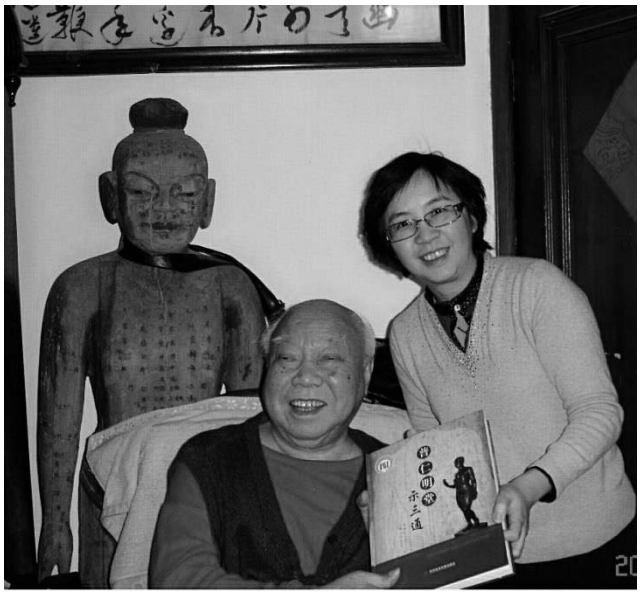
本书一开始写作就已经获得国家科学技术学术著作出版基金的资助，经过一年的奋斗，科技文献出版社 2011 年正式出版。书名为《普仁明堂示三通》,16 开 53 万字。这部书是医者的引路之石，如果你够勤奋努力，持之以恒，深刻感悟，你会在修行的路上越走越远。千万不要以为我在变相做广告宣传啊，稿费早已落袋，再次印刷和我没有任何关系。如果你是名针灸医师，希望提高针灸疗效，你应该拥有它，因为它含有贺老的毕生心血，且毫无保留的奉献给我们的最后力作。

七 感恩 感动 感谢

今年两位培养过我的针灸泰斗国医大师相继病逝。中医界第一位工程院院士的程莘农教授是我的引路导师。86 年我报考了程老的研究生，招生名额一名，复试时看见还有一位男生，顿时心里忐忑不安。轮到我时，程老最后一个问题是:只有一个名额，你想让谁上。紧张的我口是心非的说让他上吧。程老微笑地说:不说真话吧。我心里一凉，没戏了。最后程老提出扩招，我们两位都上了，他就是同仁医院针灸科主任杨威主任医师。此后的三年，程老指导我们临床实践和毕业论文，使我们顺利地完成学业。是程老的提携改变了我的事业轨迹，感恩不尽。

当我得知贺老因病去世，在英国的我就想应该做点什么以示悼念我们的恩师，老师对我的教诲栽培，跟随贺老多年的经历浮现眼前。怀着感恩缅怀感动的心情，完全自愿由感而发地写出这些短文，发在我的微信朋友圈里。没有想到发送后国内外众多的朋友点赞点评，2 天后朋友圈里的同行邹金盘打电话给我，他已经把这个《日子》系列贴转发，扩大到英美加中医群。大家很想接着看下文，想通过这种形式了解学习老中医的宝贵经验。一个美国朋友连续数天文章发表瞬间第一个点赞，美国加拿大昔日研究生的同学直接回信鼓励，英国相识的不相识的同行每日点评，还要把这个系列贴刊登在行业杂志上，对此我非常感动，我看到大家对贺老的真情，看到渴望学习掌握三通法的动力。

感谢恩师对我的培养，感谢大家的持续关注和支持。



(本文作者和贺普仁大师， 摄于1993年)

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病例一，患者男，30 岁，全身弥漫性神经性皮炎，瘙痒难忍，精神紧张抑郁，用过很多方法无效，我用常规腹针，引气归元，腹四关，双侧天枢，加血海，三阴交，
开四关，第二次来就诊非常高兴，全身皮炎已经开始消退而且不再瘙痒，睡眠好转，称我是神医，后来又针了大概十次皮炎全消。后因我去另外诊所未再随防。

病例二，患者女，84 岁，有慢性腰痛史多年，以前的医生常规局部针灸，时好时坏，后来我去接替以前的大夫当班，考虑久病多虚，又年事已高，就用腹针，只用引气归元，局部没有扎针，只做简单按摩，针后老太说腰不痛了，感觉非常好，当时又续了一个大疗程，当时前台对我刮目相看，老太后来疗程没用完，腰痛就消失了，不再吃止痛药，非常感谢我。

病例三，患者女，35 岁，因家兄自杀后，长期抑郁饮酒消愁，每天一瓶酒，曾怀孕一次但因长期饮酒流产，她来找我是朋友介绍过来的，先戒酒再治怀孕的事，用腹针加开四关，百会，印堂，膻中，治疗一次后，当天就没再饮酒，也不再想喝酒，感觉前所未有的轻松，治疗 8 周后，来电话告之已怀孕，非常惊喜但又害怕会再度流产，告之此次怀孕期间没有饮酒，应该无妨，后又针灸保胎，一直针至怀孕 7 个月，顺产一女，非常开心。

小结：腹针是个好东西，让我这个本不是针灸专业的中医来英国后很快能够为病人解除病痛，并让我从此迷恋上针灸，举个不恰当的比喻，如果说传统的体针是我们治病的军队，腹针就象一个非常好的指挥官和后勤补给站，让我们的前线永远有用不远的武器和给养，所以才能战无不胜。个人的一点粗浅体会，让大家见笑了，希望各位指正。

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

Recent Development in Research of Meridians and Acupoints

Bai-Yun Zeng
Institute of Pharmaceutical Sciences, Faculty of Life Sciences and Medicine, King's College London
E-mail: b.zeng@kcl.ac.uk

Summary
Meridian and acupuncture point (acupoint) are the most fundamental parts of acupuncture in traditional Chinese medicine. Since 1950s, scientists have pursued the characteristics of meridian and acupoint from anatomical, physiological, biophysical and molecular biology aspects. Many hypotheses were proposed about the meridian and acupoint from basic and clinical studies. Research progress has been made toward revealing the nature of meridian and acupoint, and mechanism of acupuncture action. In this article, current research progress regarding dominated hypotheses of meridian and acupoint are summarized to facilitate the understanding characteristics of meridian and acupoint.

Key words: Acupuncture, Meridian, Acupoint

Introduction
Traditional Chinese medicine believes that there is a distribution network for the fundamental substance Qi throughout the body (Longhurst, 2010). This distribution network is called meridian system consisting of 12 standard meridians, 8 extraordinary meridians and collaterals and subcollaterals. It is believed that the whole body is internal and external connected by those upward and downward distributed meridian channels where majority of acupoints locate, thus transforming whole body into one entire organ.

Philosophically, the meridian system explains how we live and why we become sick. When the vital energy, qi flows freely through the meridians, the body is balanced and healthy, but if the energy becomes blocked, stagnated or weakened, it can result in physical, mental or emotional conditions. Inserting thin needles to specific acupoints is believed to stimulate the qi circulation within body and to restore the healthy balance energy within the meridians. Then the body is able to recover from pathological conditions.

Although acupuncture is widely used to treat many conditions worldwide the effectiveness and mechanisms of the acupuncture action is still controversial. Indeed lack of anatomical and scientific evidence supporting the characteristics of meridians and acupoints makes more difficult for acupuncture therapy to be generally accepted in modern science. The noticeable research in meridian and acupoint started from the middle of 20th century. In 1963, a Korean physician Kim Bonghan reported the findings of anatomical structure of meridian in rabbit and named it as Bongham corpuscles (primo-nodes) (Soh, 2009). The existence of Bongham corpuscles is controversial because scientists in China were unable to duplicate the results (Chan, 1984). Since then scientists has pursued the characteristics of meridian and acupoint and explanation of their action mechanisms from anatomical, physiologic and biophysical aspects. In this review the main hypotheses that dominated the research development of meridian and acupoint during past a few decades were summarised.

Special conduit for electrical signals
It is believed within acupuncture community that meridian and acupoints are special conduits for electrical signals due to their low resistance and high capacitance since 1950s (Nakatani, 1966; Brewitt B. 1995; Falk et al., 2000; Johng et al., 2002; Lee et al., 2005). This led to the assumption that meridians and acupoints are distinguishable by their lower electrical impendence compared to adjacent control areas. This view gained popularity as researchers used it as a possible mean to explore the possible acting mechanism of acupuncture.

Many studies indeed reported acupuncture meridians as yielding lower electrical impedance compared to adjacent controls. Nakatani, a Japanese scientist, was the first person to measure the electrical activity of acupoints and found that electroconductivity was higher than the surrounding area on a series of acupoints along meridians in 1960s (Nakatani, 1966). Meanwhile, the French physician Niboyet found that the acupoints have a lower electrical resistance than the surrounding skin in 1961 (Zhu, 1981). Furthermore, Voll investigated the electrodermal properties of the meridians and acupoints, known as "Electro-acupuncture according to Voll" or EAV and found that almost two-thirds of the EVA points were classic acupoints (Voll, 1975, 1980). These studies significantly enhanced our understanding of biophysical characteristics of the meridians and acupoints. Further, Reichmanis et al. (1977a,b; 1979) used bipolar electrodes to detect electrical resistance and capacitance between two acupoints on the same meridian in 19 human subjects and found significant lower resistance and high capacitance along the meridian compared to adjacent controls. Using four-electrode system, Zhang et al., (1999) was able to measure the impedance along Pericardium meridian in 12 human subjects and observed markedly lower impedance than adjacent controls. Similar results were observed on Large Intestine meridian in human subjects (Johng et al., 2002; Lee et al., 2005). It has been reported that low-resistance of acupoint is related to its high-temperature characteristics. Wang et al., (2007) using infrared images and surface resistance measurement, detected lower resistance and higher temperature in PC6 and BL15 acupoints than control points in rabbits and found that resistance values were closely linked to the changes in skin temperature (Wang et al., 2007).

However, others studies reported inconsistent results. Ahn et al., (2005) used four-electrode system to detect electrical impedance of meridian associated connective tissue along Pericardium and Spleen meridians in human subjects, and found significantly lower impedance along Pericardium meridian than adjacent controls but not along Spleen meridian. Pearson et al., (2007) also failed to detect skin impedance in three acupoints GB14, PC6 and TW1 in human subjects. Later electrical skin resistance measurements were taken from a skin area of 6 x 6 cm using an array consisting of 64 (8 x 8) electrodes and were measured at acupoints TE5, PC6, LU6, ST36, SP6, GB39 to assess the phenomena of electrical skin resistance in human subjects (Kramer et al., 2009). The results showed no difference in resistance between acupoints and surrounding areas. So far existence of high-electrical potential, conductance, and capacitance, low impedance or resistance characteristics of meridians and acupoints is controversial (Ahn et al., 2008).

It has been suggested that many technical factors can influence the skin resistance or impedance which primarily stem from the stratum corneum, including number of electrodes used, probe (size and shape, duration of application), and variations in skin condition (thickness, dry/moist and temperature etc). Better device that could avoid the problems mentioned above may be able to clear some of confusions and advance our understanding of electrical properties of meridians and acupoints in the future.

Low hydraulic resistance channels

In the 1960s, Fujita, a Japanese scientist, considered that the nature of the meridian is the flowing pathway of the body liquids in the extra vascular systems produced by the Kino-dynamic force on the muscular contraction (Fujita, 1964, 1967). Although Fujita did not mention how the meridian system works, his theory paved way for further research.

Later Chinese scientist Wei-Bo Zhang put forward a hydro-mechanic model as a fundamental nature of acupuncture meridian system. Zhang considered that interstitial fluid or extra vascular fluid, characterised by a higher flow rate, flows toward and along the meridian following a paths of lower hydraulic resistance (Zhang, 1997). This is called low hydraulic resistance hypothesis for acupuncture meridians (Zhang et al., 2008). The concept was based on the idea that the interstitial substance is heterogeneous, where some parts are highly permeable and low resistance to the flow of interstitial fluid, and form a low hydraulic resistance points. It was assumed that adjacent points may transfer hydraulic wave and form a channel similar to acupuncture meridian. Using biophysical and biological and radiological techniques, it has been observed, on mini pig and human, that there was a lower hydraulic resistance along meridian route compared with controls (Zhang et al., 1995, 1997); that single pressure transducers located the lowest hydraulic resistance point, very closing to low electrical impedance point along meridian (Zhang et al., 1998). Migration of radio-labelled material was found along meridian channel (Darras et al., 1993; Wu et al., 1994). The layer of channel was detected by injection of a basic dye Alcian blue and the track was found beneath the skin (Zhang et al., 2008). However further studies are needed to show direct flow of interstitial fluid and microstructure of meridian channel.

The neural pathway hypothesis

In the 1950s, Professor Zhang Xi-Jun and colleagues considered that the action of meridian is mediated through neural reflection (Zhang et al., 1983). Although most acupoints are located on or adjacent to peripheral nerve trunks or branches, and meridians correspond with trajectories of relevant peripheral nerves, especially below the elbows and knee joints, there is no definite evidence to support the existence of a novel or special structure beneath acupoints along meridians (Wong, 1999, 2001; Zhou et al., 2010). Acupuncture analgesic studies showed that nervous system is critical for the action of acupuncture on pain. For example, Chiang et al., (1973) reported that vascular occlusion of the upper arm in healthy human adults could not prevent the analgesic effect of acupuncture needling of acupoint LI4, and on the other hand, infiltration of procaine, a local anaesthetic, into the deep nerve around the acupoint LI4 abolished entirely the analgesic effect of acupuncture (Chiang et al., 1973). Further studies showed that acupuncture stimulation at LI4 activated surrounding fine myelinated Group III sensory nerve fibres (Bowsher, 1987). However the studies did not address the question whether acupuncture analgesia acted locally or at a more distant location.

It has been suggested that acupuncture analgesia is a result of acupoint afferent impulses and afferent signals from painful area interacting in the brain. In 1972, Professor Han Jisheng and colleagues collected cerebrospinal fluid from rabbits received acupuncture stimulation and infused into the pain models, and provided the first evidence that acupuncture alleviated pain by releasing neuromodulatory substance in the brain (Wang et al., 2008). A few years later two polypeptides released from brain with potent opiate agonist activity after acupuncture, called endogenous morphine-like factor or endogenous opiate-like substance were discovered (Hughes et al., 1975). Subsequently naloxone, an antagonist of opiate was found to be able to block acupuncture-induced antinociceptive effect (Mayer et al., 1997). These studies confirmed the central action of acupuncture analgesic effect in response to the activation of ascending sensory nerve tracks. However central action of acupuncture cannot explain why needle is conventionally placed in close proximity to the locus of pain and why analgesic effects of acupuncture are restricted to the ipsilateral side.

Although local effect of acupuncture has been proposed long time ago no scientific evidence was provided until recently. The delicate studies, published in Nature Neuroscience in pain model, using microdyialysis, showed that microdialysis probe was placed along the peroneal nerve and samples of interstitial fluids were collected before, during and after acupuncture stimulation at ST36 acupoint, and HPLC analysis showed that acupuncture induced a significant increase in adenosine, a

neuromodulatory with antinociceptive property, concentration, and that adenosine level remained elevated for at least 30 min after acupuncture needle was removed (Goldman et al., 2010). The studies were subsequently replicated in human subjects (Takano et al., 2012). These studies demonstrated acupuncture exerted local analgesic effect through the releasing adenosine, an anti-nociceptive substance, in addition to its central action.

Neuro-mechanism of acupuncture action was further supported by a recent report published in Nature Medicine that electroacupuncture stimulation at acupoint ST36 activated sciatic nerve and controlled systemic inflammation, by inducing vagal nerve activation of aromatic L-amino acid decarboxylase, leading to the production of dopamine in the adrenal medulla, and rescued mice from polymicrobial peritonitis (Torres-Rosas et al., 2014). The anti-inflammation action of acupuncture was specific because stimulation of non-acupoint did not inhibit pro-inflammatory cytokine levels (Torres-Rosas et al., 2014). Together these studies showed that neural pathways with either local effect or central modulation activated by acupuncture are essential and critical for the action of stimulation.

While studies concerning characteristics of meridian have made good progress, studies regarding characteristics of acupoint have been advanced. Indeed, histological studies showed a relative dense and concentrated distribution of certain neural and biological-active substance beneath many acupoints compared to adjacent areas (Zhou et al., 2010). Recently, a hypothesis of neural acupuncture unit (NAU) has been proposed (Zhang et al., 2012). NAU is defined as a collection of activated neural and neuroactive components distributed in the skin, muscle and connective tissues surrounding the inserted needle. The concept of NAU was based on observations that most acupoints are surrounding by free nerve endings, cutaneous receptors and sarcous sensory receptors, and many acupoints reported have relatively high dense neural components compared to non-acupoint area (Han et al., 1996; Hu et al., 1980; Lu et al., 1979; Zhou et al., 2010; Silberstein et al., 2012). Neuroactive components surrounding acupoint are thought to include 1). Neuro-mediators e.g. histamine and substance P released from mast cells (Zhou et al., 2010); 2). Various neurotransmitters, neuromodulators and inflammatory factors produced by macrophages, fibroblasts and lymphocytes (Zhou et al., 2010); 3) Other neuroactive substance released from sympathetic nerve-rich blood vessels and small lymphatic vessels (Zhou et al., 2010; Liu et al., 2014). It is believed that those components directly or indirectly acted on their corresponding somatosensory receptors on the surface of peripheral afferent nerve fibres, and then signals are transported through different neural pathways to the corresponding nuclei within spinal cord or brain. Efficacy of the acupoints may dependent on the convergent inputs of these somatic areas and the related visceral organs in the brain as well as integrative function of the neurons in the brain. NAU not only include meridian based acupoints also A-shi points and non-acupoints as insertion of needle would induce mechanical and biological response regardless at specific or non-specific point. The concept of NAU may help us better understand the essential mechanism of acupuncture such as interaction between neural and neuroactive components and relation between local and central response to acupuncture stimulation. Further it may help to develop more efficient acupuncture stimulation modes for acupuncture clinical application.

Conclusion

Although many hypotheses about meridian and acupoint have been proposed during past a few decades evidence from studies suggests that meridian and acupoint are closely linked with nervous system. Acupoints have relatively high density of neural and neuroactive components. Meridians locate over nerve bundles consisting of sensory and motor fibres that project to corresponding area in the spinal cord and brain, and regulate relevant physiological functions such as pain, blood regulation and many more. Although there is still lack of morphological evidence of meridian existence, research studies imply the presence of biological basis of meridian phenomena. Further research on meridian should continue as research techniques advance and hopefully will eventually reveal the morphological structure of meridian.

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ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

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For years Linda worked with international companies and devoted her time in training and development, coaching, workshop facilitations, and working with people from all over the world. In recent years, life circumstances brought the studies of Traditional Chinese Medicine and Western Medicine close to her. Seizing the opportunity again to pursue her childhood dream in healing people, Linda happily re-embarked on this life changing career path. She has a passion for promoting health and well-being and combining the complimentary power of both Eastern and Western medicine.

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

A Systematic Review on the Efficacy of Acupuncture in Treating Menopausal Hot Flushes

Linda Reijngoud-Chen
Shenzhou Open University of Traditional Chinese Medicine, Amsterdam, the Netherlands
Supervisor: Huijun Shen

Abstract:

Hot flushes are the most common menopausal vasomotor symptoms (VMS) suffered by women going through the years spanning around menopause (i.e. peri-menopause, menopause and post menopause). (Feldman, 1985) Hormone therapy has often been used for relief of hot flushes, but concerns about the health risks of hormone therapy have prompted women to look for alternative treatments. The aim of this paper is to firstly focus on the treatment and efficacy of acupuncture for reducing the severity and frequency of hot flushes. And secondly, as Traditional Chinese Medicine (TCM) believes that "prevention is better than treatment", this paper will also touch upon pro-active ways to help women make a smoother transition around menopausal period, including a systemic perspective of the influence of the cultural/ societal aspect.

Keywords: menopausal syndrome, hot flushes, VMS, acupuncture, randomized controlled trials

Menopause is defined as occurring 12 months after the last menstrual period and marks the end of menstrual cycles. It can happen in women in their 40's or 50's, but the average age is 51 in the United States. (Mayo Clinic) It is the phase in a woman's life during which she makes the transition from a reproductive to a non-reproductive stage: this transition is a period of declining ovarian function which usually spans 2-5 years around the menopause. (Maciocia, 2011, p. 735)

In TCM, menopausal syndrome is called Jue Jing Qian Hou Zhu Zheng (絶經前後諸症) or various symptoms/ manifestations arising before or after the cessation of menstruation. The permanent cessation of menstruation for 6-12 months i.e. menopause occurs at 49 (7x7) according to the first chapter of the Simple Questions/ "Su Wen". A survey of seven Asian countries found that most women reached menopause at around 50. (Maciocia, 2011, p. 735) This article reviewed the clinical studies published in recent years on efficacy of acupuncture in treating hot flushes as the most predominant menopausal symptom.

1. Methodology:

1.1 Aim:

The aim of this literature review is to look into the efficacy of acupuncture for reducing the severity and frequency of hot flashes of menopausal women and propose suggestions for future research.

1.2 Data Collection and Inclusion Criteria

Thousands of research articles from PubMed (NCBI), Google Scholar, The Cochrane Library, EMBAS, and Journal of Chinese Medicine were screened using key words "acupuncture", "randomized controlled clinical trials", "menopausal", "hot flushes/ flashes" for the period 2006-2014. Clinical trials comparing any type of acupuncture to no treatment/control or other treatments for reducing menopausal hot flushes of peri-menopausal or postmenopausal women were included. Trials concerning women with hot flushes due to breast cancer treatment were not included.

A decision was made to focus on the latest researches with an assumption that the research quality has been improved from past trials (given the availability of the STRICTA[1] guidelines) (MacPherson, 2010) and thus deemed more robust and scientific. Eventually 15 articles (studies) fit the selection criteria, including 1 article which is a follow-up of an earlier study.

2. Results:

2.1 Efficacy of Acupuncture Treatment

Out of 14 studies (total 1173 participants),

- 4 showed traditional acupuncture (TA) is (statistical significantly) superior than sham acupuncture (SA). (Nedeljkovic, 2014) {p=0.016, p=0.013, p<0.001, p=0.048} (Sunay, 2011) {p=0.001, p=0.001} (Luca, 2011) {p<0.05} (Zaborowsk, 2007) {p<0.05,p<0.01}
- 3 showed traditional acupuncture plus self-care is (statistical significantly) superior than control group which has only self-care. (Baccetti, 2014) {p<0.001} (Kim, 2010) {p<0.0001, p<0.001} (Borud, 2009) {p<0.001, p<0.001}
- 3 showed traditional acupuncture more beneficial than sham acupuncture in reducing hot flush severity, but no statistically significant difference in hot flush score/ frequency compared with sham acupuncture. (Dong, 2011) {p=0.081} (Nir, 2007) {p=0.042} (Huang, 2006) {p.0.017}
- 4 showed traditional acupuncture and sham acupuncture is more effective than control group/ baseline, but there is no statistically significant difference between the traditional acupuncture and sham acupuncture groups. And 1 study showed that SA severity scores remained static after the initial reduction while the TA scores continued to reduce

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throughout the three month period. And TA alone may impact the HPA axis, not sham acupuncture. (Painovich, 2012) {p=0.2, p=0.04} (Venzke, 2010) (Avis, 2008) {p<0.05} (Vincent, 2007)

To summarize, all (14) studies showed acupuncture treatment being more effective than no treatment or control group. However when taking into account of sham acupuncture, which is meant to simulate the "placebo" effect, 7 out of 11 studies showed acupuncture treatment is (statistical significantly) superior than sham acupuncture; among which 3 showed acupuncture treatment efficacy (statistically significant) on reducing hot flush severity, not frequency.

2.2 Sustained Effects of Acupuncture Treatment

Out of the 4 studies with follow-up,

- 1 showed improvements from acupuncture treatment versus sham acupuncture 12 weeks after treatment ended. (Nedeljkovic, 2014)
- 1 showed improvement from traditional acupuncture versus control group 8 weeks after treatment ended. (Kim, 2010)
- 2 reported no adverse effects during treatment period and at follow-up 8/7 weeks after treatment ended. (Dong, 2011) (Vincent, 2007)
- 1 showed statistically significant differences between the study groups found at 12 weeks were no longer present at 6 and 12 months. (Borud, 2010)

To summarize, 2 studies showed continued impact of traditional acupuncture 8-12 weeks after treatment period ended and 1 study showed that the statistically significant differences from control group during treatment period were no longer present at 6 and 12 months. And 2 studies confirmed no adverse effects 7-8 weeks after treatment period ended.

2.3 Acupuncture Treatment vs Sham Acupuncture

11 out of the 14 studies where sham acupuncture was involved, only 5 studies described the set-up of the sham acupuncture. They either used 1. shallow needling, or 2. transdermal needling or 3. non-acupuncture specific points (which are in the proximity of acupuncture points) and the disposable acupuncture needle and plastic needle tube were placed on the sham points, manipulated without skin penetration and secured with adhesive tape. One study concluded that traditional acupuncture is more effective than the placebo control group. One study concluded that traditional acupuncture is more beneficial than sham acupuncture in reducing hot flush severity, but not frequency. Three studies concluded that both traditional acupuncture and sham acupuncture treatments were more effective than control group with no statistical significance between themselves.

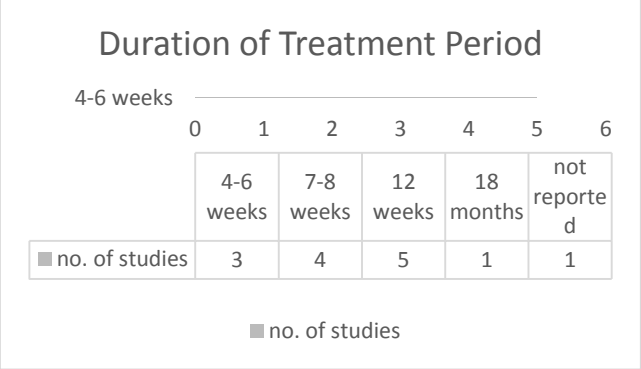
2.4 No Adverse Effects

Among the studies where adverse effects were noted during the treatment periods or during the follow-up's after treatment period ended, there was no adverse effects reported.

2.5 Treatment Periods

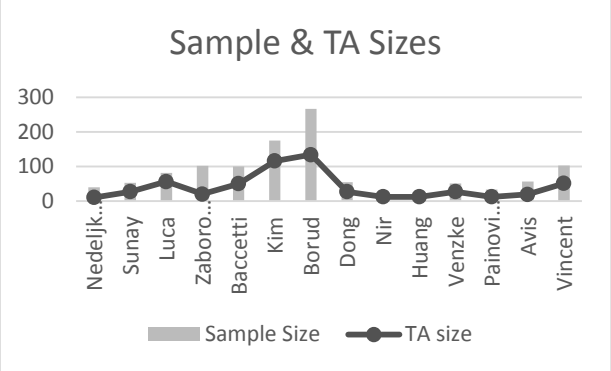
The duration of the treatment periods varied from:

- 4-6 weeks: three studies, including: Baccetti (2014), Kim (2010), Vincent(2007)
- 7-8 weeks: four studies, including Dong (2011), Avis (2008), Nir (2007) Huang (2006)
- 12 weeks: five studies, including: Nedeljkovic (2014) Painovich (2012) Venzke (2010) Borud (2009) Zaborowsk (2007)
- 18 months: one study i.e. Luca (2011)
- Not reported: one study i.e. Sunay (2011)



2.6 Sample Size

Across the 14 studies, the sample sizes ranged from 29-267 and as a result, the TA group sizes ranged from 10-134.



2.7 Set-up of Randomised Controlled Trials

The set-up of the 14 Controlled Trials varied which does not facilitate comparison across all of them. Two studies used TA, SA and WG (Waiting Group)/ CG (Control Group). (Painovich 2012) (Avis 2008) Nine studies used TA and SA. (Nedeljkovic 2014) (Sunay 2011) (Luca2011) (Dong 2011) (Venzke 2010) (Nir 2007) (Vincent 2007) (Zaborowsk 2007) (Huang 2006) And three studies used TA plus self-care and CG with self-care. Baccetti (2014), Kim (2010), Borud (2009).

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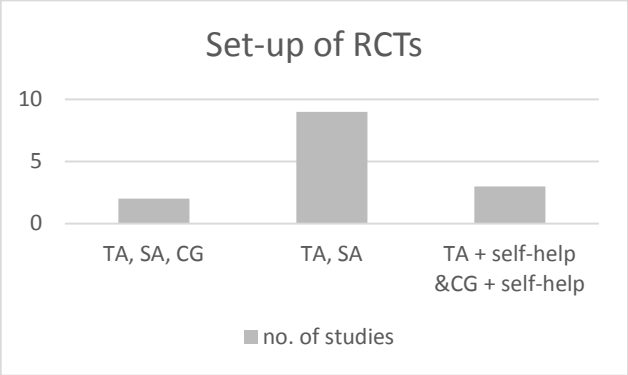

2.8 Country Origin of Study

This review has included 15 studies from the following countries of origin:-

- USA: 6
- South Korea: 2
- Norway:2
- Brazil:1
- Sweden: 1
- Switzerland: 1
- Turkey:1
- Italy:1

2.9 Acupuncture Treatments (Individualised/ Standardised)

Based on the publicly available data, four studies applied individualised acupuncture treatment for each participant. (Venzke, 2010) (Borud, 2009) (Nir, 2007) (Huang, 2006) And five studies applied standardised acupuncture point prescriptions on participants. (Painovich, 2012) (Dong, 2011) (Kim, 2010) (Avis, 2008) (Vincent, 2007)There is no obvious pattern established between either individualised or standardised acupuncture treatment producing a more positive result or otherwise.

3. Discussion

3.1 Acupuncture Treatment versus Sham Acupuncture

The lack of statistical significant differences between verum acupuncture and sham acupuncture reflected by the three studies could be due to the following reasons:-

- Sham acupuncture interventions are often associated with moderately large nonspecific effects which could make it difficult to detect small additional specific effects. Effects associated with SA might be larger, which would have considerable implications for the design and interpretation of clinical trials. (Linde, 2010)
- German researchers have used fMRI scanning to compare needling at a verum acupuncture point to the needling of a sham point. It showed that the sham point also affected the brain region despite a different region from verum acupuncture. (Usichenko, 2014)
- Tactile stimulation, e.g. with a non-penetrating placebo needle or touch, produces a physiological response and may overlap therapeutic components of verum acupuncture, it may compromise sham acupuncture as a placebo control. (Lee, 2014) (Kerr, 2011)
- Shallow needling may have therapeutic effects in itself reducing its utility as a "placebo" control for verum acupuncture. This result is consistent with other published studies. (Venzke, 2010)
- Transdermal needling could access the cutaneous collaterals and therefore the vast meridian system. And Japanese acupuncture often use "non-deep" needling to effect therapeutic impacts.
- One may also contest that sham acupuncture involves patients laying down and resting for 20-40 minutes is a therapy of its kind. Having been a career driven working mother of two children, the reality of the lack of "me" time is very often shared by many female professionals. Going through sham acupuncture treatments regularly for a period of time could be experienced as very relaxing and a stress relief.

A US/Korean team has developed and tested a novel form of placebo acupuncture, dubbed 'phantom acupuncture' (PA), which reproduces the acupuncture needling ritual without any tactile stimulation. In effect, it dissociates the somatosensory and cognitive/affective components of acupuncture stimulation, i.e. it completely excludes the tactile component of real needling while maintaining the credibility of the acupuncture treatment context in many subjects. (team, 2014) This phantom acupuncture can replace the current sham acupuncture design and reduce the compromise of sham acupuncture on the placebo effect.

3.2 Sustained Effect of Acupuncture Treatment

Two studies showed continuous impact of acupuncture treatments after 8-12 weeks following a treatment period of 4-12 weeks of 12 sessions. However no continuous impact of acupuncture treatments was noted after 6 and 12 months according to 1 study.

Menopause transition is a natural physiological and biological development concerning women's health/ lives affected by external factors such as life-styles, relationships, stressors and climate. The remission and relapse can be caused by many factors and therefore acupuncture treatment needs to be continued as when required for preventive, maintaining or healing purpose. One course of acupuncture treatment (e.g. 6-10 weeks, 12-16 sessions) can help reducing the severity and frequency of hot flushes, it is not a pathology that can be eliminated at once. Hormonal therapy also lasts for several years or longer.

3.3 Improving Quantitative Data Gathering

In addition to qualitative and quantitative measurements such as the hot flush diary, MENQoL[2] questionnaire, follicle stimulating hormone (FSH) and luteinising hormone (LH) levels etc, other objective biological measurements, such as dehydroepiandrosterone (DHEA), adrenocorticotropic hormone (ACTH), cortisol metabolites

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and adrenal androgens, can be added with explanations herewith.

The study (Painovich, 2012) showed:-

1. Both TA and SA reduce VMS frequency and severity and improve VMS-related quality of life compared to Waiting Control (WC); however, TA alone may impact the HPA axis.
2. The majority of the reduction of VMS frequency (≥ 86%) and severity (≥78%) occurred by week five of treatment, however, the SA severity scores remained static after the initial reduction while the TA scores continued to reduce throughout the three month period.
3. Exit 24-hour urinary cortisol measures demonstrated results in the hypothesized direction, where the TA group had the lowest levels of DHEA, cortisol metabolites and adrenal androgens (etiocholanolone + androsterone). Additionally, there is a correlation between improved urinary cortisol F levels (exit-entry) and improved VMS frequency (exit-entry) in the TA group, compared to no correlations in the SA and WC.
4. These study results further suggest correlations between improved depression, anxiety and sleep scores with improved VMS, supporting further study into the psychological and physiological role of stress in VMS mechanistic pathways and treatment.

According to the team (Painovich, 2012), dysfunction of the central thermoregulatory center associated with declining ovarian function is the leading hypothesized etiology of VMS. (Shanafelt, 2002) An understanding of the hypothalamic-pituitary-ovarian (HPO) axis provides a framework from which to investigate additional/alternative hypothesized mechanistic pathways of VMS. The hypothalamic-pituitary-adrenal (HPA) axis under stressful conditions can negatively impact the HPO axis (Berga, 2006) (Tolis, 2006), Recent data suggests that women with severe VMS have increased urinary F secretion (>10 ng/mg creatinine) during the late menopausal transition stage compared to women with less severe VMS, despite the fact that the groups did not differ in terms of age, body mass index, FSH or estrone glucuronide levels, health practices, exercise, mood, sleep, cognition, or stress. (Woods, 2006)

The study (Painovich, 2012) has claimed that there is limited knowledge regarding the HPA axis, specifically cortisol (F) production, and VMS.

However in a study (Eshkevari, 2013), researchers used electro-acupuncture[3] (EA) to stimulate the acupuncture point Zusanli (ST36), they then measured blood levels of proteins and hormones such as neuropeptide y (NPY) and norephinephrine (NE) secreted from the sympathetic nervous system and cortisol and ACTH coming from the HPA axis that are known to be involved with the stress response. They found that electronic acupuncture blocks the chronic, stress-induced elevations of the HPA axis hormones and the sympathetic NPY pathway.

Moreover, another study with rats has found that after treatment with EA, the stress-induced increase in NE, dopamine (DA), corticosterone, and ACTH inhibited. (Han, 1999)

With the addition of the above two research findings, the hypothesis Painvoich et al made that acupuncture has a role in regulating the stress hormones from HPA axis, impacting the HPO axis and therefore VMS shall pave a promising path forward for demonstrating the efficacy of acupuncture treatment for hot flushes with objective biological measurements.

3.4 Targeted Group, Trial Duration and Sessions per Week

Among the clinical controlled trials reviewed by this paper, consistent positive results demonstrating the efficacy of acupuncture come from post-menopausal women. When this group is also mixed with peri-menopausal women, the results start to get unstable. Therefore, a suggestion for future research is to focus on one group at a time.

Moreover, Painvoich et al observed a stabilizing effects of SA after one month of treatment compared with TA where hot flush scores continued to decrease throughout the 3 month period with 3 treatments per week. Therefore a suggestion is to ensure that the trial duration lasts definitely at/ beyond 2 months to show the difference in trends and perhaps more than one treatment per week to accelerate the therapeutic effects and therefore the differences between the various groups (TA, SA, WC).

3.5 Large Sample Size

The larger the sample size (and subsequently the larger the TA group size: 50-134), the lower the p values (ranging from 0.001 to 0.0001**).** Baccetti (2014), Kim (2010), Borud (2009). Moreover, small sample sizes may limit the replicability of the results. Both Painovich (2012) and Nir (2007) studies recommended a larger sample size for future clinical trials. Adequate sample size is crucial in detecting difference between TA and SA.

3.6 Standardise Set-up of Trails

Standardised set-up of future studies will permit a build-up of a bigger database on study data, comparison of results across studies and reflect historical track records/ trends. The ideal set-up shall include TA, SA and WG.

3.7 Minimise Potential Biases

A study conducted by Vickers et al in 1998 concluded that some countries published unusually high proportions of positive results. All trials originating in China, Japan, Hong Kong, and Taiwan were positive, as were 10 out of 11 of those published in Russia/USSR. Publication bias is a possible explanation. Researchers undertaking systematic reviews should consider carefully how to manage data from these countries. (Vickers, 1998)

First of all, this review does not include studies done before 1998. Secondly, this review has included 15 studies from the countries of origin not mentioned in the study of Vickers et al.

3.8 Pattern Differentiation

Pattern differentiation for treatment is the primary method

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which typically epitomizes TCM characteristics and advantages in diagnosis and treatment of diseases. (Zhou, 2013) There is a popular saying, "Chinese medicine differentiates "Zheng", Western medicine diagnoses diseases." (Zhongyi Bianzheng, Xiyi Bianbing 中醫辨證, 西醫辨病.) However, with the publicly available data of the trials, no conclusion can be drawn if the individualized acupuncture treatments produced more positive results than the standardized acupuncture treatment. Nevertheless, one intriguing observation is made here: among all the clinical controlled trials, none of them used pattern differentiation in selecting the participants of the trials. Women were selected based on criteria such as age group, stage of menopause they were in, number of hot flushes per day etc. A suggestion for future research is to look into selecting women of the same syndrome pattern and align the acupuncture treatment with the particular pattern. This proposition offers two advantages. It will offer an opportunity to demonstrate specifically the efficacy of pattern differentiation and individualized treatment. And this is probably a much more replicable trial design than recruiting women of possibly all different syndrome patterns (can amount to ten different patterns as mentioned under section 3.6) and thereafter apply a standardized or individualized treatments.

Pattern differentiation will help improve the clinical efficacy in clinical practice since it further specifies the indication with TCM classification. (Lu, 2009) And this was evidenced by a clinical research showed that the better effective treatment rate could be achieved from the rheumatoid arthritis patients based on their patterns differentiated. (He, 2007)

3.9 Acupuncture at Its Best

Acupuncture is only one of the 3 major modalities of TCM, together with herbal medicine and tuina message. Acupuncture at its best is to unblock qi stagnation, smooth qi flow, address rebellious qi and tonify qi. However for Yin/ Blood deficiency, acupuncture has to be combined with herbal medicine to optimize the therapeutic effects. As shown in section 3.6, there are 10 different patterns related to menopausal hot flushes. A hypothesis is to be tested that out of the 10 patterns, acupuncture stand-alone treatment can reap the best results in Liver qi stagnation and Liver Yang rising patterns. As shown in section 3.7, the acupuncture point combinations for Yin deficiency patterns are very different from the point combinations for Liver Yang rising. For future clinical trials, it is worth considering finding the participants with Liver Yang rising pattern or Liver qi stagnation pattern and match the acupuncture treatment with the appropriate point combinations. By minimizing the influence of the other patterns, this will allow a more refined research trial focusing on the main therapeutic role of acupuncture in treating hot flushes and therefore its efficacy.

Acupuncture points for pacifying the Liver, subduing Liver Yang, moving the qi and eliminating stagnation are:

- LR3 and LI4 to pacify the Liver
- LR2, GB20 to subdue Liver Yang
- LU7, HE5 to descend rebellious Qi in Ren and Chong Mai
- REN17, REN6, PC6, TB6 to move Qi and eliminate stagnation

They can be complimented by other acupuncture points such as:

- SP4 and PC6 to regulate the Chong Mai
- LU7 and KI6 to regulate the Ren Mai, strengthen the Uterus and nourish the Kidneys
- KI3, REN4, BL23 to nourish Kidneys
- LR3, LR8 and BL18 to nourish Liver
- SP3, SP6 and BL20 to nourish Yin/ Spleen

Both Yuan Source points and Back-Shu points have been selected when it concerns the organ systems Kidney, Liver and Spleen because the combination of Source Point and Back-Shu point has a benign regulation function for serum estradiol (E2), FSH and LH. It can significantly improve the Kupperman score and is superior to routine acupuncture for peri-menopausal syndrome according to the study of Shang et al. (Shang, 2009)

3.10 Pro-active Lifestyle Management

The Yellow Emperor's Inner Canon (Huang Di Nei Jing 黃帝內經) says the following around the 7-year cycle of life for women:-

「女子七歲，腎氣盛，齒更髮 長；二七天癸至，任脈通，太衝脈盛，月 事以時下，故有子；三七腎氣平均，故真 牙生而長極；四七筋骨堅，髮長極，身體 盛壯；五七陽明脈衰，面始焦，髮始墮； 六七三陽脈衰於上，面皆焦，髮始白；七 七任脈衰，太衝脈衰少，天癸竭，地道不 通，故形壞而無子也。」

The translation: "when girls reach 7 years' old, their teeth and hair is growing strong. When they reach 14 years' old, their menses start and they can get pregnant. At 21 years' old, Kidney Qi is in balance. At 28 years' old, their physical condition is at the top. At age 35, the physical body starts to weaken. At age 42, the physical deterioration manifests as dull complexion and greying of hair. At age 49, Ren Mai and Chong Mai are depleted and menopause arrives."

What this means for women is that vitality reaches its optimal state at around age 28 (4x7) and from age 35 (5x7) onwards, vitality starts to deteriorate.

Therefore, pro-active lifestyle management in work/ rest balance, diet, exercises and stress management as from age 30 becomes very important so that women shall preserve their Essence rather exhausting it too quickly, too soon; and later on non-healthy lifestyles also aggravate the symptoms of menopausal syndrome.

4. Conclusion

Acupuncture can alleviate the menopausal symptoms such as hot flushes before they become debilitating. It has proven its efficacy in statistically significant terms in reducing hot flush severity; but on hot flush frequency, further research is needed. Suggestions have been made in this paper for future research to demonstrate in more scientific terms the specific role of acupuncture in treating hot flushes. Moreover, suggestions have been made for women to be more pro-active in managing the menopausal

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transition by adopting healthier attitude and life-styles, and equally important for societies to be compassionate and respectful for aging.

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Biography: Linda Chen was born in Beijing, China, and she moved to Hong Kong at the age of six. Linda initially planned to follow medical studies at university in Hong Kong but was waylaid from this path due to her own challenging health issues. Every crisis brings about opportunity so she decided to immerse herself in business studies and graduated in Business Administration.

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Acupuncture for Labour Pain Relief – A Systematic Review

Belgude Munkhtulga, Fanyi Meng
Lincoln College
Fmeng@lincolncollege.ac.uk

Abstract
Purpose of this study was to check whether there is enough evidence to support the use of acupuncture in labour pain relief.
Methodology: A systematic review of randomised control trials was used to obtain a clear and reliable assessment on the effectiveness of the application. Research reports were checked against inclusion and exclusion criteria. The quality of reporting was assessed via modified CONSORT and STRICTA checklists.
Principal findings: A total number of 20 trials were included into this review which comprises ten manual and/or electro acupuncture, four TENS of acupoints, and six acupressure therapies. From total of 19 assessed, 14 studies had significantly better VAS score compared to control groups. Two out of five trials recorded less need for pharmacological augmentation. Post-treatment surveys also favoured acupuncture therapies. Qualities of reporting were generally low. No serious adverse effects were recorded.
Conclusion: There was inconsistency with the evidence to consider manual acupuncture and TENS on acupoints as effective. Electro acupuncture and acupressure were effective analgesics, but there is need for more high-methodological trials encompassing STRICTA and CONSORT to confirm those outcomes.
Key Words: Acupuncture, Labour Pain, Pain Relief, Clinical Trials,

1. Introduction

Labour pain is one of the most intensive pain that human being can experience. The current available means of pain relief are dependent on a self-education and pharmacological methods like nitrous oxide, opioids, and epidurals; however their use is linked with a substantial risk of adverse effects that could affect both mother and foetus (NHS, 2015). Thus, there is an increasing need for alternative therapies that could provide an inexpensive, simple and safe, but still effective pain management (Rooks, 2012).
Many clinical trials on labour pain relieving were carried out in the past 20 years, and the clinical reports were pooled together for further evaluations. Two reviews focused on evaluating RCTs of manual and electro acupuncture techniques (Lee et al, 2004; Cho et al, 2010), whereas in the appraisal of Smith et al. (2011), acupressure therapy was also included into the analysis. More recent study of Levett et al. (2014) evaluated those techniques in the systematic review appraising the evidence of those reviews. The authors of latest review concluded that although acupuncture is reported to be effective but the research projects do not show high level of design and measurement, therefor further studies were required to confirm the evidence of those evaluations.
The purpose of this study is to check whether manual and electro acupuncture, acupressure and TENS on acupoints therapies are effective as labour pain analgesia for women in labour.

2. Methodology

A systematic review of randomised control trials was used to verify the hypothesis "Is acupuncture effective for reducing labour pain?" This study design provides an objective evaluation of the accessible evidence that summarise the state of current knowledge (Linde et al, 2007). This method decreases the risk of bias from reviewer. Clearer and more reliable results are concluded when a number of similar studies are integrated in a systematic review (Neale, 2009).

Search methods

A comprehensive search was conducted through use of online search engine of 'Google Schoolar' and electronic databases of 'AcuTrials' and 'University of Lincoln library catalogue', which comprises access to AMED, Academic Search Elite, Biomed Central, Cidhal, CINAHL, Cochrane Library, EMBASE, MEDLINE, and PUBMED databases. The search was done by typing key terminologies involving Boolean combination: 'acupuncture', 'acupressure', 'electro acupuncture', 'TENS on acupoints', 'labour', 'delivery', 'childbirth', 'pain relief', 'analgesia', 'randomised control trial'. The search was done for the period from December 2014 to March 2015.

Selection of report

The inclusion criteria are:

- RCT reports in full-text,
- Published in last 10 years,
- Involves use of manual or electro acupuncture, acupressure, TENS on acupoints,
- At least one form of following measurements applied to assess the effect of intervention:
  - Pain intensity,
  - Satisfaction with pain relief,
  - Use of pharmacological pain relief,
  - Feeling of control in labour,
  - Degree of satisfaction with childbirth experience.

The exclusion criteria are:

- Other acupuncture technique not mentioned above,
- Literature in languages other than English.

Data extraction

Firstly, the general information about the studies including the name of authors, year of publication, and title of studies were collected. Then details of participants including sample size, parity, and any previous acupuncture experience were noted. After that study design details was extracted including assessed primary and secondary outcomes, intervention protocol and regimen, type of respective control group, acupuncture point selection, used instruments and tools for assessments and intervention. Furthermore, results of the interventions with control groups and side effects were recorded with statistical calculation of P values (if difference is statistically significant) or confidence intervals (CI) collected from respective articles. The conclusions and implications of the studies were lastly noted. Presented data results and calculations in the articles were firstly read from tables or figures whenever included, then checked with authors' interpretation to avoid the possibility of reporting bias. All extracted information was written down in a paper form and stored.

Quality assessments

Publications employing procedures to minimize bias and error in methodological quality provides confidence that its design, conduction and outcomes are adequately robust and trustworthy (Boland et al, 2014). Published articles included into this systematic review were more emphasized on assessing the quality of reporting, instead of the adequacy of trial design, which was similarly done in the study of Prady et al. (2008). Therefore, Consolidated Standards of Reporting Trials (CONSORT) and Standards for Reporting Interventions in Controlled Trials of Acupuncture (STRICTA) (MacPherson et al, 2010) guidelines were selected as verifying tools for quality assessment in this review.

3. Results

Out of 20 studies reviewed, ten studies evaluate either manual or electro acupuncture, six trails involved acupressure technique, and remained four are on TENS on acupoints.

Sample sizes: An overall number of 3192 participants were assessed in all twenty studies. See Figure 1 for illustration of sample sizes. The median number of parturients was 124 in those trials and the range of sample sizes were from lowest of 36 (Qu and Zhou, 2006) to largest of 607 (Borup et al, 2009).. Six studies had number of partakers below 100, whereas eleven other studies were counted with quantity between 100 and 299. Only three studies were larger trials with 300 or more enrolled women.

3.1 Acupuncture point selection

This review referred to acupoints' naming that was used by Deadman and Al-Khafaji (2007). Selection of acupuncture points in included trials were categorised into three sets. Despite range of chosen acupoints being very broad amid studies, two of them – SP6 and LI4 were selected the most often with occurring rate of 80% and 75% respectively.

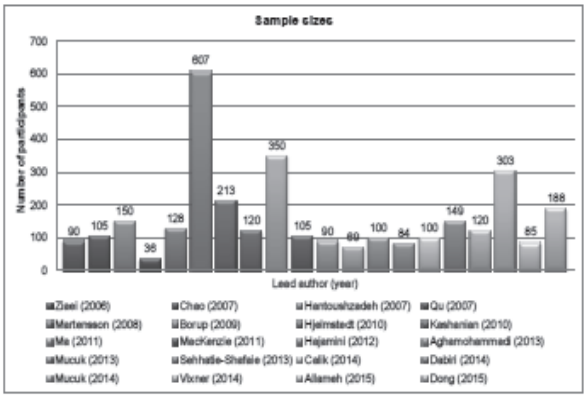

Figure 1 Illustration of sample sizes

3.2 Participants: Although, all of the partakers were women with singleton pregnancy, foetus cephalic presentation, and giving natural vaginal delivery at term ranging between 37 to 42 weeks of pregnancy; parity in those studies were selected variously. Only nulliparous women were recruited in eight RCTs, whereas primiparas only were enrolled in two trials. Nine other elaborations were with mixed parity involving nulliparous, primiparous and multiparous women; however only three studies had done stratification according to partakers' parity, and remaining five did not record this information. One study did not provide any details specifying parity among partakers. Furthermore, women that had any previous experience with acupuncture were excluded in 5 studies.

3.3 Interventions

In total, there were 28 intervention groups within 20 included studies that assessed pain relief for women during labour and were not defined in this review as control group.

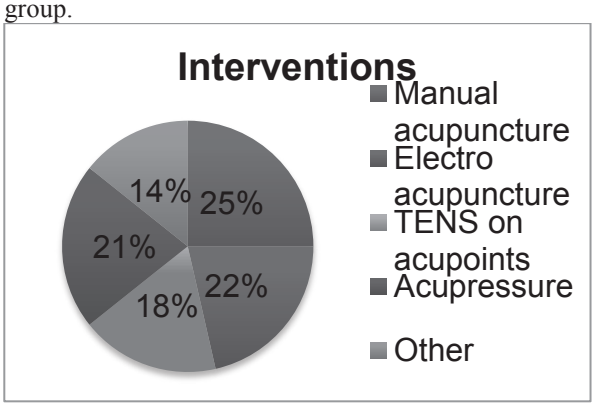

Figure 2 Illustrates percentage selections of acupuncture interventions

3.4 Outcome measurements

3.4.1 Visual Analogue Scale (VAS)

VAS is a subjective tool scaled from 0 to 10 that that was used in every study, besides appraisal of MacKenzie et al. (2011) in this review for pain intensity assessed during labour. This instrument was also involved with measuring the degree of relaxation among participants in four studies.

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One trial utilized VAS scale to rate the memory of intervention's effect on labour pain.

3.4.2 Blood samples
Women in two evaluations had blood samples collected to measure the concentration of β-endorphins (β-EP) and 5-hydroxytrptamine (5-HT) in, and adrenocorticotropic hormone (ACTH) and cortisol levels.

3.4.3 Use of pharmacological pain relief
Total number of five RCTs decided to compare the amount of pharmacologic pain relief that was required by participants between intervention and control groups. However, range of analgesics used among studies varied.

3.4.4 Post-treatment experience surveys
In the reviewed studies, five issued post-treatment surveys for subjective evaluation of treatment experiences during childbirth by parturients. The extent of pain relief was checked in four trials, whereas a degree of relaxation was enquired in three RCTs. Furthermore, three appraisals queried willingness to have same treatment for the future delivery.

3.5 Results of each interventions

3.5.1 Manual acupuncture
The manual acupuncture groups achieved significantly better pain scores when compared to minimal active penetration at 120 min (Hantoushzadeh et al, 2007), and both pethidine agent and intrapartum care at 30 min after intervention (Allameh et al, 2015). In Vixner et al. (2014) trial, there was no significant difference in first model without interactions, but there was a significant difference in the second model with interaction between time and treatment (P=0.03). The MA group achieved significantly lower VAS pain scores at 120 min and 270 min after intervention compared to EA group, however at 360 min intrapartum care group had lower scores when matched with MA group. The sterile water injection therapy had statistically better scores than MA group.

3.5.2 Electro acupuncture
The electro acupuncture groups had experienced significantly improved analgesic effects compared with IC only (P=0.018) (Qu and Zhou, 2007), and both sham EA and IC control groups at 30 min needle retention time, 2 hrs and 4 hrs after intervention (Ma et al, 2011). In study of Dong et al. (2015), two EA groups gave better pain relief than IC at 30 min, 60 min and 120 min after treatment (P<0.05). Once those two groups' scores were evaluated, $EA_{Ex\text{-}B2}$ group was superior to EA_{SP6} group (P<0.01).

3.5.3 TENS on acupoints
This non-invasive form of EA provided statistically significant pain analgesia against placebo TENS in Chao et al. (2007) study at 30 min and 60 min post-intervention (P<0.001). Likewise, trial of Aghamohammadi et al. (2013) found significantly improved effect on partakers at dilation of 10 cm (8.1 vs. 9.8, P=0.0001) also checked against placebo TENS group.

3.5.4 Acupressure
Significant pain relief properties of acupressure were recorded in all six trials. Those enhanced effects were recorded from immediately after intervention, up to 30 min (Hajamini et al, 2012), 60 min (Dabiri and Shahi, 2014), and 120 min (Hjelmsted et al, 2010; Kashanian and Shahali, 2010). Two other elaborations issued multiple interventions throughout whole labour process, scoring significant pain relief between groups. However, there was no significant difference at dilation of 8-9 cm in Calik and Komurcu (2014) study. The intervention of ice massage on LI_4 had equal effect as acupressure group, but ice massage had longer lasting analgesic features.

3.6 Degree of relaxation
From four studies that appraised the degree of relaxation, only two showed significant improvement (Qu and Zhou, 2007; Martensson et al, 2008) using VAS scale. Two other studies (Ziaei and Hajipour, 2006; Vixner et al, 2014) did not receive significant difference amid groups.

3.7 Blood tests
Blood samples were taken in two studies. Evaluation of Qu and Zhou (2007) achieved significant difference in concentration of β-EP (P<0.037) and 5-HT (P<0.03), while Mucuk et al. (2013) recorded increased level of cortisol and ACTH, however those changes were not significant (P>0.05).

3.8 Use of pharmacological pain relief
From five appraisals that assessed the amount of analgesic pain relief used, only two had significant differences between groups. In Borup et al. (2009) trial, fewer women in MA group needed pharmacological or invasive pain relief compared to non-acupuncture TENS (59% vs. 69%, P=0.031) and intrapartum care (59% vs. 83%, P<0.001). Furthermore in that study, parturients chose the augmentation with pethidine less often compared to intrapartum care group (P=0.01). Parturients in Vixner et al. (2014) elaboration required lesser amount of EDA in EA group with 46% rate, matched against MA group and IC group with 61.4% and 69.9% rates respectively [EA vs. IC, odds ratio 0.35 (0.19-0.67)]. Other studies showed no significant differences for EDA requests.

3.9 Post-treatment experience surveys
Post-labour women had experienced enhanced pain relief in four studies that both electro acupuncture and sterile water injection had improved effects than manual acupuncture. However, MA had better analgesic profile than non-acupuncture related TENS. Similar trend was recorded with degree of relaxation which EA and SWI groups were better than MA, but it still was more effective than non-acupuncture TENS. Acupressure group experienced less pain and coped more than IC, according to Hjelmstedt et al. (2010) survey. Greater number of participants was willing to repeat same intervention in future childbirth in MA group over non-acupuncture TENS group and also TENS on acupoint group against placebo TENS group, but not significant difference was between MA and SWI groups. There was no statistical difference observed with 'no EDA side effects' and 'intervention alone as sufficient pain relief'.

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3.10 Side effects

Among all reports, only six mention minor side effects, but were related acupuncture like insertion of the needles, numbness and tiredness, with no serious influence on both mother and foetus.

3.11 Quality of reporting

CONSORT standards: All included RCTs were appointed with study number and checked against modified CONSORT checklist. Collected information was presented in the table found in Appendix H and summarised in Appendix G. The results from first comparison showed that there were two trials that reported sub-items with percentage above 80% - study number 6 and 8. In the category between 50% and 79%, there were eight studies that reached those scores. The remaining ten elaborations scored below 50%. In the second analysis, 12 out of 37 sub-items were reported with a score of 80% and above, with two maximum scores of items '4a' and '17b', however the later item was only applicable in two trials numbered as 6 and 8. On the contrary, thirteen sub-items were reported with occurrence of 30% or below. The sub-item '7b' was not applicable as none of the trials did interim analyses and stopping guidelines. Also different sub-item '6b' was not reported in any of included studies.

STRICTA guidelines: A total of ten acupuncture studies that involved intervention with invasive needle skin penetration were evaluated by the reformatted STRICTA checklist and presented in tables (See Appendix I and J). Only one study by Vixner et al. (2014) featured with 100% reporting score quality. Other nine trials had achieved percentage range between 30% and 67%, with median of 55%. All studies recorded item '$2b_1$)' and every single electro-acupuncture elaboration had provided details about used electric stimulation for sub-item '$2e_2$)'. In contrast, item 5 comprising practitioner background was least recorded, ranging from 10% to 30%. Likewise, two other sub-items '3b)' and '4b)' were equal with a relatively low reporting percentage of 30% each.

4. Discussion

4.1 Parity and acupuncture experience of participants

The choice of partakers' recruitment was relatively similar among reviewed studies in terms of delivery mode and range of gestation age. Yet, researchers had conducted studies with different choice of parturients' parity. Eight studies limited this category to nulliparous women only. The rationale behind this restriction was done due to fact that nullipara compared with multiparous women requires less intrapartum analgesia, have shorter labours and higher vaginal birth rates. One of the main factors for this association was related to fear of childbirth that was higher in childbirth inexperienced women (Alehagen et al, 2001). Severe fear was more often noticed in nulliparous parturient in late pregnancy or women with history of caesarean section or vacuum extraction (Rouhe et al, 2009). The fear of nulliparous women during labour lessens the effectiveness of administrated epidural analgesia (Alehagen et al, 2006). Thus, uneven weighted number of nullipara in one of the groups might result with higher pain intensity scores than as it were collected with parous women.

Three out of nine studies with mixed parity had done stratification according to patient's parity to avoid earlier mentioned error. Though, other six trials did not report any details about even allocation of parturient according to their parity, thus there is substantial risk for that error to occur.

A total of five RCTs had limited to parturients who never had any experience with the acupuncture treatment. This restriction was aiming to eliminate the possibility of favouring one of the interventions or discovering by parturient group allocation as one who had already acupuncture could guess that her treatment was placebo acupuncture.

4.2 Credibility of assessed outcomes

Trials in this review employed various methods to measure the pain during childbirth, due to the nature of labour which involves specifically both physiologic and psychological aspects of pain perception (Lowe, 2002), which was also a reason for lack of objective pain assessing instruments. Analogue pain scores such as VAS or numerical rating scores (NRS) are widely utilized as clinical and research pain assessment tools in the labour setting, despite their limitations of being subjective tool and varying on each individual's pain perceptions (Carvalho and Cohen, 2013).

A total of five studies analysed the amount of pharmacological pain relief that was required by each group. If the acupuncture intervention provided enhanced effects on pain, then hypothetically the amount of pharmacological means requested would be lesser than in control group.

4.3 Effectiveness of acupuncture techniques

A total of eighteen studies used visual analogue scale to assess the pain intensity in all respective groups. Four of those studies had not recorded significantly enhanced by acupuncture techniques amid assessed groups. The study design of Ziaei and Hajipour (2006) was very poorly reported to reach any conclusion or reasoning for its outcome. Two studies lead by Mucuk (2013; 2014) were issued with very similar methodology design, but the intervention involving acupuncture pen was probably not strong enough with intensity to achieve significant differences against control groups. Then, intervention of sterile water injection was significantly better compared to scores of MA technique (Martensson et al, 2008), however authors did not include control group to assess whether that acupuncture group gave beneficial changes in pain scores.

The manual acupuncture therapies had seen significant improvements compared with minimally active penetration, pethidine agent, intrapartum care and electro acupuncture of second mode with interactions in various time measurements after interventions; however there were little similarities between those studies in terms of treatment regime or selection of acupoints.

Three electro acupuncture studies had recorded beneficial

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significant differences in pain scores compared to intrapartum care or sham EA. The effects of intervention were notable straight after administration and lasted up to 2hrs (Dong et al, 2015) and 4 hrs (except at 60 min) (Ma et al, 2011). Those evaluations used dense and disperse (D&D) burst mode that involved either 4/20 Hz or 2/100Hz frequencies and intensity adjustable to participants' thresholds. Electro acupuncture stimulation of 2 Hz induces the release of enkephalin, β-endorphin and endomorphin, whereas that of 100 Hz selectively inhibits the release of dynorphin; thus combined frequencies would adhere simultaneously release of all four opioid peptides (Han, 2004). That evidence was supported by the study of Qu and Zhou (2007) recording significantly increased concentration of β-EP and 5-HT after EA intervention. Two other appraisals involving EA groups had not significant changes between compared groups, but they used different waveforms of either 2 Hz (MacKenzie et al, 2011) or 80 Hz (Vixner et al, 2014). Therefore, setting the parameters of electro machine with similar to other studies may have achieved significantly enhanced results.

Transcutaneous electrical nerve stimulation when used on acupoints could be considered as non-invasive electro-acupuncture. Two RCTs of that intervention had recorded significantly lower pain scores matched to placebo TENS groups. Appraisal of Chao et al. (2007) employed the use of D&D burst mode and 2/100 Hz wavelengths and had more immediate changes on pain scores than elaboration of Aghamohammadi et al. (2013) which used 100 Hz and 250 micrometres wavelength.

The therapy of acupressure was found to be significantly beneficial with pain scores over placebo acupressure groups. The analgesia of labour pain was particularly effective straight after application of the treatment, and it gradually wore out lasting up to 120 min. Two studies repeated intervention to keep the analgesic characteristics until participants reached full dilatation. However, ice massage on acupoints prolonged the duration of analgesic effects.

4. 4 Degree of relaxation

Participants of two out of four RCTs had showed significantly better degree of relaxation. Reduction of fear and stress levels gives profound physical and emotional effects, since relaxed woman with the feeling of safety and in control of situation were more prone to undergo labour quicker and less painful (West, 2008, 173-5).

4.5 Effectiveness of selected acupoints

Studies of this review were diverse in terms of selection of acupoints. There was no set combination of most effective acupuncture needling location. Studies used standardised, semi-standardised and individual acupoints selection. Two acupoints of LI_4 and SP_6 were most often chosen, but were compared individually only in one study of Mucuk et al. (2014) which was had no significant differences between groups. Study of Dong et al. (2015) compared EA on SP_6 and Huatuojiaji which the later one had achieved longer lasting effects.

4.6 Increasing evidence of different acupuncture techniques

A total number of twenty eight intervention groups were issued in reviewed studies. Manual acupuncture was used in seven treatment groups. An even number of six groups had both electro acupuncture and acupressure techniques' studies. Non-invasive electro acupuncture was assessed in five treatment arms. Other interventions comprised of sterile water injection, TENS on non-acupuncture points, pethidine injection, and ice massage groups each. As shown in Figure 2, the number of acupuncture techniques chosen by researchers was not favouring any of groups. In previous review of systematic reviews by Levett et al. (2014), manual and electro acupuncture techniques were predominantly issued for evaluations over acupressure technique in their trials. Moreover, there were only one TENS on acupoint study – according to this review's range of search- being too few as an evidence to take into consideration of review. In terms of last 10 years, the number of issued publication on acupressure and non-invasive electro acupuncture therapies for labour pain relief has increased noticeably.

Conclusion

There was inconsistent evidence for manual acupuncture and TENS on acupoints, as their treatment protocols, outcomes measured and results were conflicting, yet those two techniques had shown significantly enhanced pain scores compared to control groups. This study had noticed a correlation in electro acupuncture interventions achieving significant pain relief and lessened requests for other pharmacological augmentation. More consistent and similar with intervention protocol evidence were found in the acupressure therapy. The analgesic effect of this therapy was beneficial straight after application, but wears off in relatively short time. The results from post-treatment surveys completed by parturients were more favourable towards acupuncture therapies. The overall reporting qualities of included acupuncture studies were low. There is need for more high-methodological randomised control trials to support these findings. No serious adverse effects were recorded amid reviewed RCTs.

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Guo-Li Acupuncture Methods in Dermal to Produce Warm and Cool Effect on Lesion and Body

Wang Ying, United Kingdom

The traditional acupuncture method "Shao Shan Huo and Tou Tian Liang"(Shao-Tou Method) was valued by acupuncturists in Chinese medical history due to its unique clinical results. However most acupuncturists felt the textbook description was too complicated to follow and repeat. This made the Shao-Tou method a secret kept in hands of few people. After studying Shao -Tou method with various specialists and large amounts of clinical observations, Dr Guo Songpeng and Dr Li Yujie finally put the focus of the method on the skin. They discovered that how acupuncture could create the warm and cool effect on the body (partial or whole body) is closely related to the physical structure and functions of the skin. They created the concept of "Four Layers of Acupuncture Points" and creatively invented the new Shao-Tou method: "Guo-Li's Acupuncture Methods in Dermis to Produce Warm and Cool Effect on Lesion and Body".

1. The Four layers of acupuncture points

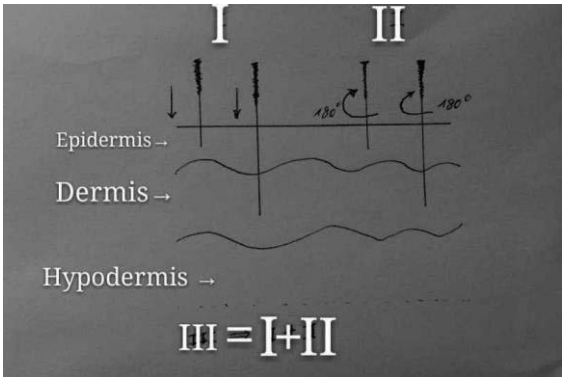
According to Guo-Li's theory and the traditional three layered skin structure, The point is three-dimensional; standard acupuncture points could be divided into four layers:

1.1 The shallowest layer: It is located between epidermis and dermis. The depth is 0.2~2mm.
1.2 The shallow layer (the first1/3 of the acupuncture point): The depth is 2~4mm
1.3The middle layer (the middle 1/3 of acupuncture point): The depth is 5~60mm.
1.4The deep layer (the last 1/3 of the acupuncture point)
It is closed to periosteum, or reached to periosteum.

2. The manipulation of the Guo-Li method (new Shao-Tou method)

2.1 The manipulation of acupuncture in shallowest layer to produce the warm effect on lesion and body

Chart 1



* Simply press down method. The arrows above in chat I –No.I indicate the direction of force in Epidermis and Dermis.;
* Clockwise twisting method. The arrows above in chat I-No. II indicate twisting needle in clockwise of 180 degree.;
* Pressing plus twisting combination method. No.III=.I + II。

2.2 The manipulation of acupuncture in shallowest layer to produce the cool effect on lesion and body

Chart 2: Stucking and Picking up method

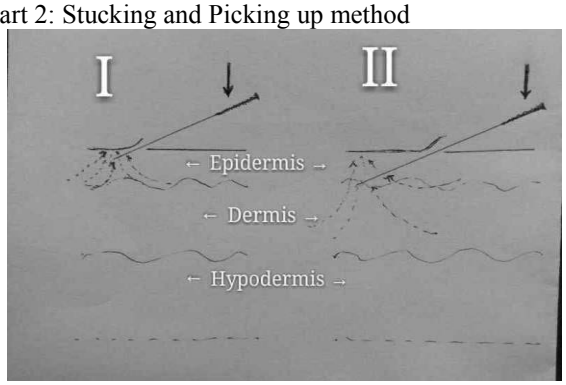


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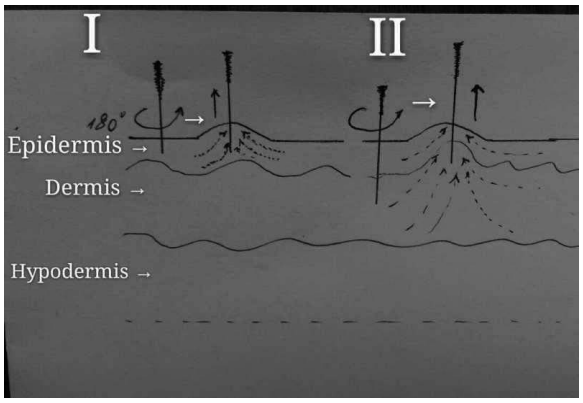
Chart 3: Stucking and pulling up method



3. Precautions

3.1 In the above mentioned techniques, we still keep the traditional method of twisting the needle in clockwise and anticlockwise.

3.2. Reaction point is means the first spot where you feel the De Qi sensation during you slowly insert the needle into the acupuncture point.

3.3 In Order to keep the needle tip on the right reaction spot, the practitioner could use the techniques of stuck needle and astringent needle to prevent the needle tip to penetrate it. But these two methods are not directly related to produce warm and cool effect.

3.3.1 The stuck needle method:
On the reaction spot, the practitioner gently twist the needle 180° one or two times to make the needle stuck into the skin. Under pressure, you will feel resistant force.
3.3.2 Astringent needle method:
On the reaction spot, the practitioner gently twist the needle until you feel resistant sensation. This is friction and tight astringent sense.

3.4 This new Shao-Tou method could use as same as traditional Shao-Tou method.

3.5 The new Shao-Tou method is easy to practice and repeat. It does not involve Qigong and mind focus.

3.6 The success rate depends on practitioner's experience. More practice will lead to the best results.

3.7 A further purpose of the new Shao-Tou method is to balance Yin and Yang. A warming effect is an exciting effect, conversely a cooling effect means inhibition. We do not always focus on the change of body temperature, as long as yin-yang is balanced.

4. The mechanism of Guo-Li Acupuncture Methods in Dermal to Produce The Warm and Cool Effect on Lesion and Body

4.1 There is a direct relationship between the dermal cold or warm change and the blood perfusion of the dermal microvascular bed.

Microvascular circulation is composed of arterioles and venules. Venules have sympathetic and parasympathetic nerve endings.

Mechanical changes caused by the needle tip pressing down and lifting up is detected by the skin pressure and temperature sensors, causing effects in the skin. Incoming information is integrated in the temperature centre in the brain and also in the peripheral sympathetic and parasympathetic nerve mechanism, which together causes the microcirculation of the blood perfusion increase or decrease, so there is cold warm feeling and partial or full body temperature changes.

4.2 In fact, there are still many questions about the mechanism body temperature changes induced by the special technique of acupuncture, from the angels of the traditional Chinese medicine and modern medicine do research will have very important significance.

5. Case Report

5.1 Male, 56 years old, engineer. Chief complaint: lower back pain with left sciatica for 2 months.
First, using the dermal warm effect method at right Dacha point, the patient felt warm in the lower back immediately. Secondly, after selecting Jing Gu point and applying the same method, patient felt warm sensation run from the foot up to lower back along the Bladder Meridian, and the pain was reduced significantly. After 6 treatments the pain totally disappeared.

5.2 Male ,50 years old. Chief complaint: eczema, skin on both hands painful, dry and cracked.
Selecting Zhi Wu point, Mu xue, Yu Ji, and Qu Chi points on both sides, the dermal cool effect method was applied at Qu Chi point. The patient felt cool sensation run from the elbow down to the fingers. He felt the pain reduced immediately in the fingers. After 3 treatments the skin became mostly healed.

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Tuina - Indications, Counter-Indications and Cautions

Ming Cheng

Tuina, as one of the therapeutic procedures in Traditional Chinese Medicine (TCM), is used to treat diseases by manipulation of certain parts and acupuncture points of the body. It is one of the external treatments that are used by TCM practitioners. It is not a general treatment method which can be used by amateurs such as the so called "masseurs".

In recent years in the UK, as TCM becomes popularised, some TCM shops covertly and overtly employ masseurs to carry out Tuina therapy. Although some TCM practitioners do Tuina themselves, most of them are not specialised in Tuin therapy in their TCM training. The employed masseurs, the vast majority of them being female, have had even less TCM training. In the meantime, there is no professional regulation of these "therapists". This becomes a perfect situation to generate a chaotic market place, where frequent allegations of sleazy practice occur.

In this paper, the history of Tuina in TCM is to be reviewed. An attempt is to be made to clarify the indications for Tuina. It will also deal with the important counter-indications and the cautions that have to be taken in genuine Tuina practice. It is not the scope of this to deal with the Tuina methods in detail, as these are available in numerous textbooks and practice of them are available from many genuine TCM Tuina courses.

1. A Brief Review of the History of Tuina

No one knows exactly when and how Tuina originated, but it can be imaged that in ancient times, people had to labour hard to survive. Injuries such as fractures, contusions and strains happened constantly. It must be a natural instinct that man would use his hand to try to stop bleed and eliminate swelling and pain (Jin 2002, Zhang 1990).

There is very little record about Tuina for the period before Qin Dynasty, although in "52 Bing Fan (Prescription of 52 Diseases)", there are some descriptions of Tuina with the use of some medicated ointments and some simple tools. In the Qin and Han Dynasties, records show that there was a specialised book on Tuina called "Huangdi Qibo Anmo Shijiuan (The 10 Volumes of Tuina by Emperor and Qibo)", but the book did not survive the history. It is however fortunate that "Huangdi Neijing (The Emperor' Inner Cannon)", which was compiled in the between Qin and Han Dynasties, systematically describes Tuina as a therapeutic method. Inspection, listening and smelling, interrogation and palpation are the most important diagnostic methods, with palpation being applied to improve the accuracy of diagnosis. Huangdi Neijing reaffirms that the functions of Tuina include promoting qi and blood circulation, unblocking and dredging the Jingluo system, eliminating cold, clearing heat, stopping pain and tranquillising Shen. There are many descriptions of tuina manipulation methods, such as pressing, rubbing, cutting, palpating, feeling, clapping, flicking, grasping, pushing, weighing, flexing, stretching rocking and kneading.

"JingKui Yaolue (Synopsis of the Golden Chamber)", written by Zhang Zhongjing in the Han Dynasty, describes the use of an ointment called Modinggao which contains Fuzi and Salt to be used in Tuina treatment for headache.

From Jin through to Qing dynasties, more developments of Tuina were to happen. In Tang Dynasty, specialised Tunia therapists on different grades were appointed by the central imperial government. In Yuan Dynasty, "Shenji Zonglu (General Collection for Holy Relief)" listed Tuina as a single chapter, while "Rumen Shiqin (Essential Affairs in the Confucianists)" stated that Tuina belonged to one of the 8 treatment methods the "sweating method".

In Ming and Qing Dynasties, Tuina developed application to TCM paediatrics. "Xiao'er Tuina Wuanshu (Complete Classics of Infantile Tuina)", described the application of Tuina to children. There were also developments of specialised Tuina in Traumatology, ophthalmology, surgery and general healthcare.

Since 1959, Tuina has become a major subject in TCM education and training. There have been systematic studies on TCM Tuina classics. The application of Tuina has evolved with the modern time as modern technologies such as X-ray, ultrasound, electromyography, CT scan and MRI scan have been applied by Tuina practitioners in making diagnosis and treatment plans. An coherent education system has been established to tried Tuina practitioners alongside the TCM medical treatment in China's TCM medical schools. More scientific research has been done and scientific papers published in finding out how Tuina works.

2. Indications for Tuina Therapy

It is generally accepted that Tuina therapy can be used extensively in many diseases. Traditionally, Tuina is mostly used for conditions of TCM orthopaedics and Traumatology (Gu Shang Ke in Chinese). This means that Tuina is applied mainly to the musculoskeletal system. However, as described above, Tuina have evolved and the therapy is applied in TCM internal medicine, gynaecology, paediatrics, neurology and ENT. In recent time, Tuina has been used for weight control, cosmetology and general health maintenance.

It is therefore, impossible to have an exhaustive list of indications for Tuina therapy. In this paper, only the common conditions that Tuina can be applied in the UK are listed below:

Musculoskeletal system:
Stiff neck
Cervical Spondyloarthropathies

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Acute lumbar Sprain
Sacroiliac joint semi dislocation
Posterior articular disturbance syndrome
Chronic lumbar muscle strain
Degeneration of lumbar vertebrae
Lumbar disc diseases, Sciatica
Third lumbar transvers process syndrome
Scapulohumeral periarthritis
Subacromial bursitis
Tendinitis of the supraspinatus
Epicondylitis of the humerus (lateral – tennis elbow; medial – golfer's elbow)
Tenosynovitis (radial styloid process and other fingers)
Sprain of joints
Superior cluneal nerve injury
Ligament injuries of the knee

Internal medicine:
Neurosis
Gastric and duodenal ulcer
Chronic gastritis
Constipation and diarrhoea
Asthma
Headaches
Common cold
Essential hypertension
Obesity

Gynaecology:
Dysmenorrhoea, Amenorrhoea

Paediatrics:
Fever, Cough
Indigestion, Vomiting, Diarrhoea
Malnutrition
Night crying
Myogenic torticollis
Subluxation of the capitulum radii

3. Counter Indications and Cautions

Although Tuina is effective for many conditions (Xia et al 2014, Yang et al 2014), there have been reports of massage causing adverse effects, some serious, from various pain syndromes to ruptured uterus and peripheral embolization (Ernst 2003; Tak et al 2014; Chang et al 2015).

Any open soft tissue injuries, bleeding, fractures, skin infections and inflammations, disease with haemorrhagic tendency, internal organ injuries, acute infectious disease, critical illnesses such as diabetic crisis, heart, brain, liver and kidney diseases, women during menstruation, pregnancy and neonatal period are all counter indications of Tuina therapy. Tuina practitioners must know the red flag situations to prevent adverse incidents.

There are different opinions on using Tuina for some other conditions, particularly conditions that occur in sensitive areas of the human body, as to whether a practitioner should carry out Tuina therapy. For example, breast conditions such as mastitis, mammary nodules, prostatitis, incontinence, uterine prolapse and rectal prolapse. According to the Chinese textbooks, Tuina therapy can be used for these conditions.

It is essential that Tuina practitioners obtained explicit consent from their clients before carrying out Tuina therapy. In many circumstances a chaperon should be present when Tuina is carried out. It is unwise to tough any sensitive areas of the client.

In the past few years, there have been a few cases of complaints from patients who were given Tuina therapy by TCM practitioners. It is interesting to note that all the cases were not a specific condition that the patients had. They actually sought Tuina as a way for health maintenance or control their weight or to relax as they are stressed.

In these cases, the major allegation by the patients was the TCM practitioner who did the Tuina therapy "touched" the patients' sensitive areas, such the breast, the inguinal area and the genital area. Some patients alleged that the touches were of sexual nature and they reported the incidents to the police, resulting in the police taking actions and the cases going to court.

4. Summery

Tuina is one of the therapeutic procedures in Traditional Chinese Medicine (TCM). Its practice is guided by the fundamental TCM theory and based on the TCM's Jingluo system. Therefore Tuina practitioners must have solid TCM knowledge and experience. It is preferable that Tuina practitioners are qualified TCM practitioners. The major indication for Tuina is in the field of musculoskeletal disorders, although it can also be used in TCM internal medicine, gynaecology and paediatrics.

The Counter-Indications of Tuina must be taken into consideration when practicing Tuina. Cautions must be taken, especially if the patients have disorders in the "sensitive" parts of the body. Consents must be obtained before any Tuina treatment is carried out, and a chaperon should be present in the patient requires. Patient's modesty and dignity must be carefully protected in Tuina practice.

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ATCM微信群讲座汇编

编者按：*应会员们的要求，ATCM理事会决定于今年六月开设了学会的微信群---ATCM会员学术群 （原名ATCM官方微信群，八月间接受大家意见更改为现名）。本群是专门为ATCM的会员而建立的（因语言限制，仅适用于讲中文的会员），非会员不得加入。在建群的短短三个月内，已有两百余位会员入群。 本群突出以学术交流为主，同时促进会员之间的信息交流和沟通，兼顾联络感情，调剂生活和娱乐休闲。许多会员在此交流中医中药和针灸推拿等临床经验和病例讨论等，以及由学会安排的专题学术讲座等，使得本群已然成为ATCM及其会员的一个重要和便捷的学术交流平台。会员中许多有一技之长的大夫们，不辞辛劳和毫无保留地向大家介绍经验和咨询答疑，如王迎医师介绍的极浅刺制热制冷特殊针法，吴继东医师介绍的浮针疗法，祝柏芳医师的皮肤专科讲座和不厌其烦的皮肤病答疑等等，使会员们普遍感到获益良多，从中学到许多东西。本刊在此发表以下几个讲座和病例的文稿，并向几位主讲人表以感谢和敬意。ATCM理事会号召会员们积极参加这个会员群，相信您一定会从中受益。您可以直接联系学会秘书王剑霞女士（微信号ATCM-OFFICE），以便被邀请入群。*

哮喘病的中医药防治与体会

邹金盘

各位老师，各位同仁大家晚上好!我是邹金盘，首先请允许我衷心感谢学会的盛情邀请精心安排。我今天汇报的题目是：哮喘病的中医药防治与体会。

这个题目有点大，由于时间和形式的限制，所以我想今天定位在学术沙龙，学术探讨的层面，将分以下三部分进行展开，总占用大家时间35分钟. 1.概述部分; 2.中医中药防治哮喘还有用武之地吗？ 3.中医中药是如何认识防治哮喘的。内容中将有一个好消息，两个首次公开提出的新概念与大家分享。

概述：

1.流行病学：2014年WHO发布的统计数字，全世界有超过3亿的哮喘患者，其中成年人中发病率为8%左右，18岁以下儿童青少年发病率为9%左右。近年来哮喘患病率及死亡率仍有上升趋势。在英国哮喘病也是常见病多发病，是青少年缺课的第一原因。每天有3个哮喘病人死亡，但是如果预防好了其中有2个是可以免死的。

2. 1995年始WHO 及NIH(美国国家卫生研究院）共同组织专家撰写《全球哮喘防治创议》简称（GINA)。此后每二年修改一版，其核心内容就是规范哮喘病阶梯式的药物防治方案，同时强调哮喘病人及其家属需要健康教育管理的重要性（换句话说就是病症控制不理想病人与家属也有很大的责任）。最新的2014年版的GINA总结有两个重点：分别是有关阶梯的药物疗法小有改动； 另外就是提出了要重视治疗方法的多样性，不同文化认同，不同的保健方法需要加以考虑。

3. 一个好消息：宣告哮喘病人是可以治愈的。原来是“内不治喘，外不治癣，治喘治癣，大夫丢脸”，谈喘色变，很多患者是生活在没有治愈希望，必需终生用药的错误观念下。近年医药学术界达成共识：哮喘病是可防可控的，哮喘病人是可以治愈的。条件是患者必须坚持正确有效的综合预防和治疗措施，就可以使症状完全消失，像健康人一样的正常生活。

4.世界哮喘日（WORLD ASTHMA DAY)定在每年五月的第一个星期二。

形势这么好，那么用中医药防治哮喘还有必要吗？我的回答是：有！中医药综合疗法防治哮喘大有作为。

为什么中医药防治哮喘大有作为？

1. 哮喘病防治两大主力西药（β2受体激动剂和激素），虽然使用方便，品种丰富，战术多样，但存在严重战略不足：其中一个来源于中草药麻黄。1926年美国Merck制药公司根据当时广泛使用麻黄止喘经验，首先成功地合成了的麻黄碱，广泛用于临床哮喘病的症状控制，经过不断改进成了今天哮喘病人人必备的各种作用于β2受体的气雾剂。

这一思路可以追溯到2000多年前的《神农本草经》记载“麻黄平喘”, 和张仲景《伤寒论》多个含麻黄的治喘方剂。麻黄碱单味主药的作用明显，但是方剂优势丧失了啊。正所谓双拳难敌四手，看过《神雕侠侣》的也许记得：在绝情谷中，东邪+南帝+老玩童完胜金轮法王，而论单打独斗的话，恐怕任何一个也不是金轮法王的敌手。另一个十分重要药物是可的松（联同其衍生物，现在统称激素Steroids)。1949年在美国Mayo Clinic 工作的Dr. Hench, Dr. Kendall首次公开其研究成果合成药－Cortisone，并且获当年Nobel Prize。当时Dr. Hench的研究探索受启发于一个病人告诉他的一个奇怪现象：该病人突然患黄疸病，随之而来的是严重的风湿性关节炎所致的慢性关节红肿疼痛明显消失了。还有就是有的病人怀孕后炎症性疾病可以消失。提示了人体自稳自愈是有内在物质基础的。

虽然目前实现了“哮喘病可防可控”，但奇怪的是哮喘病的发病率和死亡率在全球范围内仍是上升的趋势。这就值得人们去深入反思。激素发现并应用于临床已近70

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年了，时至今日，还有很多问题有待探索。1950年英国风湿病专家Dr. Oswald Savage慕名私访Dr. Hench，看到他获诺奖也很不开心，私下请教他为什么？Dr. Hench说：“这不是什么神奇万能的，用就有效，不用就复发，而且长期大量使用后副作用太严重，后果不堪设想。”

2. 当前全球对哮喘病概念的共识是：哮喘病是多细胞多因子通过多途径参与的导致气道慢性变态反应性炎症改变而引起的疾病。气道慢性炎症是多种原因共同参与的结果，但反过来又是临床症状的原因。内在脏腑功能平衡才是药物治疗的终极目标。人体内分泌是个复杂的大系统，只是单纯从体外补充肾上腺皮质激素是远远不够从根本上消除气道炎症而治愈哮喘的。所以可以说主流医学在提高哮喘病临床治愈率方面还是有很多的力不从心。

3. 中医药防治哮喘已积累了2000多年的临床经验，中医临床治疗立法既强调共性，也重视个性。治疗措施也有途径手段的多样性和其不同组合的灵活性。实现调理脏腑，平衡阴阳，疏通经络，激发经气，活血化瘀，内病外治，冬病夏治，治未病的思想已经显现出优势，这都迎合了当今哮喘高效防治需要结合中医药综合措施的迫切性和必要性。

中医如何认识防治哮喘病

新形势下我们首先提出哮喘防治3P新战略（P+P is the best way of P）和新战术：APEC疗法。

P (puff：哮喘防治气雾剂) + P (patche：消喘膏穴位外敷，外治) is the best way of P (prevention：预防)。
APEC疗法：是针对哮喘病和其他一些常见慢性难治病，为了促进康复，提高临床疗效，需要有一定临床经验的医生根据病人具有情况，择优有序选用的中医外治法组合。A (Acupuncture:针刺)，P (patche:穴位外敷中药)，E (Exercise包括调神调息的运动，如呼吸意念气功)，C (Cupping:包括背二区，被肩区和短裤区的平衡拔火罐，又叫脊督火罐)。

1.中医如何认识哮喘病

哮病是由于宿痰伏肺，遇诱因或感邪引触，以致痰阻气道，肺失肃降，气道挛急所致发作性的痰鸣气喘。发作时哮鸣有声，呼吸气促困难，甚则喘息不能平卧为主要表现。

历史沿革：
《内经》时称本病为“喘鸣”，“喘呼”，“喘喝”。汉代张仲景《伤寒论》“喘家作，桂枝加厚朴杏子佳”。《金匮要略》“咳而上气，喉中水鸡声”。宋代王执中的《针灸资生经》出现“哮喘”之病名：“因与人治哮喘，只缪（刺）肺俞，不缪（刺）他穴”；“ 凡有喘与哮者， 为按肺俞无不酸疼，皆为缪刺肺俞，令灸而愈”。金元时期的朱丹溪在《丹溪心法》中首先以“哮喘”作为独立的病名成篇，而且确定了本病的施治要领。明代虞抟《医学正传》进一步对哮与喘作出了明确的区别：“喘以气息言，哮以声响言，夫喘促喉间如水鸡声者谓之哮， 气促而连续不能息者谓之喘”。后世医家鉴于哮必兼喘，故一般通称哮喘。但是喘未必兼哮，为与喘证区分，最新中医内科教材改为哮病。

2.历代医家对哮病病因病机的探讨
① 邪气入肺：清代叶天士“宿哮，沉痼之病， 寒入背腧，内合肺系，宿邪阻气阻痰。”
② 伏饮痰浊：如张仲景，朱丹溪等都认为哮病反复发作的主要病理因素是“痰”。“脾为生痰之源，肺为贮痰之器，肾为痰病之根”。张仲景的小青龙汤，射干麻黄汤至今仍为治疗哮病的常用方。
③ 情志内伤：如明代赵献可说：“或七情内伤， 郁而生痰，一身之痰，皆能令人喘”。
④ 瘀血内阻：如清代唐宗海《血证论》：“盖人身七道，不可阻滞，内有瘀血，气道阻塞，不得升降而喘”。
⑤ 饮食不节：贪食生冷，或嗜食酸咸，或进食鱼虾等发物。
⑥ 先天遗传：如许叔微说：“此病有苦至终身者，有母子相传者”。
⑦ 多种病因相合论：清代李用粹《证治汇补》把哮病的病国病机高度概括为“内有壅塞之气，外有非时之感，膈有胶固之痰，三者相合，闭拒气道，搏击有声，发为哮病。”已更接近了哮病的实质。

关于哮病的宿根说：明清近代医家多推崇朱丹溪“哮喘专主于痰”之说。而近年通过实验研究，瘀血为宿根说较为盛行。

3.哮病的辨证分型论治（中药）
辨证要点：分清寒热虚实，脏腑阴阳。注意多有兼杂。
治疗原则：发时治标，平时治本，或标本兼治。

分型论治：
发作期
①寒哮：主症+渴喜热饮，天冷受寒易发，形寒舍怕冷，舌苔白滑，脉紧。
治法：温肺散寒，化痰平喘。
方药：射干麻黄汤，小青龙汤，杏苏散，苏子降气汤。
② 热哮：主症+咯痰色黄或白，粘浊稠厚，烦闷不安，面赤口苦，舌红苔黄腻， 脉弦滑或滑数。
治法：清热宣肺，化痰平喘。
方药：定喘汤。
③气郁哮：主症+胸胁胀满，心中懊恼，发病与情志或月经有关，苔薄腻， 脉弦。
治法：疏肝理气，降逆平喘。
方药：四逆散加苏子，前胡。或黛蛤散合泻白散。三子养亲汤。
当哮喘出现持续状态或大发作时，要谨防喘脱和内闭外脱，应及时抢救。

缓解期：
①.肺虚：气短声低，咯痰清稀，平素怕风，常感冒，每因气候诱发，发作前喷嚏频作，鼻塞清涕，舌淡苔白，脉细。
治法：补肺固卫。

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方药：玉屏风散加味（如桂枝，白芍，姜枣，制附片等）
②.脾虚：平素倦怠乏力，食少便溏，每当饮食不当诱发，面色萎黄，舌淡苔薄白，脉细。
治法：健脾化痰。
方药：六君子汤加制附片，干姜。
③.肾虚：平素短气息促，动则益甚，吸气不利，腰酸腿软，劳累后易发，畏寒肢冷，面色苍白，舌胖嫩，脉沉细。或颧红，烦热，舌红苔少。
治法：补肾摄纳。
方药：金匮肾气丸或七味都气丸。

4.中医外治优势序通法防治哮喘
原理：体表－脏腑相关论。通过激发经气（主要是卫气），调理脏腑，平衡阴阳，疏经通络，活血化瘀。使得“正气存内，邪不可干”。
理论依据：《灵枢本藏》：卫气者，所以温分肉，充皮肤，肥腠理，司开合者也”《素问痹论》：“卫者，水谷之悍气也，其气慓疾滑利，不能入于脉也，故循皮肤之中，分肉之间，熏于盲膜，散于胸膛，”指卫气运行于脉管外的分肉间隙，也似已感应到T细胞免疫体系等产生部位，“盲膜”疑是指胸腺等中枢免疫器官。
具体手段如下：
1.针灸：常用穴位有素髎，天突， 孔最，定喘，膻中，足三里，气海，血海，太冲，丰隆，太溪。要求做到针针得气，每个病人必须出现至少一次循经感传，或者出现气至病所。重要的手法是烧山火，和浅刺多捻，还有王迎介绍的下压上挑。
孔最穴手法分二步：下传至拇指，上传至病所，立刻止哮平喘。
平时多多艾灸肚脐，艾灸背二区。

2.消喘膏穴位外贴法（这个多次在中央电视台作过现场直播，请感兴趣的同道参见我上传的链接）。
3.通脊火罐法（这个也多次在中央电视台作过现场直播，请感兴趣的同道参见我上传的链接）。
4.儿童可用手指四缝穴挑积法和背部捏脊法。

最后也是最重要的是强调医生要想成为治疗哮喘病的高手必须全面掌握中西医关于哮喘病诊断，病情判定，防治与急救等知识与技能。否则诊疗失误，一口痰上不来会憋死人的！

中医治疗 IBS 的临床体会

张超
Manchester， UK

Irritable bowel syndrome 简称 **IBS**， 就是我们常说的肠道易激综合征，是一种以慢性腹痛，腹部胀满不适和排便习惯改变为特征的肠道功能紊乱性疾病，没有已知的可解释症状的解剖学的改变和生化异常。流行病学调查显示，IBS 在英国同一年龄组的发病率是 1：5，女性多于男性，男女之比大约是 1：2。
现代医学认为 IBS 的病理学基础是胃肠动力学改变，内脏感知异常，与肠道感染，抗生素的滥用，肠道菌群失调有关。

IBS 属于中医学胃脘痛，腹痛，便秘，泄泻等范畴，其发病多由于情志失调，肝郁气滞，克脾犯胃或情志所伤，损伤脾胃，致脾胃运化失司，升降失常而发病。病位在胃肠，涉及肝，脾，肾。

IBS 的辩证分型，各家报到不一，从 2 型到 8 型不等，比较繁杂，容易混淆。为了便于操作和掌握，在临床工作中我把它分为三型：实热型，虚寒型，虚实寒热错杂型。

1，实热型：

辩证要点：大便秘结，或数日一行，腹部胀痛，按之痛甚或可左下腹结块，拒按伴烦躁焦虑，口干泛酸，舌质红，苔黄少津，脉弦数。

辩证分析：本病的”实”主要是肝郁犯胃，本病的”热”主要是郁久化热, 因而”实热证”的主 要病机特点是”肝胃郁热”。

治则：疏肝理气，解郁清热

方药： 化肝煎合麻仁丸

加减： 1）兼有湿热而见胸闷不舒，腹痛，大便泻而不爽，肛门发热者，可合用葛根芩连汤；

2） 若是胃热津亏，而见胃脘部发热，大便干而不爽，舌质红少苔，脉细数者，可合用玉女煎；

3） 若泛酸明显者，加左金丸；

4）若单纯的肝郁气滞，化热不明显，无大便秘结者，用五磨饮子合柴胡疏肝散；兼胸胁胀痛者加金陵子散。

2，虚寒型：

辩证要点：大便溏泻或可见便秘，腹部隐痛喜按，得温则减，伴食少纳差，疲乏无力，畏寒肢冷，舌质淡或胖有齿痕，苔白或黄而水滑，脉弦细弱。

辩证分析：本症的”虚”主要是指脾胃虚弱，中气下陷; 本症的”寒”，主要是指脾虚及肾，脾肾阳虚。

治则：健脾益气

方药：参苓白术散加减

加减：1）若腹痛喜按，畏寒便溏者，合理中汤；

2）若中气下陷而见便溏或便秘，疲乏无力，头晕耳鸣，寸脉小而尺脉大者，合补中益气汤；

3）如为痰泻而见脘腹满闷，大便溏泻，带有白色粘液为特征者，用平胃二陈汤加桔梗，枳壳，防风；

4）若脾虚及肾，清晨腹泻者合四神丸。

5）若是肝郁脾虚，肝脾不和而见腹痛即泻，泻后痛减，常因情志因素而诱发，伴少腹拘急，肠鸣矢气，胸胁胀满窜痛，用痛泻要方和柴胡疏肝散。

3，虚实寒热错杂型

辩证要点：腹泻便秘交替发作，大便粘稠，腹胀肠鸣，心下痞满，胃中不和，呕而发热或口苦，口臭或畏寒肢冷，大便泄泻，舌质暗红，苔白或腻，脉弦细或滑。

病机分析：本病的病机特点是胃气虚弱，寒热互结或上热下寒，气机不利致肠道传化功能失调而发病。

治则：辛开苦降，健胃和中，温补脾肾

方药：1）以胃上消化道症状为主者，用生姜泻心汤合二陈汤加减; 伴泛酸者加栀子，吴茱萸。

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2）以腹痛泄泻，肢冷等胃下消化道者，用乌梅丸去附子，细辛合二仙汤。

小结：

1， IBS 为临床常见病和多发病，现代医学对本病的治疗常常是对症处理，但由于药物的副作用和长期依赖性，使患者无法接受。但中医学对本病的治疗有其独到的优势，辨证施治是中医学治疗本病的基础。

2， 在临床工作中，要重视 IBS 的胃肠道外症状，如头痛，失眠，烦躁，疲乏无力等，有部分患者常常是以这些胃肠道外症状为主诉就诊。但确定这些是 IBS 的伴随症状时，我们要按 IBS 的方法去治疗，常常会收到较好的疗效。

3， IBS 的便秘可见于实热症也可见于虚寒证，要认真辩证分析，否则一味的清热泻下，常常会犯虚虚实实之戒。

郭氏~李氏皮膜极浅刺制热温阳和制凉泻热针法

王 迎 英国

各位老师，朋友，大家好。今天我要讲的是郭松鹏和李玉洁两位老师发明的新针法，皮膜极浅刺制热温阳和制凉泻热针法。这套针法是两位老师在研究传统的针刺手法“烧山火，透天凉”的基础上，从皮膜结构入手，对机体的凉热反应，进行了全面的原理分析以及经过大量的临床实践之后而发明出的新针法。具有微痛无创，可以补虚泻实，平衡阴阳的特点。

今天我要谈的主要内容有两大方面
第一，具体的谈一谈两位老师对传统的针刺手法烧山火透天凉的研究过程，以及如何从人体的生理结构和功能上来阐述这两个手法作用机理的。
第二，具体的介绍郭氏~李氏皮膜极浅刺皮内制热温阳针法和制凉泻热针法是如何操作的。

一 烧山火和透手法的生理机制探讨

1 经典回顾/ 传统的烧透手法是如何操作的

《金针赋 》

一曰烧山火：治顽麻冷痹，先浅后深，凡九阳而三进三退，慢提紧按，热至紧闭插针，除寒之有准。二曰透天凉：治肌热骨蒸，先深后浅，用六阴而三出三入，紧提慢按，徐徐举针，退热之可凭，皆细细搓之，去病准绳。
传统的烧山火透天凉手法教科书里都有详细的描述。一般都是分天人地三部逐层做手法。这里我就不浪费大家的时间了。

这里我要重点提的是，近代还有多针灸大家的改良烧山火，透天凉的手法。如焦勉斋，陆瘦燕，周树东，周眉生，彭静山，刘柄权，张鹤一，楼百层，管正斋，郑毓明，郑魁山，李志明，李世珍等针灸前辈。这些前辈根据自己的临床经验分别对传统的手法做了不同的改进和发挥，如从医患的呼吸补泻，提插补泻，左右捻转，69 阴阳之数，开合补泻，以及滞针等方面进行了改进和发挥。使临床中烧透的成功率大大的提高，值得我们敬佩。

大家都知道，传统的针刺复式手法烧山火，透天凉，因其神奇的临床效果而被历代针灸大家所推崇。但是烧透手法，另一方面却因其复杂模糊的描述，让我们普通的针灸医生往往不能依法重复做出！这也是传统的烧透手法不能大面积推广的原因。
为什么针灸会引起身体的凉热反应？烧山火透天凉手法的生理机制到底是什么？这个问题，在开始的时候，同样也困扰着两位老师。

2.两位老师的研究过程

在这里，我特别提的是李玉洁老师出国前是一位做手术的西医妇科专家，出国后，才改学中医。一次，当她看到别人在网上对“烧山火”和“透天凉”的描述后，感到很奇妙，就在网络里搜了一下相关文章，用她的话来说：“一看就把我搞蒙了，那么复杂”！但她还是坚持按书上讲的在病人上试着操作，可几周下来根本就没有做出，后来，一个偶然机会，由于一个病人怕针怕痛，她就在皮肤上轻轻的针刺穴位，没有想到病人说”有全身热的感觉”，她不由得眼前一亮。极浅刺皮肤竟然可以做出烧山火的效应！

后来在使用脐针的过程中，她又发现针尖轻压或者上挑皮肤，竟然也出现了热和凉的效应。

皮肤与经典烧山火和透天凉手法到底有什么关系？
是不是三部的“烧透”手法奥妙就在皮肤呢？

为了揭示烧透的秘密，两位老师在研究传统的烧透手法的基础上，做了大量的临床观察。终于在不断的验证传统的烧山火和透天凉的整个操作过程中，发现了传统的三部针刺法也是要通过皮肤来进行的，皮肤是两种针法不可逾越的一层，于是他们的着眼点集中到了皮肤上面。

皮肤做为我们身体的第一层膜，我们先来谈一谈皮肤的构造(如图)

皮肤分为表皮、真皮和皮下组织。皮肤上也存在有毛囊、竖毛肌、指甲、皮脂腺、汗腺等附属器官。皮肤的厚薄因年龄、性别、部位等因素而异，人体皮肤最后处是 4mm, 一般在 0.5~2mm 左右。通常眼睑部位的皮肤最薄，而手掌脚掌处最厚。
(1) 表皮

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表皮厚度约为 0.1～0.3mm,由外而内可以分为五层，最外层是角质层，厚度约为 0.014～0.02mm,最外层的陈旧角质累积一定厚度后，会形成皮垢而脱离。角质层提供表皮基本的防护、防晒、保湿等功能。

(2) 真皮

真皮层包含骨胶原、胶原蛋白及玻尿酸等三种重要成份。骨胶原形成 95%的皮肤细胞，主要是构成真皮细胞网层组织，胶原蛋白维持皮肤弹性，玻尿酸保持皮肤水份。真皮内的毛囊，可以生出毛发，竖毛肌可以控制毛发矗立。皮脂腺分泌皮脂，防止水分蒸发。真皮内还有感觉细胞，感受器，例如触觉感受器，轻压力感受器，重压力感受器，等等。还有不少汗腺，这些是调节体温的非常重要的构造。

(3) 皮下组织

在真皮层之下为皮下脂肪层，具有保存体温和对外力的缓冲功能。

3 人体发热发凉的机制

通过皮肤的构造，二位老师发现针灸可以产生凉热的原理:就是各层的皮膜结构，末梢神经，特异位点，压力感受器，温度感受器，皮肤温度自主调节，大脑温度控制中枢调控，针刺信息传输，等人体功能的协同效应。其中压力感受器，皮肤温度自控和大脑体温控制中枢是产生局部热凉和全身热凉效应关键。

下压，触及皮肤表皮或真皮，激起压力感受器或温度感受器等膜点感应， 信息经整合传入。在大脑中枢或外周多机制共同协同下而出现了产热或热感。

上提(或上挑)的作用机制正好与其相反，故产凉而出现凉感。

回过头来，我们再仔细体验领会传统的烧山火，透天凉的描述“紧按慢提，慢按紧提”。

a. 烧山火，紧按是加强下压力，利于产热，慢提则是尽量减少外拉力，避免产凉。

b. 透天凉，紧提是加强外拉力，利于产凉，慢按则是尽量减少下压力，避免产热。

三层皆经过皮膜，各层皆存在皮膜。经典秘密就在这里。这也是第一次，我们针灸人用现代的语言，用简单的人体生理现象，破解了烧透手法的秘密！

下压产热，上提产凉，其实在郑魁山郑老的烧山火透天手法里已经有下压产热，上提产凉的影子在里面。但郑老并没有明确的提出来。

两位老师曾谦虚的说自己的发现是站在巨人的肩膀上。但又有谁知道，这个发现是通过上千人次的临床试验总结验证出来的呢！如果不是他们无私地公开自己的研究发现，对于我们普通医者来说，烧透手法永远都是一个谜！

《内经》中的卫气学说，说明我们古代贤人对皮肤的重要性早有认识，遗憾的是，几千年来，一直保持《内经》原样，我们后学者没有做进一步发展，没有从“术”的层面上进一步把握皮肤的功能和应用。

其实，中医和西医对皮肤的认识都不是特别全面，基于针灸临床的许多现象，皮肤应该有另外更重要的功能。于是两位老师在揭示了传统的烧山火透天凉手法之所以产生热凉的机制之后，又提出了腧穴的四层皮膜概念，并且创造性的发明了数种制热制凉针法。

腧穴的四层皮膜概念，就是在传统的三层天地人的基础上，又提出了极浅层的理论。

4 腧穴的四层皮膜概念

穴位为立体，除浅薄部位外，按照《郭氏-李氏皮膜元论》和经典三层分法，一个标准穴位，可大体分为四层。

a. 极浅层

(表皮和真皮间， 0.2-2mm)

b. 浅层 （天部， 腧穴 上 1/3）

浅皮膜层，2-4mm。

c. 中层 （人部， 腧穴中 2/3）

深膜, 5-60 mm 不等。

以上三层，因部位不同，针刺的深度也不同。

d. 深层 （地部， 腧穴 下 1/3）

深近骨膜，或达骨膜。

在大家了解了腧穴的四层皮膜结构之后，我们就开始谈今天要讲的主要内容

二 皮膜极浅刺皮内制热温阳针法和制凉泻热针法的原理及六种操作方法

另外还有皮膜浅刺皮下制热制温阳针法和制凉泻热针法只是针刺深度的不同，我们今天就只以皮膜极浅层为例，展开论述郭氏-李氏制热温阳针法和制凉泻热针法，共分为六种。

1. 极浅皮内制热温阳法

单手持针，缓慢进针，于极浅皮内即可得气，针的深度以得气为度。

a. 单纯下压法

针尖保持在感应原位，用力下压，皮肤下陷，既保持压力，又不使针体和针尖进一步深入，候热至。

b. 顺时针捻转法

针尖保持在极浅感应原位，顺时缓慢捻转，候热至。

c. 捻转下压法 ： 针尖保持感应原位，顺时捻转, 并同时下压，这种结合手法，可提高制热成功率。

2. **极浅皮内上挑制凉泻热法**

单手持针，缓慢进针，于极浅皮内得气，针之深度以得气为度。

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a. 单纯上挑法
针尖保持在得气感应原位，拇中指做上挑动作，至皮肤出现小皮丘，持续上挑，候凉至。

b. 单纯逆时针捻转法
针尖保持在得气感应原位，缓慢逆时针捻转，候凉至。

c. 逆时针捻转上挑法
针尖保持感应原位，逆时针捻转，轻轻上挑。这种结合手法，
可提高制凉成功率。
关于这几个手法，大家可以课后仔细看一看我们上传的手法视频。

下面我就举几个例子。

1 这是李玉洁老师治疗的一个病人
患者 女 1974 年生,花粉症多年，对草种敏感，7-9 月份为重。双眼发胀，充血，干涩。鼻塞轻。草莓舌，尖红，脉左沉，右脉浮。
肺反射区压痛
取阴陵泉 ，行极浅刺制凉泻热法。5 分钟后双眼发胀，干涩的感觉消失。肺反射区压痛消失。病人很惊奇

2 我的一个病人，患者因行子宫卵巢切除术多年。感潮热出汗。自述面部有红色皮疹。因化妆未见，平时易着急躁热。伴胃脘胀痛。检查上腹部压痛。舌暗红。苔后面薄黄。取太阴阳明回环，极浅刺后，在 4 个合穴，印堂行持续制凉泻热法。下针后立感胃痛消失，按压也不痛了，并感觉 calm 舒适。留针 40 分钟。起针前，患者述已经感到全身凉爽舒适。说过去在别处针灸从没有体会到针灸可以让她凉爽！

3 一个腰痛伴左侧坐骨神经痛的男病人。病人仰卧在床上，我先取的是右侧的大叉穴，运用极浅刺制热温阳手法，一会儿病人就感腰部发热。接着我又取了左侧膀胱经的原穴京骨穴，再施制热温阳手法。患者立刻感觉到热由下沿膀胱经而上到达腰部，与腰部的热融为一体，非常舒适。立刻疼痛减轻。一共治疗了 6 次，再无任何疼痛不适。

我在各个微信群发现，许多朋友都在学习和使用大叉穴，但大多数人都是报道的出热感。其实也是可以出凉的。就是这个病人腰痛好了之后，又告诉我，还睡觉打鼾。于是我就取了大叉，下关，印堂。用制凉泻热手法。不一会儿就感前额，鼻子区域凉爽舒适，然后就在诊室里睡着了。治疗结束后问他的妻子，高兴地说，鼾声教其前明显好转。

4 一个双手指有湿疹裂口疼痛的病人，当时，我取了双侧董氏奇穴的制污，木穴。和肺经的鱼际，大肠经的曲池穴。我在曲池穴做的制凉泻热手法，凉感由肘传至手指，患者立刻就感到手指疼痛减轻，活动好转。一共治疗了三次，皮损就基本好转了。

另外在浅层，极浅层的针刺过程中，我们还发现了一些有趣的现象，同大家说说

a 在同一病人身上，可以同时做出热凉效应。

我有一个脑瘤术后的女患者，左眼视物不清伴右足下垂。并且还有高血压病史。我当时扎的脐针的坎离两针，水火济及。在坎位我用的是制热温阳的手法，患者感热自髋部沿胆经下传至外踝，并上传至又肋下。在离位我用的是制凉泻热，左脸及眼部感凉。患者非常舒适。

当时美国的陈靖老师看了我的这个手法视频后，曾赋诗一首:
精妙绝伦出岐山，神手经天坎离间。
阴阳一轮才升起，为何冰火两重天！

为何冰火两重天？这个问题问得好，其实人体凉热的产生，虽然大夫的手法非常重要，但是人体的自我调节机制，人体的自稳定系统更重要。因为患者的病症是虚实加杂，所以才会凉热同时出现。

b 在同一穴位上，使用不同的手法，可以做出凉和热

李玉洁老师曾经在我们针灸梦工厂报道了这样一个病例
2015.04.21 18:29.26。**今天 在一个敏感人的水泉穴上我实验了六种制热制凉方法。以皮下约 0.5 针深 有针感后进行。**
在 1 分钟左右 瞬间改变手法，让她产生制凉制热感。结果 多次重复 病人一会儿热 一会儿凉，反复做了接近 10 分钟。
我的针如按钮。

c 当针灸过程中病人出现感觉不适，病灶区症状加重时，可以立即改换相反手法而获取佳效。

我曾经治疗过一个男病人，双侧曲鬓，耳门，听宫穴疼痛。以左侧为重。患者舌暗红苔薄黄，脉结代。伴有高血压。我取了双侧的然谷，太冲，足临泣。第一次用的制凉泻热手法，疼痛明显减轻。第二次就诊时，右侧只剩轻微疼痛，左侧只有曲鬓，耳门疼痛。又说有 anxiety. 所以仍然取双侧的然谷，太冲，足临泣。制凉手法，述感觉疼痛减轻。但当我取神门穴制凉，想镇静安神的时候，患者突然感到疼痛加重。 我意识到可能是手法有误，于是改为制热温阳，疼痛立刻缓解。之后的治疗中均采取制热温阳法。一共治疗 4 次全部疼痛消失。

d 制热反凉的现象。其实这是身体排寒的过程。如果多针几次。身体就会逐渐的热起来了。

下面是澳洲李晓宁医生报道的一个病例。
患者 65 女, 西人,腰部沉滞闷痛就诊, 命门双制热, 热感传至膝关节,纵深向前。平卧后 关元制热腹部通透热感。舒适 。二诊自诉,周身较以前舒适,不那麽怕冷了,膝足部仍冷, 再用关元毫针,双太溪制热, 配大叉,这次有趣,热感直达小腹,上至胸口, ,之后冷热波浪式交替约 20 多分钟, 曾试图从脚排,未果,最后从另一只未扎针的

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右手排出。自觉热自内发,舒适。冷感最有趣的是,从足底沿着背部脊柱上升,患者形容如躺冰床。

为了大家能够更好的理解这两类手法，需要注意如下事项:

(1) 在上述两种针法里面，我们还是保留了传统的顺时捻转产热为补，逆时捻转为泻的理论

(2) 感应原位，就是缓慢进针过程中最先得气的那个穴位点。

(3) 为了更好的将针尖固定在极浅层皮内的感应原位，初学者可以结合使用滞针，涩针手法。

a. 滞针手法
在感应原位，食指拇指同一方向轻轻捻转针柄一到二次，使针尖缠绕，滞在皮内，下压时，针尖有对抗力。

b. 涩针手法
在感应原位，轻轻捻转针体，至旋转时有阻力感，即，针与皮肤产生摩擦阻力，紧涩感。

滞针和涩针的目的就是为了固定针尖，有利于保持针尖在针感原位，防止用力过大，造成穿透感应点和皮肤。滞针和涩针手法与产热产凉无直接关系。

(4) 这两套针法，做为现代版的凉热针法，大家可以应用在任何古典烧透手法的治疗范围。

(5) 这套制热制凉针法还有一个最大的特点就是容易操作，不是用气功，不是用意念。

(6) 成功的出凉出热，还与施针者对针法的理解和操作的熟练程度直接相关。因为不能面授，初学者需要一定的熟悉时间, 坚持几个星期，您会有更多收获，成功率会提高。

(7) 另外，对于这套针法，其更高层次的效应是平衡阴阳，制热温阳就是兴奋，制凉泻热就是镇静！只要我们做手法能够达到这个目的，就算是成功了。不一定非要强调有热和凉的出现。

3. 制热温阳针法和制凉泻热针法的原理

为什么会在这么浅的部位能够产生凉热感呢？
皮肤温度的热凉变化与皮肤微血管床血液灌注量有直接的关系。微循环由微动脉和微静脉构成，在微动静脉上有交感和副交感神经末梢。针尖下压和上挑产生的力学变化作用在皮肤内压力和温度感受器，产生皮效应，信息经整合传入，在大脑体温中枢和外周交感和副交感神经多机制协同作用下，微循环血液灌注增加或者减少，所以出现热凉感觉和局部或者全身体温的改变。
实际上针刺特殊手法诱发人体产生的体温变化的机制还存在许多疑问，从中医理论和现代医学两种角度，对此做深入的研究将有十分重要意义。

这是第一次两位老师让人们从模糊的皮肤卫气理论:气聚则热，气散则凉。变成了人人都能够懂得的人体生理功能。
大家可记住下面十六个字:

下压产热
上挑产凉
顺转产热
逆转产凉

两位老师的针法，没有神秘难懂的理论，也没有花哨复杂的动作！用一句话来形容就是:
浅刺皮肤，制热制凉，阴阳调整，易如反掌。而所有的这一切都发生在我们的针尖之下！
左常波老师曾经说过，"世界之大，莫若眼界之宽，眼界之宽，莫若针尖之精微"!

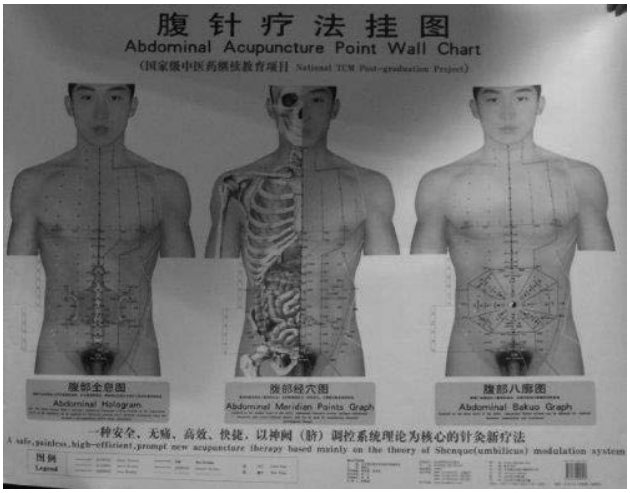
当然，在临床中，非常敏感的病人，你不用做手法，他就会自动的产热产凉或出现其他感传现象，气至病所。大多数的人，则需要我们用手法来轻轻地推他一下。但是我们也不否认，有大约 10%多病人针灸无效。你怎么扎也没有反应。

条条大路通罗马，针灸也是这样，今天我之所以要把两位老师的针法介绍给大家的主要原因。就是希望大家都能够多掌握一把打开穴位密码的钥匙。

腹针临床体会

朱红艳

（编者注：本文来自“英国中医群”，由作者投稿。）



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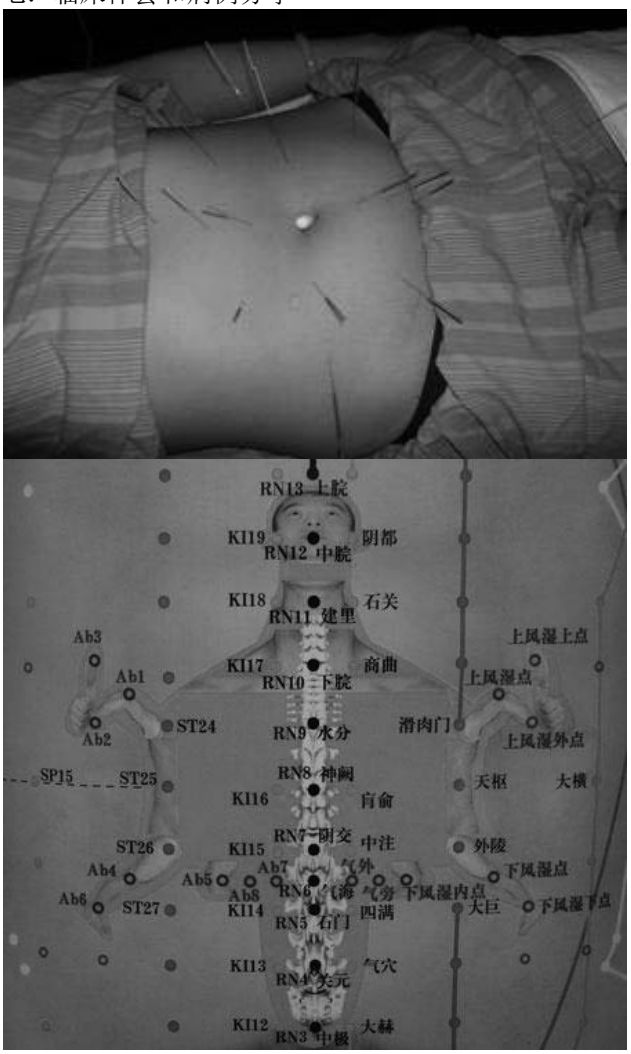

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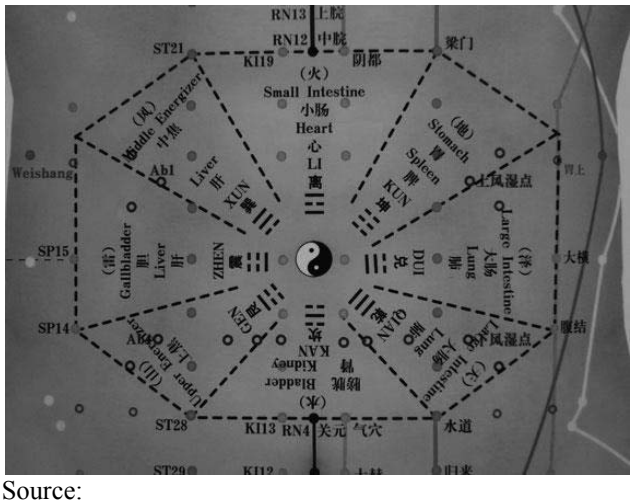

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一．腹针的起源

1972 年，腹针发明人薄智云教授在偶然的针灸临床工作中，针刺腹部气海关元穴治疗急性腰痛出现神奇疗效，引发了他对腹针的极大兴趣，他开始了对腹针的研究，并惊奇的发现腹针临床疗效的快捷，超出了人们的想像。

二．腹针的理论根据

薄教授经过 21 年的艰辛努力，提出了“神阙经络调控系统”，不仅是腹针疗法的核心理论，也与世界上科学家们所提出的腹部是人体的“第二大脑”的论述所共识，西方的医师感叹：“美国的科学家才提出腹部是人类的第二大脑，中国的医生连控制第二大脑的方法都研究出来了，中国人真聪明。”

腹针的理论很长，相信大家都能在网上查到，这里不再赘述

三．腹针的优势：无痛，安全，高效

无痛或微痛是腹针最大的一个优势，因为腹部的疼痛比较弥散，一般对疼痛并不十分敏感，有些时候虽然腹部有疼痛的感觉，但疼痛的部位经常是模糊的，因此，对于疼痛的反应比较迟钝，主要是腹部没有大的神经干和大的血管分布在穴位的周围，为我们的治疗提供了许多的便利。

腹针不痛的另一个原因是，根据腹针理论，腹壁浅层有一个影响全身的先天经络系统，全身任何部位都可以在腹部找到应答关系非常明确的穴位。我们只需按照要求于腹壁的浅层轻微的刺激相关的穴位，就可以迅速产生止疼的作用，所以腹针不需要传统针灸酸麻胀痛的针感来发挥疗效，只要“刺至病所”，就是把针刺到病变的相对应腹部的部位，便可以达到治疗的目的。

安全，高效在临床体会里讲。

四．腹针取穴方法

1.传统针灸对经络的认知建立在经脉是运行气血的循行线(通道)的基础上，因此 强调取穴时可以“离穴不离经”。 腹针疗法认为任何穴位都是已知的定位点，强调取穴准确的重要性。因此，用 “差之毫厘，失之千里”来形容取穴准确与否对临床疗效的影响。

2.腹部取穴时，以任脉为纵轴坐标。 以神阙穴为腹部体表的中心点。 以中庭穴为腹部体表的上标志点。 以曲骨穴为腹部体表的下标志点。 以双侧的乳中穴为腹部体表的横向取穴标志点。

3.上腹部以神阙到中庭分为 8 寸。 下腹部以神阙到曲骨分为 5 寸。 腹部的横寸，传统针灸以双侧的乳中穴之间的距离分为 8 寸。 腹针疗法以神阙到平行的腹侧的外缘定为 6 寸。

4.取穴规范：水平线、比例寸 患者平卧后，在腹部的体表标志点作垂 线向上延伸，用水平线对两个标志点之间的距离进行度量，排除因腹壁凸凹不平造成的视觉差。 根据腹部的比例分别对上腹部、下腹部 和侧腹部对测量的数据进行计算，为取穴时做好准备。

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5.中庭和曲骨具有明显的骨性标志，因此 定位不存在难度。但中庭取穴时，手法宜轻，以免引起患者胸部的憋闷或其他的不适感。 神阙的度量以中心为准，不能以脐的上缘或脐的下缘为标志点，以保证取穴的统一和规范。

6.度量时的注意事项 对侧腹部的横寸度量时，以神阙通过天枢到侧腹的水平线进行度量。 可在腹侧用一直尺贴腹壁外缘与床成 90%角向上方伸出，用另一尺 与前尺的平面 90%相交，测量到神阙穴的长度为 6 寸，其 2 寸处为天枢穴的定位点。

7.取穴规范：任脉为中心标记 传统针灸取穴以正中线确定为任脉，因此取穴时，以正中线为标记。 经过二十多年的研究，笔者把腹白线作为任脉的体表标志。腹部取穴时必须对腹白线进行准 确的辨认，以免取穴的失误。

8.腹白线的特点 腹白线偏移时，任脉的穴位在比例寸的 平行线与腹白线的相交处取穴。腹白线在正中线时，任脉的穴位按照比例在正中线取穴。 依据腹白线的走向，确定任脉的走向， 由任脉的走向，确定足阳明胃经的走向， 并以此对其他的穴位进行度量。

9.取穴操作规范要点 操作规范化，首先是取穴的规范化，如果没有取穴的规范化，就不存在处方的标准化。处方的标准化，首先建立在穴位的标准化上。因此，在腹针中任何穴位的定位只有一个。必须进行认真的度量。疗效与取穴的准确相关，疗效不理想首先 必须对穴位进行校准。

10.常用穴位的定位与功能 腹部的穴位有许多，其中有经穴、经外 奇穴和新穴。 腹针的常用穴位， 腹部的经络是多层次的立体空间结构。 因此，穴位的穴性在不同的深度有不同的功能，进行分别的介绍。

五．腹针常用 18 个穴位和功用

1.中脘 定位：中脘位于神阙穴上 4 寸的任脉上。

功能：浅刺治疗：头、面部的疾病。

深刺治疗：胃炎、胃溃疡、胃下垂、胃 扩张、胃痛、呕吐、腹胀、腹泻便秘、 消化不良、高血压、神经衰弱、痢疾、 气喘、中风偏瘫等疾病。

2.下脘

定位：位于神阙穴上2寸的任脉上。

功能： 浅刺治疗：颈部、咽喉的疾病。

深刺治疗：消化不良、胃痛、胃下垂、 腹泻、反胃、慢性胃炎、便秘、恶心、 呕吐、腹胀等疾病。

3水分

定位：位于神阙穴上1寸任脉上。 功能： 中刺治疗：慢性炎症，有消炎止痛 作用。 深刺治疗：腹水、呕吐、腹泻、肾 炎、小便不通、肠鸣泻痢等疾病。

4.神阙

定位：位于脐正中。 功能：急、慢性肠炎、慢性痢疾、肠结 核、中暑、风痛角弓反张、中风脱症、 小儿乳痢脱肛、妇人血冷不受胎气等疾 病。 注：由于神阙穴不宜消毒，皮下组织菲 薄，因此禁针。

5.气海

定位：位于神阙穴下1.5寸任脉上。 功能： 深刺治疗：腰2.3椎的病变。下焦虚 冷、呕吐不止、腹胀、腹痛虚阳不足、 惊恐不卧、神经衰弱、四肢厥冷、肠麻 痹、遗尿、尿频、遗精、阳痿、赤白带 下、月经不调、痛经、尿潴留等疾病。

6石门

定位：位于神阙穴下2寸任脉上。 功能： 腹胀坚硬、水肿、尿潴留、小便赤不利、 小腹痛、泻泄、呕血、疝气疼痛、崩漏、 闭经、乳腺炎等疾病。 注：石门穴别名绝孕，因此禁针禁灸。

7关元

定位：位于神阙穴下3寸任脉上。 功能： 深刺治疗：腰椎4.5的病变。脐下绞 痛、腹痛腹泻、肾炎、月经不调、痛经、 盆腔炎、子宫脱落、遗精、阳痿、遗尿 闭经、带下、不孕、尿路感染、疝气、 血崩、产后恶露不止等疾病。

8商曲

定位：位于下脘旁开0.5寸。 功能： 浅刺治疗：颈肩结合部位的病变。 深刺治疗：腹中切痛、积聚不嗜食、 目赤痛从内 始、腹膜炎等疾病。

9.气旁

定位：位于气海旁开 o.5寸。 功能： 中刺治疗：2.3腰椎体周围的病 变、腰肌劳损、腰部疼痛、酸困、下肢无力、小儿腹股沟疝等疾病。 注：经外奇穴名为金河。

10.气穴

定位：位于关元旁开0.5寸。 功能： 中刺治疗：4.5腰椎体周围的病 变、泻痢、月经不调、带下、不孕症、尿路感染、腹泻、腰脊痛等疾病

11.滑肉门

定位：位于水分旁开2寸。 功能： 浅刺治疗：肩关节周围的病变。 中刺治疗：癫痫、哮喘病、脑供血不足、面神经麻痹、上肢无力等上 半身疾病。

12.天枢

定位：位于神阙穴旁开2寸。 功能： 中刺治疗：呕吐、泻泄、赤白痢、 消化不良、水肿、赤白带下、月经 不调、不孕、癫痫、便秘、腹胀、 肠鸣腹痛、腰肌劳损等疾病。

13.外陵

定位：位于阴交穴旁开2寸。 功能： 浅刺治疗：髋关节炎、股关节供血 不足、坐骨神经痛等髋关节周围的 疾病。 深刺治疗：腹痛、疝气、痛经、附 件炎、

14.上风湿点 定位：滑肉门旁开0.5寸上0.5寸。 功能：

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浅刺治疗：肘关节周围的疾病。 中刺治疗：上呼吸道感染、流感、扁桃 体炎、咽炎、过敏性鼻炎、带状疱疹、 面神经炎、支气管炎等疾病。

15.上风湿外点

定位：位于滑肉门旁开1寸。 功能： 浅刺治疗：腕关节炎、手关节活 动障碍、手指麻木等腕周围的疾病。

16.下风湿点

定位：位于气海旁开2.5寸。 功能： 浅刺治疗：膝关节炎、类风湿性 膝关节炎、老年性骨性膝关节炎、滑膜炎、膝关节周围韧带损伤、中 风引起的膝关节运动障碍等膝关节 周围疾病。

17.下风湿下点 定位：石门旁开3寸。 功能： 浅刺治疗：小腿外侧疼痛、踝关节 扭伤、踝关节炎、中风引起的足外 翻、踝关节活动障碍、麻木等踝关 节周围的疾病。

18.大横

定位：位于神阙穴旁开3.5寸。 功能：健脾燥湿、滑利关节的作用。 中刺治疗：风湿性关节炎、类风湿关节 炎、风湿性肌炎、周身风湿疼痛、四肢 无力、中风偏瘫麻木、便秘、下痢、惊 悸、洞泄等疾病。

六. 腹针的处方特点

1. 天地针的组成及适应证

天地针是一组腹针的常用方，由中脘和关元组成，中脘为天，关元为地，有培肾固三，补气回阳之功，故两穴合用具有补脾肾之功能。

2. 引气归元的组成及适应证: 引气归元由中脘，下脘，气海，关元4穴组成，四穴含有以后天养先天之意，故名引气归元。

3. 腹四关的组成及适应证 腹四关由滑肉门，外陵左右共四个穴位组成，滑肉门位于神阙之上，治疗躯干上段及上肢的疾患，外陵位于神阙之下，治疗下腹及下肢的疾患，该四穴是通调气血，疏通经气，引脏腑之气向全身布散的妙穴，故称腹四关。我在临床上几乎每个病人都用。

七. 临床体会和病例分享

我的临床体会也是腹针的特点的写照：无痛，安全，高效，

1.腹针无痛和微痛，使病人接受度高，一般腹部脂肪比较厚的人痛感很少，但瘦人特别是腹肌比较发达的人还是有痛感的，一般不强烈，但也有个别患者感觉非常疼，我就解释安慰患者说这是你所对应的部位有问题的原因。对于初次来针灸的病人先扎腹针可以让病人觉得针灸一点不痛么，病人就会减少对针灸的恐惧感。也有一些病人认为你要在他的肚子上扎针会有些恐惧，一般稍作解释就没问题。

我有一个女病人，极度怕针，除了腹针，其它任何体针都会出现晕针现象，后来只用腹针，病人再无晕针反应，而且疗效很好，本来月经不调，两次针灸后，月经就正常了，而且紧张，压力和睡眠明显好转。

2.安全

腹针非常安全，但有时会出血出现大片淤青，特别是女性或者是服用华法令的病人，只要提前和患者说明，一般没有安全问题。

3 高效

1）疗效快

一般情况下，病人在扎过腹针 1-2 次就会有明显好转感觉，我对自己的要求是尽量让患者第一次就能有好转，当然也有个别患者感觉症状先加重后好转，一般建议病人一周来针一次，一般 5-6 周病人会明显好转并稳定，等病人完全好转后建议他们每月来一次巩固，我会让病人自己根据自己的感觉来自己决定什么时候开始巩固治疗，这样让病人感觉没有压力。

2）腹针对于慢性虚损复杂病症和精神紧张抑郁导致的各种病证效果很好

我在临床的体会是腹针对于抑郁症，失眠，紧张导致的暴食症，妇科疾病，胃肠道疾病，慢疲，全身弥漫性皮肤病，长期虚损的病人，总之与精神紧张导致的一系列病症加上腹针效果会很快。我一般会长用引气归元，腹四关，双侧天枢常用。有一点需要注明，因为总想让病人早点有效果，我一般还会加开四关，只有特别怕针的才单用腹针，但有一点肯定是加用腹针肯定会使治疗效果明显加快。

3)腹针治疗后常见的病人反馈

A 多数病人会感觉放松，疲倦，一般会提早入睡，睡眠很好，第二天早上会容光焕发，睡眠好转根据病情轻重不同可以是一晚或者多晚，病人从而增强对针灸的信心。

B 一些胃口大且肥胖的病人会诉胃口明显减少，不感觉有饥饿感，个人理解腹针令患者放松后，病人不需要暴饮暴食来缓解压力的原因，还有腹针调理了脾胃的阴阳，增强了肠胃的消化吸收功能，还有我猜想会不会针灸会有缩小胃容量的作用。

C，有的病人仅一次针灸后会觉得腹部明显缩少，衣裤宽松，非常高兴，个人体会是腹针调节肠胃功能，使患者腹胀消失，再加上食欲降代，所以腹针减肥作用很好也很快。

D 多数患者在几次治疗后面部皮肤明显由晦暗变得光滑有光泽，特别是女性患者非常开心。好睡眠是最好的美容剂。

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ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

病例分析三则

贺福春 李贺 Herb China UK

按照老师和同仁的要求，分析以前展示过的病例，请提意见。

病例分析一：

患者女，成人。觉耳鸣耳胀一月余。当地 GP 医生让其做耳烛，经过 2 次耳烛后无改善。查体所见：唇干、耳鸣如蝉，口燥咽干易烦躁，舌红、少津、无苔，脉细数。双天柱穴压痛。建议针药治疗。患者拒绝用药。仅给针刺治疗。

诊断：耳鸣——肾阴不足，虚火上炎

治法：滋阴降火养肾

取穴：

俯卧位：天柱、神道、心俞、肝俞、肾俞、命门、阴陵泉。

仰卧位：听宫、神藏、列缺、期门、太溪、照海。

各组留针 20 分钟，每日 1 次针，共针 4 次诸症消失而愈。

分析心得：

肾藏真阴开窍于耳，虚则不能上承，外窍失濡养故现细小鸣声，阴虚则生内热，虚火上炎则干燥外现，上扰心神则烦躁，舌脉为阴虚火旺之象。治不仅滋养肾阴还要兼顾其标。

听宫穴：宫，五音之首，因此穴在耳屏前，深居于耳轮之内，而以宫相喻。《素问•五藏别论》：“……小肠，……天气所生也”。此为阴亏，顺自然，通耳窍。

天柱穴：《穴名选释》：“天柱，擎天之柱”。支柱头部有擎天之象。天柱骨现称颈椎骨。寻找局部痛点为其一。此证要注意颈椎问题为其二。膀胱经和肾经相表里为其三。

神藏穴：“神藏者，是阴能生阳化神，五脏之阴灵化神，通识觉，神藏于胸中，故名神藏”。在《素问•宣明五气篇》：“穴主心疾，心藏神，故名神藏”。此穴肾经输穴，治心神疾病。

命门配肾俞调补肾气，太溪为肾之输土穴原穴，有先天滋后天之寓，（太溪配列缺，新报导有对肾功影响，强泌尿功能），阴陵泉脾经合水穴，有后天补先天之意。照海配列缺滋阴清热。肝俞、期门为俞募配，泻肝郁热。神道配心俞宁心安神。

此为耳鸣虚证，随记载治疗较少，但此型较多，细辨其质，收效则速。

病例分析二：

女患，28 岁，英籍非洲人。头痛时作已 2 年余，痛时两目流泪羞明，甚则泛恶欲吐，时作时解。近 2 个月以来发作频繁。曾做各种检查无著变，在 GP 处取一些止痛药，痛时服用可暂时缓解。查体：面容苦闷、觉紧张压力、情绪易激动、胸脘胀满、口干喜呕、纳差、舌质红绛、苔薄白，脉弦数。

诊断：头痛——肝郁化火

治法：疏肝解郁，泻火理气

方药：

化肝煎加减：白芍 9 克、青皮 9 克、陈皮 6 克、丹皮 6 克，栀子 6 克、泽泻 6 克、土贝母 6 克、柴胡 9 克、川芎 20 克。水煎日服 1 付，早晚饭后温服。

7 付药后头痛大半已缓。唯双太阳穴及目眶依然隐痛，迎风则刺痛，夜寐不安。舌红体中苔白，脉弦略细。

前方减栀子、土贝母、泽泻，加茯苓 9 克、当归 9 克。用法同前。

又 7 付药，3 付药后疼痛显著减轻，仍以原法巩固疗效，旋即痊愈，经随访未复发。

分析：

《素问•至真要大论》：“诸逆冲上，皆属于火”。此例为肝郁化火气逆于上所致。白芍养血柔肝，配柴胡疏肝解郁。青皮、陈皮理气疏肝健脾，调畅气机升降。栀子清泄三焦之热。土贝母宣肺利肃降平气逆，清上焦之热。泽泻利小便清下焦之湿热。张介宾说：“结热在脏腑者宜通之利之”。热降则气降。川芎“上行头角助元阳之气而止痛”，活血搜气止痛。丹皮凉血散瘀。

7 付药后，因热势已清降，时表现为血亏之象，故减栀子、土贝母、泽泻，加茯苓、当归。葛可久说：“留得一分自家之血，即减得一分上升之火”。

化肝煎常用于胃脘痛、泄泻、头痛。如遇其他病证可见火、气、弱者均可选之。

病例分析三：

女患，29 岁，英籍东欧人。大便秘结，3-4 日解 1 次，3 年余。3 年前因产后遗留此症，经多方治疗如茶、汤药、药片、针灸等，均用时则通、停时则秘。现伴胸闷不舒、头痛时较剧烈，纳差，舌紫暗散在瘀点、苔薄白、脉细涩。曾给针刺及血府逐瘀汤加减治疗，也是用则通、停则秘。

诊断：便秘——血瘀血虚型

治法:活血破瘀，养血通便

方药：

以活络效灵丹加减。药用：当归 15 克、丹参 10 克、乳香 6 克、没药 6 克、大黄 9 克、郁金 9 克、山楂 6 克、香附 6 克、炒白术 9 克、炙甘草 3 克。7 付水煎服，日 1 付，早晚分 2 次温服。

用后大便通畅。10 天后打来电话说无便秘，由此所引起的周身症状亦随之消失。随访半年远期效果良好。

分析：

中药治便秘方法诸多，但以血瘀立方较少；又因活血方药诸多，用活络效灵丹较少。张锡纯认为此方：“为宣通脏腑，流通经络之要药，虽为开通之药，不至耗伤气血”。丹参调理血分祛瘀以生新，乳香活血行气，没药破血散血，当归补血活血为血虚之要药。加郁金活血行气，为血中之气药；香附行气活血，为气中之血药。山楂散瘀行气、消食化积，大黄逐瘀泻下，白术、甘草益气健脾以助推力。诸药合用达到活、破、补、行之功，则瘀去正补脏腑功能正常。

体会：

1、《金匮》曰：“新产妇人有三病，……亡津液，胃燥，故大便难”。产后给药须谨慎。

2、有其证必用其方药，不要忘记活络效灵丹。

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

探讨中西医差异和融合及特色中医

聂卉 英国 曼彻斯特

摘要：本文阐述了中国传统医学和西方医学在原古时代有着相似的起源历史，从公元二世纪后由于中西方的文化，教育和法律的影响，从而形成了各自的医学体系，因而存在很大的差异性，如对待疾病的认识有‘症’和‘病’的不同概念。由于国际间的科学文化，卫生健康事业的交流，人民的需要，又显现出两种医学的融合应用于临床。有的学者认为中医应该发展为现代化中医，相反有人提倡中医应发展为经典中医，不管如何中医学术争鸣，作者都希望中医发展成为一个科学的中医，特色中医，为地球上所有的人类健康而服务。

关键词：中医 西医 中西医结合 对比差异

中国传统中医学和西方医学目前已成为世界人民卫生健康事业的主要两大医学手段，在现代社会中人民越来越认识到这两种医学并驾齐驱，在治病防病中缺一不可，各有不同的优势。本文就两种医学的起源，发展史和诊断治疗做一个对比探讨，并提出中医展望和特色中医。

中西医学起源和理论的形成

1 中西医学的起源：

最开始中西医学的起源大致相同，源于救护、求食的本能行为，生活经验，医学与巫医的混和与分开。中西医学的两部代表著作，也为经典之作，是中医的黄帝内经和西医的希波克拉底文集。古希腊医学最高成就的代表人物希波克拉底，他把唯物主义哲学用于医学之中，认为癫痫病不是神圣所致，是起源于自然的原因。希波克拉底文集没有解剖学、生理学和病理学。建立在临床实验和哲学推理的基础之上。废巫存医是中西医学起源的共同点。

2 中西医学形成期是公元二世纪.

这时中西医开始走向不同的发展道路。西医是 16 世纪形成解剖生理学，17、18 世纪形成病理学（1）。东西方的两位医学巨匠.张仲景和盖伦，创建、发展和完善了各自的理论体系，使中西医学走向了两条完全不同的发展道路。张仲景的贡献继承‘内经’思想，总结了自己的经验，编著‘伤寒杂病论’应用至今。盖伦著述 200 余部著作，现存 83 部，内容涉及解剖、生理、病理、卫生、药物等，倡导实证医学(2)。

3 中医理论形成受到中国古代哲学观的深刻影响。

中医学是在古代朴素的唯物论和自发的辩证法的思想指导下，以精气神学说、阴阳五行学说和气一元论为理论基础。，中医从有机自然观出发，认为生命的本质是气的生化运动，所谓视其外应，已知其内脏，则知所病矣，司其外而揣其内，不必解剖探视。中医可认为是一种图像医学，从色、形、态等方面定性。中医强调整体观，重视宏观辨证，。而西方哲学的特点是把事物看成组合物，深入探求物质内部结构，重视微观分析，西方主流哲学认为万物的本原是原子，世界是构成的，而非生成的。15 世纪的文艺复兴唤醒了人们的科学意识，出现了以实验为基础的科学理论。19 世纪的道尔顿提出的化学原子论，引导西医学把研究视点投向实质脏器(3)。

4 中医古代五行学说和西医古代的四行说。

最初，中西医学在古代很有‘不谋而合’之处，如中医的五行学说与古希腊的四行说， 都是宏观的整体医学理论，只是到了近现代的西医那里，中西医的差异才凸显出来。

古希腊的四行说，也叫四行体液学说，包括四原性和四体液。四原性即水、火、土、气（寒、热、燥、湿）。四体液即血液、粘液、黄疸汁、黑疸汁。是古希腊人恩培多克勒提出的（4）。但随着当时希腊帝国的覆灭，罗马帝国的兴起和实证医学的建立，四行说没有发展起来。

相对比较之下，中医古代五行学说发展完善，沿用至今，是我们中华民族医学的骄傲。

5 中国传统医学和西方传统医学经历的四大主要阶段：

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西医	中医
1)古希腊的希波克拉底医学 2）古罗马的盖伦医学 3）被誉为‘中世纪医学灯塔’的阿拉伯医学，《医典》的作者就是享有‘阿拉伯医学王子’美誉的阿维森纳。《医典》曾被用 700 年。 4)文艺复兴后的近现代西方医学。 5) 近 40 年发展为科技电子西医学。	1）几千年前(5)的易经首先提出了阴阳两仪。 2)两千年前的黄帝内经形成了中医学。 3）华佗，张仲景和李时珍时代等中医先驱逐渐完善中医。 4）20 世纪曾经出现了废止中医的呼声。 5）近 40 年发展有争议的经典中医和现代中医。

6 中西医证和病的比较

有学者提出以病为经，以证为纬。中医强调人体是一个相互依存和相互制约的有机整体，强调辨证论治中的‘证’，是所谓的辨病机，即八钢辨证。

而西医是寻找疾病的病理，是以各系统中组织、细胞以及分子水平的病理变化为其确切的诊断学基础，西医将复杂的人体划分为九大系统。

中西医各科疾病的异同

1 内科疾病诊断的异同：

中医四诊八钢，宏观诊断。西医以实验和分析的方法，用现代技术，用微观的角度，以大量的量变参数，确定病因而诊断。

2 内科疾病治疗学的比较：

中医是治病求本，辨证施治，有治疗八法。

西医是针对病因，利用特异性药物，以及用现代科技治疗方法如：血管病的溶栓、抗凝，心脏病的起搏器和支架疗法，慢性肾病的透析，血液病的骨髓移植。

3 外科

14 世纪文艺复兴之前，中西医外科几乎水平接近，尤其是早期起源阶段，都是在处理外伤和脓肿的基础上发展的。文艺复兴后期，随着医学革命的到来，解剖学和器官组织病理学的诞生和发展，西医外科得到很大的进步，尤其是 19 世纪后半叶，西医外科解决了一些关键性技术难题,如手术痛疼、伤口感染、止血和输血等。20 世纪 80 年代后，以电子影像技术为代表的一系列技术的革新，给西医外科的治疗再次带来革命性的改变。如腹腔镜技术、器官移植、器官克隆，修复外科等。对中医的挑战，有人提出快速康复外科，是融会了中医针灸学，微创外科、营养学、心理学等多学科协作的课题

4 骨伤科

中医骨伤科学历史悠久约 5 千年的历史，公元前 3 世纪中国著名的外科之祖，**华佗**及其弟子施行了骨科手术。中医骨科的特点是手法整复骨折移位，关节脱位，应用小夹板固定，外敷药物等。 西医有系统的治疗骨折，近两千四百年的历史，1895 年 x 线的技术使西医骨科提高了一个层次。中医治疗骨折是‘动静结合’，西医是‘广泛固定完全休息’。目前的中医骨伤科在中国几乎是一种中西医结合的状态。

5 妇科

中西医妇科的生理方面认识不同，中医是肾气、天癸、冲任督带、胞宫。西医是下丘脑、--垂体—卵巢—子宫、雌激素、孕激素。治疗上各有优势，中医偏于痛经、崩漏、不孕；西医偏于子宫肌瘤，剖腹产、人工受孕。

中药学和生药学的异同

中药学和生药学均以天然产物（植物为主，包括动物和矿物类药物）为研究对象。而中医药学所走的道路，是中药的四气五味、升降浮沉、引经报使等理论，是中药学独有的特色，而且近 40 年随着中国的经济发展，和人民生活水平的提高，中药应用广泛，但没有质的飞跃。

古罗马时期的盖伦，与张仲景几乎同时代的医家，他记载了 540 种植物药，180 种动物药和 100 种矿物药(4)。现代生药学的发展进程缓慢，有生物药的提取，如银杏叶制剂，从罂粟中分离出吗啡，从金鸡纳中分离奎宁，从麻黄中提取麻黄素和麻黄碱等。另外目前的西草药、替代医学等，都是单味药应用，而且是重视里面的生物化学成分，并且西方生药学家们也开始研究中药，并推广应用，如黄芪，当归滴剂等已在英国的西草药师诊所中出现。

中西医学优势互补

1 诊断中的优势互补

1） 中医三个特点，一是在实践经验基础上可重复性；二是整体观；三是中医辨证是中医临床的精华所在。中医诊断是望闻问切四诊。

2） 西医辨病是西医的诊断方式，所谓辨病就是用现代高科技知识和方法，做出某一疾病的具体诊断，有人偏见的认为，西医学没有发展，是科技的发展。有人提出是否应用‘双重诊断’更有助于我们的中医临床。

3） 病证结合，优势互补: 西医辨病常是病原学的概念，中医辨证常是病理学综合征的概念，有人提出中医可提倡辨病和辨证相结合，如肝炎—辨病甲肝，辨证肝胆湿热或其它证型，中医必须有辨证；可西医只能辨病，不会中医辨证，这是西医的“缺陷”。有人提出是否提倡中医功能辨证和西医形态辨病相结合，功能辨证是以中医脏腑生理功能为依据的临床症候辨证，形态辨病是指西医解剖学为依据的病理结构辨病。

2 治疗中的优势互补

1） 西医治疗偏重祛除病因，针对性强、疗效快是其优点，但较少从整体认识疾病；中医注重整体功能的平衡，但缺乏对确切的致病因素和发病机理的研究。

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2） 中西医对治疗的共同认识：a 中西医都认为诊断与治疗是密切相关的两个环节；b 中西医都强调治疗的个体化原则；c 中西医都强调治病求本的原则，但双方对本的认识不同；d 中西医都正确认识到‘治愈’和‘自愈’，治疗与调养的关系，西医强调免疫力，中医强调正气存内邪不可干。

3） 西医的治疗优势，急症和重症；中医的治疗是慢性病，亚健康状态有优势。

3 用药中的优势互补

1）西药起源于 400 年前，是明末清初传到中国，被中国大众所“喜爱”；中药起源于 2 千年以上，传到西方可能不到 100 年，而且目前不被西方公众普遍接受，更不被西方主流医学认同。

2）西药多数是化学合成，用药方便，长于急救，副作用大；中药多数是自然的，处方加减灵活，长于调养，可根除疾病，副作用极少。

3）中药西研，对中药进行现代科学的化学、药理学和临床学研究已成为 21 世纪药物研究的热点课题。

4）西药中研，运用中医手段和方法对西药进行研究开展很少，但有学者认为，阿司匹林为辛凉解表药；可的松似为补阳药。也就是西药的中医作用。

4 科研中的优势互补

现代中医应具有中医严谨化；疗效标准化；病症规范化；治疗手段可重复化。即用现代科学的语言来表达其理论体系与致病机理和疗效。

1） 中医的量化研究是经验方式和理性方式的互补

2） 在中西医结合的疗效上，并探索其作用机制。

中西医学体制于交融中求发展

1 科学与文化的关系

科学技术一般受国家文化的影响，中西医是中西方不同文化的产物。但有技术不一定有文化如美国，有文化不一定有先进的技术如中国、印度，希腊和埃及。

2 中医药的国际化促进中西医相结合。

全球经济的多元化引导了文化的多元化。技术越发达的国家越重视文化的差异及相互的交融，如欧美等国。

3 化学药物带来的反思，药源性疾病，合成药的毒副作用，导致了绿色消费和回归自然，水清则无鱼；食至精则有害；药至精则有毒。

4 提倡医学多元化，各国和各民族都有某些有效的防病治病手段，只要有科学性就应该采用。

提倡中医现代化

1 利用现代科学技术理论，丰富和发展中医理论。

2 中医四诊信息客观化，创建脉学诊断仪，物理舌诊仪，用 MRI、CT、血液化验与八钢辨证相结合。

3 中医理论的传承和创新，如新八钢、微针系统、易经理论及一些中医世家的秘方的认证和实践。如中医教育的先学院教育和后师承教育相结合。还如激光针是现代科技与传统针灸相结合的产物等。

4 构建中医现代化研究的方法体系，以信息化带动中医现代化；以标准化建设促进中医现代化。

5 现代医学的基因调控与中医阴阳平衡所阐释的生命规律，不谋而合，而且与中医整体观、辨证观有许多相似之处。

创建 特色（或经典）中医

1 中西医结合是大势所趋，学术要与时代同步；与科技同步；与国际同步。

2 中医有精华但也有糟粕；西医也是如此。中西医的精华是西医诊断，中医辨证治疗；西医治急症，中医治缓证。

3 完善中医理论的物质基础

4 中药的脱色，脱味技术改良。

5 针灸的精穴验证，和中药效方验证及两者的交流推广。

6 经络实质的探讨，有人提出经络就是人体功能没有实质，如何用现代科技验证。

7 中医疗效的标准性和可重复性，建立可重复性的客观指标。

8 舌脉诊的诊断标准统一性。

9 中药成分单方和复方的现代化检验标准程序简易化。

10 中医师的培养全面性和正规性，要用现代化科技的培养模式，多数人支持目前中西医教育目前各占比例的模式，但也有人提议要“原汁原味”的培养学生中医思维。《素问》“医道”要求：“医者，上知天文，下知地理，中知人事，无失阴阳、表里、上下、雌雄相输应”。我国最早隋唐时期就出现了官办的医学教育机构太医署，中医教育是中医发展的原动力。

总之，本文就中西医的各自优势，目前中医市场现状，结合中国中医高等院校教材及个人学术观点，献给大家这一篇综合性的文章，如有不当之处，请谅解并指正。不管从任何角度看中医，展望中医，都希望中医学发展，强大，被世界人民所接受。

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作者简介：

聂卉， 1983 年毕业于黑龙江中医药大学，之后留校任教并在附属医院神经内科工作，曾任科副主任，针灸教研室副主任，副教授。曾脱产 6 年分别获得本校针灸学硕士和博士学位。2001 年来到英国，一直做中医师至今。曾在国内发表学术论文 20 余篇，合编著作 6 部，获中国省级科研进步奖三项，曾在 ATCM 学术杂志发表论文 2 篇。

探索软科学与硬科学下的新医学模式

季杰[1]，袁建平[2]
1.Uni-balance Chinese Health Care Ltd；2 上海文绿生物科技有限公司

工业革命后的今天，人类生存环境与人类自身均发生了重大变化，工业废气，环境污染，饮食更换，细菌、病毒变异，药物出新，起居无时，竞争压力倍增，导致人类疾病谱发生巨变。新形势势必催生新医学模式。这里所谓的新有几重含义：一、是指外延宽泛，是新纪元里可以融合软科学[1]和硬科学[2]的新医学模式。二、是说该医学模式要弥补“生物-心理-社会医学模式的不足，切合人类实际需要。三、是说我们要推陈出新，不要固步自封，只继承不发展。下面我将从以下几点探索新医学模式。

1“软”科学与“硬”科学的出现是新医学模式产生的契机

长久以来，医学科研大多是以西医研究的方法为主，采用“动物模型”或“随机、对照、双盲”法设计临床科研方案。很多中医院一边用着“高血压”、“糖尿病”、“带状泡疹”等西医诊断的病名写着中医的病历，一边用着各种“静脉点滴”加上中医的治疗。一切所谓的中西医结合，使中医陷入不伦不类、不中不西的尴尬之中。证明中医学是否科学，方法其实很多。而中医学、西医学、甚至其它非主流医学，都是医学园林中的奇葩，这就好比有的是橘子，而有的是苹果。虽都为水果但各有不同属性，决不能要求橘子按苹果的标准培育、生长。反之，亦然。因此，中医既无法按西医科研方法并入西医范畴，又必须另辟蹊径，找出适合中医发展的科研形式，使之真正登上新医学舞台，走向 21 世纪。目前，软科学与硬科学的出现为新医学模式的产生创造了契机。

1.1 软科学与硬科学的概念

软科学（Soft science）指对科技、经济、社会发展战略和宏观控制进行研究，为决策提供科学依据的综合性科学。它是借用电子计算机软件的名称而来的，可综合运用系统理论、系统方法、决策科学与计算机技术等现代科学技术的知识和手段，对各种复杂社会问题和自然现象，从政治、经济、科学、技术、教育等各个社会环节之间的内在联系中，研究它们的客观规律。

硬科学（Hard science）指：自然科学与技术科学两大系统所同学科与其交叉学科的统称。借用电子计算机的“硬件”而得名。其研究内容包括数学、物理学、化学、天文学、地理学、生物科学以及技术工程等学科。

1.2 软科学与硬科学是新医学模式形成的基础

医学既不是纯粹的科学，也不是单纯的哲学，它夹杂着社会学、人学、艺术、心理学等等。这种综合性特点决定其发展模式也必须依靠多种学科的发展。

1.2.1 软科学如何利于新医学模式形成

中医临床上的特色之一是“辨证论治”，在辨证中信息数据的采集，以“望、闻、问、切”四诊合参为基础，常依据医者自身临证经验而得出结论，（有主观成分）。临床验案也因不是“随机对照研究”而被认为是个案和“不科学”。随着云时代的来临，随着软科学中计算机技术的的发展，大数据（Big data）[3]理论也吸引了越来越多的关注。在维克托·迈尔-舍恩伯格及肯尼斯·库克耶编写的《大数据时代》中大数据指不用随机分析法（抽样调查）这样的捷径，而采用所有数据进行分析处理。大数据的 4 个“V”，或者说特点有四个层面：第一，Volume（数据体量大）。从 TB 级别，跃升到 PB 级别；第二，Variety（数据类型繁多。网络日志、视频、图片、地理位置信息等等。第三，Velocity（处理速度快），1 秒定律，可从各种类型的数据中快速获得高价值的信息，这一点也是和传统的数据挖掘技术有着本质的不同。第四，Value（价值密度低）只要合理利用数据并对其进行正确、准确的分析，将会带来很高的价值回报。如果我们能够充分利用大数据的上述特点来分析所有中、西医病历，一方面，我们可以避开所谓随机数据的硬性要求，另一方面又可以用视频、图片量化望诊、问诊结果，让验案也经得起现代科技的“检验”。

1.2.2 硬科学如何利于新医学模式形成

众所周知，我们的中医理论一直局限在“宏观抽象”范畴，而西医理论依靠细胞医学则相对“微观具体”。随着多学科科技发展，特别是硬科学中物理学的“量子”理论的出现，使中医和西医的理论都陷入相对“宏观”之境。如果我们能运用量子医学理论，建立微观的新医学体系，就可以至少在微观水平上让我们处在同主流医学平等的出发点。国内介入量子医学研究的现在已不乏其人。其中谢景安[4]教授首创的“生物电子动态平衡”理论和“量子导平医学”入选《20 世纪中国医学首创者大辞典》。笔者也曾于 2014 年 3 月 7 日经朋友引荐，有幸登门拜会谢教授，深受启发。

在诊断水平上：最近几十年临床医学使西医的检验医学从细胞深入到了分子基因；而影像医学也从一维发展到了四维，使西医学诊断水平大为提高。相比较而言，中医临床脉诊仍是“心中了了，指下难明”，即使对中医从业者而言都是难以掌握，有时甚至出现不同医师同一时间对同一患者的脉象所下结论不同的情况。对此，王唯工[5]教授从物理学角度以压力和共振理论来类比血液在人体中的运作，成功地找出了脉搏与生理现象的关联，认为“气是心脏打出去的动能转成的动脉血管上的位能；脉诊其实就是听人体状况的总体报告，看看能量、相位和缺氧的情况。”并在此基础上发明了脉诊仪，量化了脉诊数据。

由此可见，软、硬科学的发展已为今日之新医学模式的形成准备了多种方法与途径。

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

2 新医学模式应“以人为本，寰宇共衡”

医学模式的变化体现了在不同时期人们用什么观点和方法研究处理健康和疾病问题。西医作为主流医学，其医学模式的转变经历了神灵主义医学模式、自然哲学的医学模式、机械论的医学模式、生物医学模式、生物-心理-社会医学模式。然而，至今为止这些模式都单纯从“以人为本”即从病患个体的身体、心理甚至社会关系出发考虑诊治方案，忽视了人与外部自然界的互动平衡。随着时代的进步，人们更多考虑的是如何不生病，而且有质量的生存，并尽可能长寿。于是，日益趋多的人口，老龄化社会结构，给自然环境也带来极大的挑战。如何为几十亿人口提供健康饮食，又不破坏土壤、植被、食物链、还不加重环境污染？

目前，无论是传统医学还是现代医学都认识到“保持机体内、外环境平衡稳定性”对生命健康的重要意义。由于内环境的稳定目前可微观到“细胞功能的平衡”，而外环境的平衡稳定则可延伸到饮食、土壤、气候、甚至浩瀚宇宙的天体活动对地球生物及人体所带来的影响。然而，微观无限小，宏观可无限大。随着科学的进一步发展，可以预见的是，将来还可以发现小于量子的物质，也可以宏观到银河系之外。这就决定新医学模式应有大宏观与小微观的双极性。而且这种模式要利于维持人类内外环境从宏观到微观的系统稳定平衡。因此，一切服务于维护人类内外环境平衡、稳定的学科皆可被纳入进新医学模式体系。

例如，我们能利用农业生态服务于生物生态，进而服务人体生态，这将使我们的机体从外到内，从宏观到微观的寰宇共衡。

综上所述，如何运用软科学与硬科学的发展完善新医学模式，使之切实渗透在养生，保健及治疗的各个领域，具有能使人们不生病,即便生病也能通过多种调节使机体恢复稳定，使细胞功能恢复平衡，进而使人类健康、长寿，有待我们进一步去探索研究。

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方证辨证浅议

薛秋龙　郭尊莉

摘要：方证和药证，是古老的治疗方法，现在仍呈现出新的生机，用之临床常常能应手取效。笔者试图通过本文诠释方证辨证的意义和方法。

1 概述

《伤寒论》和 《金匮要略》 被喻为方书之祖，为历代医家所重视，历史上对伤寒论进行过注解的医家有数百家[1]，跟《伤寒论》有关的文献浩如烟海，《伤寒论》和《金匮要略》的药方被后世称为“经方”。经方疗效卓越，运用得当效果如鼓应桴。《伤寒论》《金匮要略》成书于东汉，年代久远，文词比较古奥，对现代人学习《伤寒论》和《金匮要略》造成很大的困难。但是理解书中条文含义是研究经方避不开的坎，理解了条文的含义，就能更好的理解证，理解了证才能更好地运用经方。现在普遍认为张仲景创立了‘六经辨证’，但有一点被忽略了的是他还创立了另一个辨证方法------方证辨证。每当我们一提到“方证”就会首先想到日本汉方，殊不知方证辨证的创立者正是东汉张仲景。金氏也认为，“方证相对”的原则，源自于张仲景所倡导的“汤方”、“汤证”，以及《伤寒论》101 条“伤寒中风，有柴胡证，但见一证便是，不必悉具”等理法[2]。

2 方证辨证的回顾

‘方证辨证’一词最早见于顾武军的文章[3]，他认为《伤寒论》的研究应当重视方证辨证规律的探讨。方证辨证方法早在 1800 多年前，甚至更早之前就开始应用。当时的张仲景即在临床上运用方证辨证，并根据自己的临床经验总结出了他的旷世著作《伤寒杂病论》。在书中，张仲景多处提到诸如‘桂枝证’‘桂枝汤证’‘柴胡证’‘柴胡汤证’等药证和方证。方中带有药方的条文均按方证的形式书写，方与证直接对应。但后来却一直未被重视。

《伤寒杂病论》因年代久远和战乱而流散。到晋朝王叔和整理出版了《伤寒论》部分，使一部分得以重新流传。但此后直到清朝（1729 年）柯琴才重新拾起方证辩证研究的薪火， 他的《伤寒来苏集》就是以类方的形式编撰《伤寒论》的[4]。所谓类方，就是以方类证，以方剂为中心，对治症进行归纳分析的一种研究方式[5] 。清朝（1759 年），另一个医家徐灵胎积三十年研究心得写成《伤寒论类方》，他认为《伤寒论》“不过随证立方，本无一定之次序” [6]。纵观《伤

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寒论》，除了六经次序外，300 余条文，皆依方证体例书写，如‘辨太阳病脉证并治第七’，有大陷胸汤，大陷胸丸，小柴胡汤，甘草附子汤等治疗阳明，少阳，少阴的方。在‘辨阳明病脉证并治第八’里却有治疗少阳，太阳，少阴的药方。在其它篇章里也是如此。 而徐氏觉得《伤寒论》是一本救误的书，“误治之后，变证错杂，必无循经现证之理”[6]。随后有很多方证研究方面的医家不断涌现，形成了颇为引人注目的‘类方派’[5]。在日本，也在方证研究方面取得了很多建树，1762 年吉益东洞完成了他的著作《类聚方》，该书按同类方排序，以方统证，开启了日本汉方研究的新时代，该书对日本汉方医学影响深远。通过阅读后世浅田宗伯，大竹敬节，桑木崇秀等人的著作可以了解到，此后的汉方界，无论是古方派还是汇通派，均偏向于方证相对临症施治。

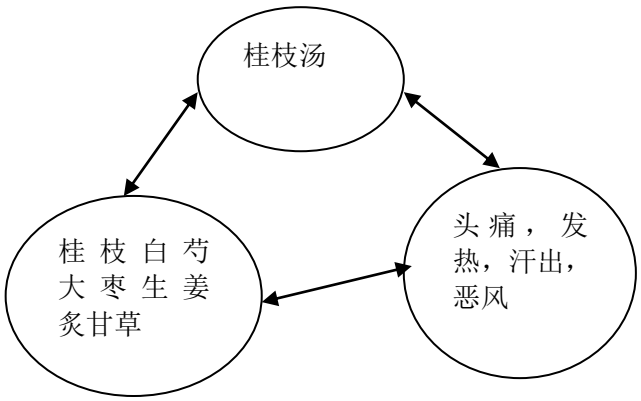
3 什么是方证辨证

方，在《说文解字》和《康熙字典》里的意思是‘併船’的意思，两船并在一起为方，也指船的两头。所以方是超过一个以上，双方、四方、八方、方向等都是复数词。药方就是两个药以上的组合。证是一组征候，病人发病以后出现一系列的症状，症状组成证候，证候组成病，证就是机体最直接的生理病理反应。

方证辨证首先就是方与证的对应联系，比如桂枝汤证就是桂枝汤方与一系列，诸如发热，头痛，出汗，恶风或恶寒等症状的对应，并有治疗特效，特定的方适应特定的证，一个萝卜一个坑[7]。

经方的证是经过前人千百年的实验总结定型的，有极强的针对性。桂枝汤证：头痛，发热，汗出，恶风，脉浮缓；麻黄汤证：头痛，发热，无汗，恶寒。症状有异同，方证的对应，药物的配伍严谨，主药的变更，药量的增减都会改变整个药方的治证。

图 1 桂枝汤证



方证辨证并非简单的方与证的对号入座，同样要求医生对患者整体体质的把握，在明辨主要方证的同时要对整体体质有所调理。比如曾经治疗过一个更年期的患者，症见晚上潮热，出汗，热感如波浪式一阵阵出现，平素乏力，脉迟无力。我根据患者的症状诊为桂枝证，方用桂枝加桂汤，但因为患者有乏力，脉沉迟无力，故用黄芪，再加生地清热。结果患者服药一周后诸症衰其大半，脉转浮且较有力。方证的关系往往如此，就像子弹与靶一样，医生就是枪手，枪手能否瞄准靶子是子弹能否中靶的关键。

现在方证辨证研究主要讲的是《伤寒论》和《金匮要略》经方的方证，相对于经方的严谨配伍，药味少而精当，后世时方配伍比较松散，治证相对模糊[7]，边界不太清晰，比如归脾丸，益气补血均可，难于界定明确的方证，对时方的方证还需要更多的研究。

4 方证辩证的意义

中医理论经过几千年的发展，实践与理论都已经相当成熟，《黄帝内经》和《伤寒杂病论》都是其中必然的产物。但我们也必须注意到理论泛化的一面， 到元宋明以后，这种现象有愈演愈烈的趋势，就连《伤寒论》这样临床实践性很强的书也被各大医家以经解经弄得云山雾罩，各家学说百家争鸣，临床应用往往难以把握。现代多数医家，是以六经辨证为主，并对各经病机深度解读，而对药方的功用也是以泛化的医理进行解释。这样就造成了方证的脱节，临床应用漫无目的。

中医在最早期就是药与症，用某药对某症，在远古时代没有多少的理论，偶然用某草对某个不适的体症产生效果，在长期的使用中就形成了固定的经验，慢慢的人们发现一个人可以同时出现几个不同的症状，需要同时用几个不同的草药，还发现一个药可以同时治疗几个不同的症，后来又发现一组药可以解决一组相对固定的症状，这就有了方，有了证，方与证被相对的固定下来，成了固定的临症经验。

药---方（证）----法---理 是过去中医的发展形式，发展到今天变成了理--法--方--药，使多数医者临症惘然。‘药方证’是前人经过千百年实践的精华，到了张仲景那里这些经验得以有机统一了，并做了承前启后的总结和升华而有《伤寒杂病论》的问世。张仲景引用《黄帝内经》六经理论统筹各种病理变化，但他的条文叙述却是方证对应的方式，《伤寒论》每条条文都如实记录了张仲景的临症心得，如第 37 条：“太阳病，十日以去，脉浮细而嗜卧者，外已解也。设胸满烦痛者，与小柴胡汤。脉但浮者，与麻黄汤”。条文里面展现的是人体对疾病的病理反应，方药是对这些病理反应的直接对应。不管是古人还是今人，他们的生理和病理反应是一样的[7]，尽管疾病谱已经产生了很大的变化，正如徐灵胎说：“方之治病有定，病之变迁无定，随其病之千变万化而应用不爽”，这个方指仲景之方，病指证候，抓住方与证，则可以以不变应万变。方证辨证的意义具体表现在如下几个方面：

4.1 证即是药，药即是证

临床上常常会出现搜集完病人的资料，认真分析得出证型，但在辨证分型后却搜索枯肠寻找可用之药而不得。比如一个血瘀型患者，当用活血剂，但活血药，活血剂那么多，该如何选择一首对证的方剂或活血药是一个需要面对的挑战。但如果用方证辨证就会比较直接了，比如患者同时肌肤甲错，粗糙，少腹硬而小便利者可用抵挡汤；女病人伴见月经血块多，少腹部和左腹直肌偏硬不适者用桂枝茯苓丸，等等。经方药证和方证非常明了。证的层次性也决定了相对应的方剂，通过方证辨证的学习都能掌握。

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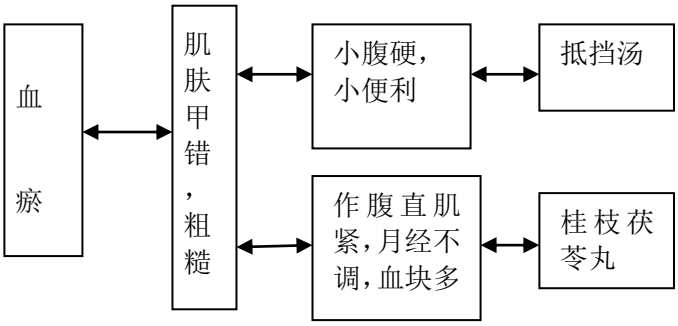
图 2 方证对应



4.2 古方新病也相能

《伤寒论》和《金匮要略》由张仲景撰于 1800 多年前。据现在最新的研究认为张仲景生活的年代平均气温要比现在低好几个摄氏度[8]，据此认为这就是那时多发伤寒的原因，现在气候特点和生活环境都大不一样了，现代人的体质和古人也有变化。疾病谱系也很不一样，病种也翻了几翻，多数疾病古人没见过。因为这些原因，古方不能适用于现今的疾病。还有人觉得《伤寒论》方主要是用于伤寒，对于其它杂病并不适用。其实持这些观点的人并没有真正理解《伤寒论》，或者没有从方证的角度去理解《伤寒论》。提出古方不能治今病的首先是张从正，他的名句：“运气不齐，古今异轨，古方新病不相能也”［9］。对后世影响很大。对于古方治今病的问题，黄煌有一个很好的比喻：如果我和古人谓一起去做桑拿浴，我们都会大汗淋漓，如果我们都用 20 克大黄，我们都会明显大便次数增加[7]。两千年前的人和现在的人体质不会有很大的差别，我们的生理和病理反应是一样的，这也是《伤寒论》和《金匮要略》方能历经两千年仍效如桴鼓的道理，关键就在于这些方的立方之旨在于证，是治疗“病的人”而不是人的病[10]，证是人体的直接病理反应，正是体现了病的人。

5 方证辩证的方法

5.1 理解条文含义

张仲景生活在 1800 多年前的东汉末年，据记载他出生在南阳郡涅阳，他的著作必然带有时代和地方方言习惯，这就需要我们去破解有些词的含义。比如‘熬’字，现代汉语的‘熬’是煮的意思，但在《伤寒论》里则是炒的意思了[11]，《伤寒论》里有“巴豆，熬，去油”“白粉熬香”。只有理解了这些术语的含义，才不至于把巴豆放水里煮。

除了理解词义之外，还有就是理解条文描述的病症的内涵和外延，这是能否有效应用仲景经方和方证辨证的关键。比如：“太阳病，下之后，其气上冲者，可与桂枝汤”。这句话可以理解为：患者有发热，恶风，汗出，医生误用下法，导致胸腹有气上冲感，可以用桂枝汤治疗。这个“太阳病”包含了太阳中风和太阳伤寒两个证，而“气上冲”是一个症状，是表证用下法导致正气抗邪的反应。这些是内涵。“气上冲”还可以理解为心悸，腹部动脉悸动，更年期综合证的潮热等都可以理解为“气上冲”，这是外延，是方证的现代延伸。

5.2 理解方证和药证

方证是《伤寒论》和《金匮要略》的核心，方证包括方与证，运用方证除了对《伤寒论》和《金匮要略》原文中证的理解外，还要对方进行消化。方又以药成，所以一条方除了方证还有药证。长期以来对《伤寒论》和《金匮要略》的药证缺少研究，历史上，日本的吉益东洞对两书里面的药做了专门的研究，每一味药都作了条文对比分析，并陈述辨误。黄煌也对两书里的药进行了研究总结，根据《伤寒论》和《金匮要略》方的用方习惯，对每一味药的功用进行了探讨。他们的研究弥补了这方面的空白。两位临床家对张仲景的用药思路进行了分析探索。

理解了药证，有助理解方证，帮助对证的把握。比如：葛根芩连汤组方是葛根半斤 黄芩 3 两黄连 3 两炙甘草 2 两 。我现在就用下面这个表来展示四药的功用。

表 1 方证与药证

药	主证	主要兼证	次要兼证		
葛根	项背强急	下利	—	—	——
黄芩	心下痞	若下利	若呕吐	—	——
黄连	心中烦悸 兼痞	兼利	兼吐	腹痛	——
炙甘草	缓解急迫	／	／	／	躁、急、痛、逆

从以上分析可知葛根芩连汤可治疗项背强急，心下痞，心烦。为其主要方证。兼治下利等症。这就是以药测证，以方测证。《伤寒论》葛根芩连汤条文很简洁：“太阳病，桂枝证，医反下之，利遂不止，脉促者，表未解也。喘而汗出者，葛根芩连汤主之”。从条文里面我们只看到下利，喘，汗出几个症状。临床应用受到局限。通过药、方、证的梳理，临床用起来就会变得更加广阔。

6 方证辩证的案例

6.1 **Lisa**, 50 岁，2 年前绝经后，开始有潮热，逐渐加重。西医诊为更年期综合症。刻诊：潮热在晚上加重，汗多，发作时觉有热浪袭来，呈波浪式发作。影响睡眠和情绪。舌苔薄白，舌质淡红，脉迟无力。食欲可。肝肾脾俞均有压痛感。

分析：发热，汗出，合桂枝汤证。热感呈波浪式发作，视为桂枝证“气上冲”。

拟桂枝汤加黄芩，黄芪，生地，7 天。针取肝脾肾俞。2 诊，潮热，出汗消失，睡眠好转。

6.2 叶某，男，52 岁。2 月前夜尿多乏力，去医院

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检查，诊断为肾实质病，左肾有囊肿。血压 160/100 毫米汞柱。医生安排 7 月中旬做进一步肾功能检查。在此期间处方降压药、血管扩张药和降脂药，患者症状加重。后经人介绍找我治疗。
刻诊：初步印象：脸色晦暗，体型偏瘦。
患者主诉：非常乏力，夜尿每个小时一次，影响睡眠。
一般症状：食欲全无，见食物则恶心欲呕。口干不饮。小便多泡，色黄。头晕，起身时加重。怕风，无汗，双手碰到冷水则全身冷战。
腹诊：脐下悸动，腹肌紧。
舌苔白腻，舌质淡白。舌边有齿痕。脉弦。
分析：脐下悸，起则头眩，为苓桂术甘汤证。恶心欲吐，既是“气上冲”感，也是水毒聚以胃脘。
处方苓桂术甘汤加龙骨牡蛎，取药 7 天。

2 诊：夜尿减为每晚 2 次，睡眠好转。头晕减轻。食欲稍有好转。舌质淡黄，舌质淡白，脉弦细。血压 140/90 毫米汞柱。
拟加大去湿理中，和血，处方前方加干姜，半夏，陈皮，当归。并加大茯苓用量。取药 7 天。

3 诊：头晕大为好转，偶尔有感觉，食欲恢复，看见桌上的饭菜不再有恶心欲吐感。舌质淡红，苔薄白，齿痕减少。无乏力。手洗冷水以无冷战现象。

7 总结

方证辨证，上世纪八十年代开始，重新在中国被一部分医者所重视。其中颇有成就者是南京的黄煌，他在方证和药证上都有深入的研究，并提出了“方人”“药人”等体质论观点，建立起了比较系统的方证辨证方法。

方证辨证具有方与证对应的相对明确的指导方针，临床使用易于把握。但是仍然需要更多的研究和现代临床应用经验的分享总结，对经方的证作出更多的诠释和延伸。

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辩势论治的临床应用与心得

李雁

摘要：辩势论治与辩证论治的区别，伤寒论的辩证论治是辩六经之证而分治之，其效佳，但辩证方法复杂，即使是专业中医师也需要经过多年的经验累积和反复学习才能掌握。什么是辩势论治呢？人体的元气，一气周行，左升右降，周而复始，这个动态的过程称为势。辩势论治即辨别出能量受阻的部位，而给予相应的治疗。这个方法简单易行，虽然疗效不一定是最佳最快，但是最适于普及。即使是没有医学背景的人，也可以很快入门。我在临床使用多年，疗效非常可靠，很高兴在这里与大家分享。

关键词：辩势论治，辩证论治，圆运动的古中医学，伤寒论，元气(灵气)

辩势论治来自于万病至简论的方药原理篇，根据人体元气的圆运动规律，把伤寒论的一百一十三方，简化为三个系列方剂：1.理中汤系列----补阳性能量。 2. 小柴胡系列----调升降。 3. 生脉熟地枸杞饮----补阴性能量。

首先介绍一下圆运动的古中医学。一个生物所在之地，太阳射到此地面之光热，就是阳。此地面的光热已过与光热未来之间，就是阴，阳性上澎，阴性下压，阴阳交合，发生爱力，彼此相随，遂成一个圆运动。此圆运动右下左上中，降沉升浮中，与春夏秋冬及 24 节气相应。

人身分上下左右中五部，上部之气，由右下降，下部之气由左上升，中气居中，以旋转升降。整个的圆运动图是为无病之人。上部之气不能右降则头痛。下部之气不能左升，则行动无力。而实由于中气虚寒，不能运化于中所致。

人身中气如轴，四维如轮，轴运轮行，轮运轴灵。

辩势论治即辨别出能量受阻的部位而给予相应的治疗。这是以经络为主，而不是以方药为主，通过补足缺损的能量，使经络畅通而达到疾病痊愈的效果，故方简效宏。

举例说明，比如一个人很穷，帮助他的方式可以有很多种。他想要自行车，想要新衣服，想要各种生活用品等等，辩证论治的思路是帮他买齐然后送给他。而按照辩势论治的方法则是给他一笔钱，让他自己去买。如果他理财得当的话还可以钱生钱。是不是一下就简化了很多呢？元气就像是身体的本钱，只要足够强大，就可以自己修复身体。

辩势论治的具体用药如下：

一. 理中汤系列——补阳性能量（动力）——阳虚的人用

服用时间：每天三次，1-3pm，5-7pm，9pm 各服一次。

3.王道（小剂量）（能量不足用王道，能量足用霸道）（单位：克）

（1） 加味理中汤：白术 5， 党参 5， 炙甘草 10，干姜 5，砂仁 5（捣破），山楂 8，山茱萸 8。加减：秋冬加肉桂6，当归8。

服用条件：睡眠好，无食欲。

(2) 加味生脉理中汤：党参 9，麦冬 8，五味子 3，白术 5，干姜 10，炙甘草 10， 砂仁 5（捣破），山楂 8，山茱萸 8。加减：春夏加黄芩 9，秋冬加肉桂 6。服用条件：睡眠不好，无食欲。

2. 霸道（大剂量）

加味理中汤：党参 30，白术 20，干姜 50，炙甘草 50，砂仁 20（捣破），山楂 30。加减：秋冬加当归 30，肉桂 10. 服用条件：睡眠好，有食欲。

(2) 加味生脉理中汤：党参 30，麦冬 20，五味子 10，白术 20，干姜 50，炙甘草 50，山楂 30，砂仁 20（捣破）。加减：春夏加黄芩 20，秋冬加肉桂 10. 服用条件：睡眠不好，有食欲。

二. 小柴胡系列——攻邪——有痛苦症状时用

服用时间：早上起来服用最好，每隔 2 小时一次，每天三次，最迟不晚于下午 3 点。

(1) 小柴胡加干姜汤：北柴胡 30，党参 30，黄芩 20，白芍 30，生姜 80-140（秋冬可用 140-200），红枣 12 枚（掰开），干姜 30，炙甘草 30。服用条件：睡眠不好，无论有无食欲，有痛苦症状，能量外散，相火不位。

(2) 1/3 量小柴胡加干姜汤：北柴胡 10，党参 10，黄芩 7，白芍 10，生姜 30，红枣 4 枚（掰开），干姜 10，炙甘草 10。服用条件：小儿或能量不足大人用。

三. 生脉熟地枸杞饮——补阴性能量（物质基础）——阴虚的人用

服用时间：下午 3，5，9 点各服一次。

阴虚辩证要点：

1. 脉管细小——这是金标准
2. 女性表现为月经量极少
3. 形体瘦小，皮肤干，红，舌头干红瘦小
4. 典型相火不位症状（失眠多梦焦虑烦躁，渴）但是屡用小柴胡加姜附汤或者加味生脉理中汤无法改善症状
5. 严重伤精，长期熬夜之人
6. 大失血(月经崩漏，咳吐大量血)，大面积溃疡，严重腹泻后).

4.王道（小剂量）：党参9，麦冬8，五味子3，熟地6，枸杞8，陈皮8，干姜10，乌梅1枚，炙甘草10. 服用条件：有食欲，但是能量不足，精神状态一般，易困，食量小，腹胀

5. 霸道（大剂量）：党参 20，麦冬 10，五味子 10，熟地 20，枸杞 20，陈皮 20，干姜 20，乌梅 3 枚，炙甘草 20. 服用条件：有食欲，但是能量足，精神状态很好，不困，食量大无腹胀。

辩势论治所有的辩证只考虑两个问题，第一个考虑能量的多少，第二个是考虑能量的方向，也就是升降的问题。问诊时除主诉的症状外，主问四个问题。第一个问题饮食，第二个睡眠，第三个排便，第四个手足的冷或热。首先，如果手足是冰冷的，很明显，就是能量不足的表现。因为手脚是在我们四肢相对来说最远的地方，能量不足最先体现在手脚。其次考虑升降的问题，升降的问题体现在哪里呢？睡眠。太阳能够升起来，我们能够看到他，精神非常好，太阳下去了，世界都是一片黑暗，说明阳已经藏了。所谓的阳的收藏了就相当于太阳下降了，下降到我们看不到的另一面。我们体内也有一个阳气跟着太阳的运转是同步的。在正常情况下，太阳下去了，我们的神也下降，人就能够睡眠，睡眠的问题体现的就是阳的升降。如果这个人的睡眠不好，那就说明他的阳的下降是有问题的。

睡眠不好的另一层解释是相火不位，正常我们的手足应该是温的，头脑和脸应该是凉的，头脑和四肢相对来说都是处于身体的远端。都是需要阳气充足才能到达。头在上，四肢在外，阳气不降呢就停留在外，停留在上。所以手足热的人通常脸都是热的，手足热，脸热，情绪烦躁，这就构成了我们辩证常说的一个少阳相火不位，阳气停留在外面，不能够收敛。

既然阳气都跑到外面去了，里面肯定就不足了，这就造成了脾胃虚寒。就像井水一样，天热时井水是凉的。天气是表，井水在地下是里，井水为什么是凉的呢？原本藏在井水里的热气跑到外面去了。跑到天上去了，所以井水凉了。在我们人体同样体现出来，当你手脚热了，头脑热了，睡眠不好，阳降不下来了，你的脾胃肯定是凉的，是寒的。

脾胃一寒就会出现什么问题呢？排便不好。我们知道所有的食物通过脾胃的运化之后，一些糟粕都是通过大肠排便给排走。现在脾胃的能量不足了，排邪的能力自然会下降，胃肠的蠕动能力变弱了，这时通常会伴随便秘的症状，但这种便秘不是大便坚硬的便秘，是一种大便粘质，软软的，排不尽的感觉。是有大便但是没力量排出来。这一系列的症状都属脾胃虚寒。

脾在六经属太阴，和排便其实是相关联的问题，同一个问题。我们阳气从上往下降，这个过程中，必然要经过太阴。太阴相当于一个门，阳气相当于一股力量，

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

他要进入这个门，往下面走，太阴必须把门打开。通常呢，太阴体很虚寒了。这个通道关闭了，这个神就降不下来，这就是“阳明不降，太阴不开”。所以睡眠的问题其实关系最大的是脾胃，脾胃不好了，睡眠就不好。

而导致脾胃虚寒最重要的一个因素就是寒凉饮食。吃冷的，冰冻的，寒凉的那些东西，凉性的比如梨，西瓜，水果，很多水果本身，温度上首先就是冷的，即使是它是热性的，吃进身体后，它首先就是个冷的东西，所以即使是热性的水果也不能多吃，很多人睡眠不好，其实就是和吃寒凉的东西有关系。

这个寒凉有两层意义，一个是温度的冷，一个是性质的凉。性质的凉就是说，即使你是热服的，温度是热的，吃进去了，因为性质是凉的，所以还是会伤到你的体阳。比如说降火的中药，黄芩，黄连，黄柏等，这些都是属于寒凉的东西还有我们饮用的冰水，吃冰箱里的食物，夏天吹空调，这些都是属于寒凉的因素。

所以如果睡眠不好的人，临床上遇到这些人，首先要考虑饮食的问题，是否喜欢吃冷的东西。

一个饮食，一个睡眠，这两个是最关键的。那么既然能量不足，我们如何去补充呢？补充能量最重要的是一个吸收的问题。我们现代人面临的最大问题是吸收问题，而不是营养不足的问题。随随便便一个人，现实的生活，绝对比穷苦地区的人要优越，尤其在英国，所以基本上不存在营养不够的状况，更多的是吸收的问题。有些人吃维他命，蛋白粉，吃生机饮食即生的和冷的蔬果，认为那样可以使营养不被破坏，吃大鱼大肉，每天喝牛奶，是否就能够补得了呢？未必！因为这些人共同都存在一个问题：吸收的问题。

吸收在中医来说就是一个太阴，脾的问题。脏腑论来说就是脾胃。只要你的脾胃好了，吸收能力增强了，平常的饮食就能够完全补足生活中所需要的一些能量。而我在英国行医的过程中，普遍看到的情况是，很多人喝冰水，吃冰激凌，早餐喝冷牛奶加麦片，中午吃冷三明治，沙拉，水果，仅晚上才吃一顿热食，而且餐后配冷的甜点。这样的饮食结构造就了大批脾胃虚寒的患者，圆运动变成了无法很好的运动，上下左右均病，肥胖人群由此而生。

补充能量重在增强吸收能力，提高食欲，而不是补充各种营养。

吸收能力好不好体现在食欲上，所以每次问诊一定要问食欲。

如果这个人没有食欲了，首先就必须调整，调整食欲其实就是把身体的能量调到脾胃。怎么调呢？跑到外面的能量把它拉下来，其实就是解决相火不位的问题，也就是解决睡眠的问题，处方用小柴胡加干姜汤。

这个方子里，小柴胡汤就是调升降的。在升降之中，很多人同时伴随一个虚，能量不足的问题，所以加干姜，补太阴的能量。调升降的方子和补能量的方子合在一起，就形成调整睡眠，调整相火不位最好的一个处方。当睡眠改善之后，能量吸收了，向下排泄垃圾的能力也越来越强，排便的问题自然就解决了。调整睡眠通常是一剂到三剂就可以把这个问题解决。

我的舅舅肾结石发病，疼痛难忍，不能睡觉，我介绍他服用此方，三剂不到结石就排出来了。在临床上只要患者有痛苦症状就可使用此方。生病就是能量不足了，发病就是升降不调了。最佳组合，是上午服用小柴胡加干姜汤调升降，下午服用理中汤系列补能量。一个往上发散，一个往下收敛，正好形成一个圆运动。

没有服过小柴胡加干姜汤的，只要经络没有打通，相火不位没有解决，在服用补能量的药之后，通常都会出现原先症状突然加剧的反弹现象。这是说明能量充足了(第一个问题已经解决)，就可以进入解决“阳明不降，相火不位，能量不收藏”的问题了。主要问题已经由先前的“能量不足”，变成“养足了的阳气不按照顺序走”，逆行或者不行，表现为相火不位了，所以用小柴胡汤来收拾不听话的阳气，引导能量归顺可以改服小柴胡加干姜汤。

能量渐足，而出现相火不位，体现为难入眠甚至彻夜不眠，但是如果隔天精神依然很好，就不要用小柴胡加干姜汤。就如元气渐足后的性欲强烈，不是要发泄，而是要收敛转化。改为养阴帮助收敛为宜。

组方原则：小柴胡加干姜汤，加味生脉理中汤（包括理中汤系列）都是调升降，但是寒热的升降都是在有水的基础上才能够完成。所以使用调升降的方子前提：必须有水份。体现为舌头胖大有水分。只要舌头有裂纹，干瘦红，不论升降，都必须先补充水分，养阴。先服用养阴方，直到舌头有水分，才考虑用调升降的方子。

病例分析（一）

A 男士，腹泻 40 多年。为一家企业老板，事业有成，家庭幸福，唯一苦恼的是每天早上上洗手间，没有 20 分钟出不了门，腹泻腹痛，西医无法医治。遂来看中医。查，身体壮实，胃口好，手足凉，睡眠佳，每天腹泻十几次，常常食后即泻。脉搏不规则，每跳 3-5 次停搏一次，无心脏病史，舌淡红有少许裂纹，苔白润。平时喜饮冰啤酒。早餐常喝冷牛奶麦片，中午吃冷三明治，晚餐热食。

分析：首先手足凉，说明能量不足；苔白润，说明水分足，但舌头有裂纹说明平时的寒凉饮食和多年腹泻已经伤了体阴；睡眠好，食欲好，说明升降没有问题。脉搏不规则，说明已经伤到脏了，病位比较深，寒气较重。腹泻腹痛，说明脾胃寒凉严重。因此治疗首选理中汤系列补阳性能量。

治疗： 嘱停止饮用一切寒凉食品，包括室温的水都太凉，要求尽量保证每日三餐食入的食物和水，温度高于体温，以补充内热源。特别是早上和上午阳气升起时，杜绝一切寒凉的饮食。

每天早上 7 点脾经循行时间，开始饮用姜枣汤（开太阴）：生姜 5-7 片，大枣 3 枚，红糖少许，加水烧开，5-10 分钟后饮用。代替开水，只要口渴就饮姜枣汤。下午 3 点后不要服用。(注：姜补阳，枣补阴，红糖把能量引入脾经，早上是阳气旺盛之时，故姜的用量一定要大于大枣)

下午 3，5，9 点服用加味生脉理中汤（因为患者舌苔有裂纹，故选加味生脉理中汤补阳兼顾养阴）。

针灸：曲池，合谷，天枢，中脘，关元，足三里，三阴交，艾灸中脘，关元

一周后复诊，腹泻由原来的十几次减少到 5-6 次，仍未成形。脉搏仍不规则，但感觉身体能量在恢复和好转。因早上开始工作早，所以姜枣汤从 6 点多就开始服用，平时尽量吃热食，但周末因社交原因，有时仍避免

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Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

不了冷饮，但尽量不加冰块。

嘱前方继服，坚持温热饮食。

第二周，大便仍稀，但已无腹痛，每天 4-5 次。治疗同前。

第三周，大便偶尔成型，脉搏仍每 3-5 跳停搏一次，手仍凉，前方继治。

两个月后，大便成形，脉搏恢复有规律的跳动（内脏受损的能量已经补回来），手变温，饮食，睡眠都很好，患者很满意，又继续治疗一个疗程，并开玩笑的对我说，你把我的病治好了，但是带走了我爱吃的一切食物。呵呵，他的饮食习惯已经完全改变，从寒凉变为温热，并学会用姜枣汤来保护自己的脾胃。中医说三分治七分养是一点都不错。

病例分析（二）

B 女士，斑秃三个月来诊，查后脑勺头发缺失，2*2.5cm。体瘦，皮肤干，指甲脆，潮热盗汗，易口渴，睡眠差，便秘，手足热，舌干瘦红，少苔，有深裂纹多处，脉细。平时喜食生冷水果。食欲好，餐后常常还有饥饿感。

分析：睡眠不好，说明升降不调；手足热，潮热盗汗，说明能量外散不能收敛；舌干红有深裂纹，皮肤干，餐后饥饿感，说明水不足，严重阴虚。

治疗：第一周，给予 1/3 小柴胡加干姜汤，调升降。为什么没有直接给补水的药，因为很多患者看起来是阴虚，但一给补水的药，通常不出三天就会腹胀。腹胀是水补足的标志。如果经络不通，能量很难补进去，所以先给她调升降。

嘱停止食用寒凉水果和蔬菜，如果实在想吃，先把温度加热到体温以上。

第二周，便秘好转，但仍潮热盗汗，手足热，口渴易饥，皮肤干，余证同前. 治疗：上午服用姜枣汤, 下午第 1，3，5，7 天服用加味生脉理中汤（小剂量）, 第 2，4，6 天服用生脉熟地枸杞饮（小剂量），补阳和养阴隔天交替服用。

第三周，已无便秘，口渴稍好，仍潮热盗汗，诸症同前。治疗：上午服用姜枣汤, 下午服用生脉熟地枸杞饮（小剂量）7 剂补阴，嘱腹胀停服，回来换方。

第四周，睡眠好转，潮热盗汗大为减轻，舌苔开始润泽，裂纹变浅，头发缺损处开始有细小的绒毛生长。令我很惊讶的是患者服了一周的养阴药，都没有出现腹胀，说明缺水（阴虚）很严重，于是继续补水，方同前。

第五周，头发缺损处，毛发长势喜人，已有 3-4 厘米长，色略白，微黄。仍无腹胀。

于是继续补充阴性能量，两个多月后，斑秃处已覆盖满头发，色白（周边正常的头发是棕色的），而且，有黑棕色的头发开始长出。潮热盗汗已经完全好转，睡眠好，舌红苔润，裂纹变浅，几近无。患者已经基本痊愈，在整个治疗过程中，当阴性能量补足的时候，头发自然就生长出来了。

可见斑秃，潮热，便秘等等这些症状都只是身体能量水平失衡的表现，只要对能量失衡做出正确判断，并给予纠正，疾病就可以痊愈。

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学习《素问.举痛论》心得
—百痛生于气 气不通则痛

徐廣文

【摘要】：作者根据“百病生于气”首出自《素问.举痛论》篇的末段之首，“百病生于气”是对《素问.举痛论》整篇的总结。整篇讲的是疼痛，疼痛的病因病机，和疼痛的部位。分析认为，“百病生于气”，涵概了百痛生于气。“百病生于气”，百痛生于气的“气”是指引起病痛的病因。而“寒气入经而稽迟，… …客于脉中则气不通，故卒然而痛。”的“气不通”则是致痛的病机。寒、热、湿邪，和气滞、食积、气虚、阳虚、血瘀等因素，若不导致气机不通，一般是不会引起疼痛的。只有当导致气机运行不通时，才会引起疼痛。故气不通则痛，气通则不痛。

关键词：疼痛 病机 百痛生于气 气不通则痛 气通则不痛

Learning Notes on *Su Wen. Ju Tong Lun*

XU Guang-wen

Abstract ： *Ju Tong Lun* (Discussion Highlighted on Pain) is the thirty nineth chapter of *Su Wen* which specifically discusses and analyses pain mechanism. "Many diseases are caused by Qi" first came from the last paragraph of *Ju Tong Lun*, and it is deemed as the summary of the chapter, in which the Yellow Empire and his ministers discuss the pain, causes of pain, pathological mechanism of pain, and pain manifestations. "Many diseases are caused by Qi" includes "Many pains are caused by Qi". While the "When the cold- evil invades the channel, Qi circulation in the channel will

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
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become obstructed, and the obstruction caused qi stagnation, so the pain will suddenly occur." Qi stagnation is therefore the pathological mechanism of pain. The cold, heat, dampness, Qi stagnation, indigestion, Qi deficiency, Yang deficiency, blood stasis and other factors, if not leading to Qi obstruction, they will not cause pain. Only when they lead to Qi obstruction, these pathogenetic factors will cause pain. Hence there is such a TCM saying as Qi obstruction causes pain, unblocking Qi heals pain.

Key word: Pain; pathological mechanism; Qi obstruction causing pain; unblocking Qi curing pain.

“百病生于气”首出自《素问.举痛论》篇的末段之首，“帝曰：善，余知，百病生于气也。”《素问.举痛论》的整篇讲的是疼痛，疼痛的病因病机，和疼痛的部位。故分析认为“百病生于气”涵概了百痛生于气。“百病生于气” 百痛生于气，是对病痛的病因病机高度概括。如《素问.举痛论》曰：“恐则气上，喜则气缓，悲则气消，恐则气下，寒则气收， 炅则气泄，惊则气乱，劳则气耗，思则气结，九气不同，何病之生？”说明致痛的病因是“九气”；而“寒气客则脉不通”；“寒气入经而稽迟，… …客于脉中则气不通，故卒然而痛”。“热气留于小肠，肠中痛，瘅热焦渴，则坚乾不得出，故痛而闭不通矣。”说明：导致疼痛的病机是“气不通”。气机不通则痛，痛则气不通，气通则不痛。

因为，气为一身之主，升降出入有序，无处不到，内至脏腑（如： 肝气、 肺气 、心气 、脾气、肾气 、胃气 、宗气、中气、元气、精气、阳气等脏腑之气），外达肌腠（如：卫气、阳气），运行全身（如：营气、宗气、血气、经络之气、阳气等）。气机升降出入，治节在肺，疏泄于肝胆，调节由心肾，枢纽是脾胃，运行在经脉，通达腠理皮毛、肌肉筋骨 、四肢百骸、五官九窍，以维持人体的正常生理活动。

如果各种内外因素：如情志失常、寒温失调、饮食失节、劳倦太过、跌打损伤等使气机的升降出入失常，运行通达受阻，而导致气机运行不通则可引起各种疼痛。如：

1. **寒凝而致气不通则痛**：从《素问. 举痛论》 疼痛病机十四条看，致痛之因主要为寒，分析其致痛机理：一是寒盛“络脉绌急相引”，使气血运行迟缓；二是寒凝而气滞，使气机不通则痛。如《素问·举痛论》说“寒气入经而稽迟，泣而不行，客于脉外则血少，客于脉中则气不通，故卒然而痛。” 寒凝气滞，使气机不通可致腹痛 、胃痛 、痛经 、疝气痛 、痹痛 、身痛、头痛 、颈肩痛 、腰痛等。
2. **肝郁气滞而致气不通则痛**：情绪抑郁、紧张、性格内向，有不顺心的事都埋在心里，日久则肝郁而气滞，使气机不通可致各种疼痛。如肝区疼痛，胁肋胀痛，情志不畅时更甚。肝郁气滞于厥阴经，则见少腹胀痛或窜痛，妇女可见乳房胀痛，痛经 。肝郁气滞于胃脘，则见气滞胃痛，胃脘痞胀疼痛，或攻窜引胁背痛等。
3. **食积而致气不通则痛**：饮食不节或失常，而致食积、虫积、结石等滞留于内，阻滞腑气，则气机不通，导致各疼痛。如气滞胃痛，气滞腹痛，胆绞痛等
4. **湿阻而致气不通则痛**：外感湿邪，或内生痰湿， 阻遏气机，导致气机升除出入运行失常，而使气滞，气机不通则致各种疼痛。如：痹痛 头痛 脘腹痞满疼痛，腹痛，关节肿痛，周身肌肉疼痛等。
5. **气虚而致气不通则痛**：因气虚体质；或久病致气虚，《素问·举痛论》曰:“劳则气耗”；“气为血之帅”，气虚无力推动气血运行，使气血运行迟缓或瘀积，则易气滞而血瘀，导致气机不通则痛。
6. **阳虚而致气不通则痛**：阳虚体质，或久病致阳虚，阳气不能温煦经脉，脉寒则气血运行涩滞，易致气滞血淤，使气机运行不通则痛。如《素问·调经论》说“血气者喜温而恶寒，寒则涩不能流。”
7. **血瘀而致气不通则痛**：多由跌打外伤，离经之血，瘀血而阻滞，影响气的运行；或嗜食油腻甘甜，使血脂过高；或饮食过咸，饮水不足，均能使血液过度黏稠，导致气血运行不畅，则易血瘀而气滞，使气机运行不通则痛。
8. **热壅而致气不通则痛**：热邪壅盛，正邪相搏，则影响气血运行，而火热更易灼伤津血，使经脉壅涩不通，导致气滞血瘀，则气机闭阻不通而痛。如《素问·至真要大论》云:“诸病胕肿，疼酸惊骇，皆属于火”。“*诸痛痒疮，皆属于心*”，心属火。《素问·举痛论》曰: “热气留于小肠，肠中痛，瘅热焦喝，则坚干不得出，故痛而闭不通矣。”《丹溪心法》：“痛甚者多火”。

可见寒、热、湿邪，和气滞、食积、气虚、阳虚、血瘀等因素，若不导致气机不通，一般是不会引起疼痛的。只有当寒盛、热壅、湿阻，气滞、食积、血瘀、气虚、阳虚等导致气机运行不通时，才会引起疼痛。所以，气机不通是导致疼痛的主要机理，是致痛的靶点，气不通则痛，痛则气不通，气通则不痛。

结语：

《素问.举痛论》篇的“百病生于气”涵概了百痛生于气。 “百病生于气” 百痛生于气，是对病痛的病因病机高度概括。“九气”致百病，“十病九痛”，“百病有百痛”。只有当“九气”使气的升降出入失常，导致气机运行不通则可引起各种疼痛。故“气不通”是致痛的主要机理。气不通则痛，气通则不痛。

【作者简介】徐廣文教授，1955 年出生。毕业于上海中医药大学，硕士研究生。主任医师。曾师从中国著名中医学家董建华院士，上海市曙光医院博士生导师石印玉 、姚嘉康、徐菱教授等。1993 年公派美国加州讲学和短期工作。在英国从事中医工作 15 年。发表论文 26 篇。

联 系 方 式 ：year.365@hotmail.com

前列腺癌的中医論治思路和臨床應用

香港中文大學中西醫結合醫學研究所 程劍華

摘要：前列腺癌是老年男性常见的恶性肿瘤之一，近10年对前列腺癌的不断研究, 在前列腺癌的预防与早期诊断, 以及对部分患者选择“等待观察”或积极治疗等方面取得了重要进展。本文提出中医論治前列腺癌的思路應從以下六個方面考慮。一、等待观察期的中医药治疗是中医药治疗前列腺癌的切入点。二、前列腺癌内分泌治疗或藥物去势术后综合症的中医药治疗。三、中医药在前列腺癌围手术期的干预研究治疗。四、中医葯治疗前列腺癌放射治疗后综合症。五、中医葯治疗对内分泌治疗耐药或无效、化疗失败的前列腺癌或者晚期前列腺癌患者。六、中医药治疗不願接受手術和西醫治療的晚期前列腺癌患者。並列舉出臨床應用的中醫验案。

關鍵詞：前列腺癌 中医药治疗 論治思路

TCM Treatment Ideas and Clinical Applications for Prostate Cancer

Hong Kong Institute of Integrative Medicine, the Chinese University of Hong Kong, Hong Kong
Cheng JianHua, Wu Che Yuan Justin

Abstract： Prostate cancer is a common cancer in older men. Thanks to continuous research over last 10 years, an important progression has been achieved in the prevention and early diagnosis of prostate cancer, as well as "watchful waiting" or active treatment and other areas. The treatment of prostate cancer should be individualized, life expectancy of patients, health, pathological and clinical stage, family and economic status should be considered when choosing the treatment. Whatever treatment used to the patients, complications caused by the treatment can induce the decrease of patient’s life quality significantly. Compared with Western medicine, TCM treatment can regulate immune function, enhance the body resistance, improve the effective rate and delay disease progression.

In this paper, the author discusses TCM treatment of prostate cancer from the following six aspects. 1) Using TCM treatment during the "watchful waiting" period is the entry point for TCM in prostate cancer treatment. 2) TCM treatment for endocrine therapy or medical castration syndrome. 3) TCM treatment for perioperative patients. 4) TCM treatment for complications after radiotherapy. 5) TCM treatment for patients who with endocrine therapy resistance or failure in chemotherapy, or patients with advanced cancer. 6) TCM treatment for advanced patients who are unwilling to undergo surgery and Western medicine treatment. 7 case reports are given to support the argument.

key words： prostate cancer, traditional Chinese Medicine treatment, treatment ideas

前列腺癌是老年男性常见的恶性肿瘤之一，是老龄男性的重要杀手。尽管前列腺癌的早期诊断及治疗均获得长足进步, 但 2007 年美国因前列腺癌死亡的预期患者数仍将超过 27000 人[1]。越来越多的证据显示, 若进行长期随访, 大多数健康男性将最终患前列腺癌并因之死亡[2] 。

前列腺癌的发病临床早期症状少，大部分患者确诊时已到晚期，失去手术根治时机。随着前列腺癌发病率、死亡率的上升，前列腺癌已成为现代医学研究的热点。目前美国肿瘤学界对临床局限性前列腺癌的最佳治疗手段仍存在争议。然而, 近10年对前列腺癌的不断研究, 在前列腺癌的预防与早期诊断, 以及对部分患者选择“等待观察”或积极治疗等方面取得了重要进展 [3]。

中医药在前列腺癌診治的那些领域有何作为?本人認爲中医論治前列腺癌的思路應從以下七個方面考慮。

一、等待观察期的中医药治疗是中医药治疗前列腺癌的切入点

早期低危的前列腺癌患者等待观察策略,是临床医学专家经过多年研究得出的最合理的治疗方法和策略。是因人制宜、体现个体化人性化、体现“最大程度使病人收益”为宗旨的最佳方法。大部分的前列腺癌却长得缓慢，就算不治疗，也许要10多年才会威胁生命。据统计，美国人终期一生有16%会被诊断出前列腺癌，但只有3%会死于前列腺癌。在90年代欧洲和美国利用PSA的检测大量诊断出早期前列腺癌，美国对病人进行前列腺癌治疗；欧洲则对这些患者建议接受观察而不治疗。一系列临床数据显示, 临床医生可根据肿瘤的临床特点来确定那些具有低危险肿瘤进展的患者从而对他们给予监测或“等待观察”的处理策略[4]。对低危、预期寿命短的患者;对于因治疗伴随的并发症副作用过大, 不利于延长生命和改善生活质量的晚期前列腺癌病人宜选择等待观察策略。前列腺癌早期低危患者及晚期（M1）患者，在患者充分知情及了解进展及转移风险的患者，可选择等待观察或選擇中医药治疗为主的治療。中医药治疗对这些病人能扬长避短，主要能减轻症状、改善生活质量和延长生命，这是中医药治疗的切入点和优势之一。

验案1：中医药治疗早期前列腺癌和胸腺瘤成活超

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

过10年

张某某，男，71岁，广州市人。患者素有胸腺瘤，2003年2月MR示：前列腺增大，约62x42x51mm，中央带结节样，增强后肿块明显强化，考虑前列腺癌。活检未见癌细胞。TPSA9.0ng/ml,cPSA5.7ng/ml,FPSA3.3ng/ml，FPSA/TPSA0.37。无明显症状，食纳可，小便正常，舌淡红苔薄，脉滑。病属前列腺癌低危型，西医认为宜等待观察。患者不願手術，要求中医药治疗。辩证：痰瘀互结。治法：化痰散结。方药：五指毛桃30g、仙鹤草20g、藁本10g、仙茅15g、桑椹子20g、猫爪草30g、杏仁10g、薏米仁20g、千斤拔30g、淫羊藿15g、天麻10g、石菖蒲10g、山慈菇15g、重楼15g、穿山甲5g（先煎）、白七厘10g。同服知柏地黄丸和金龙胶囊、虫草胶囊等。随症加减治疗4年餘。2007年7月19日彩色B超示：前列腺增大，约52x42x45mm，内见强回声小光团，較前明顯縮小。PSA较前好转。繼續中藥治療。以後每年檢查前列腺和PSA, 病情稳定。2008年8月患者中藥治療后眼皮沉重感減轻，小便正常，无腰痛，食纳好，生活工作自理，舌淡红苔薄，脉滑。方药：五指毛桃30g、仙鹤草20g、柴胡10g、仙茅15g、桑椹子20g、猫爪草30g、杏仁10g、薏米仁20g、千斤拔30g、淫羊藿15g、天麻10g、瞿麦20g、山慈菇15g、重楼15g、穿山甲5g（先煎）、黄芪30g、升麻10g、白七厘10g。同服金龙胶囊、平消胶囊和虫草胶囊等。随症加减治疗至今。现健康存活已10年。

按：该患者核磁共振检查为前列腺癌，PSA轻度升高，为低危前列腺癌患者。

西医认为宜等待观察。但患者合并有胸腺瘤，不能手术，故求治于中医。证属中

气不足、湿热下注、毒瘀互结。治疗宜补中益气、清热利湿、结毒散结。以黄芪、

升麻、柴胡、陈皮、补骨脂补中益气，选用五爪龙、重楼、冬葵子、瞿麦、野菊

花 清热解毒，用车前草、荠菜、补骨脂、猪苓、泽泻温阳化气利水，用穿山甲、

路路通、王不留行、全蝎、蜈蚣软坚散结。治疗后前列腺肿块有缩小，PSA下降，

小便基本正常。胸腺瘤先有增大，后调整药物后病灶亦见缩小。该患者中药治疗

后现已健康存活10年，生活工作自理。

二、前列腺癌去势术后综合症的中医药治疗。

睾丸切除术或药物去势术后其常见的并发症包括性欲降低、勃起功能障碍、阵发性潮热、乳房胀痛及女性化、性格改变、认知能力下降以及长期处于低雄激素状态下所导致的骨密度下降、贫血等，对于去势手术所引起的这些并发症中医药治疗优势比较明显。

验案2：中医药治疗前列腺癌多發骨轉移药物去势术后综合症

董某，男，66 歲，香港人。患者 2013 年 6 月檢查 PSA 為 40 多，MR 檢查確診為前列腺癌多發骨轉移，無法手術，服荷爾蒙葯后好轉，PSA 為 1.8 多，后出現肥胖，潮熱，腹脹，四肢不溫。2013 年 10 月 7 日初診，症見：腰不痛，食納好，有潮熱，肥胖，進食腹脹，大便可，有濕熱感，感乏力，夜寐不寧，夜尿 1-2 次，四肢不溫。舌苔白，脈細。西醫診斷為前列腺癌伴骨轉移，中醫診斷為前列腺癌伴骨轉移药物去势术后综合症，証屬肝腎陰虛，治宜滋補肝腎、壯骨安神。方藥：補骨脂 15、天冬 20、枸杞 15、山萸 10、淫羊藿 10、黃芪 30、透骨草 15、仙茅 9、巴戟天 15、熟地黃 20、炒骨碎補 15、炒酸棗仁 30、茯苓 15、陳皮 6、青蒿 15、地骨皮 15、薑天麻 15、製何首烏 15、炒鱉甲 20（先煎）、紅景天 15、赤靈芝 10、知母 10。隨症加減，服中藥治療 9 月多，諸症明顯好轉，2014 年 4 月作骨掃描示骨正常，PSA0.02,，腰不痛，生活行動正常。

按：前列腺癌患者行睾丸切除术或药物去势术后會产生肥胖、潮熱、烘热汗出、头晕等一系列症狀，影響生活質量。中医辨証为肝肾阴虚、气虚血亏，从补肾入手，调整阴阳、平和气血，并依据是否兼夹瘀血、痰湿、气郁而随证加减治疗。方药可選知柏地黄丸、玉屏风散、右归丸、二仙汤、柴胡桂枝汤等，并依据临床不同的证型及伴发症狀加減，可以减轻症狀，提高生活质量。本案為前列腺癌多發骨轉移，無法手術，服荷爾蒙葯后好轉，出現肥胖，潮熱，腹脹，四肢不溫，不寐。証屬肝腎阴虛，痰溼内蘊。方藥選右歸丸合青蒿鱉甲湯加減，選天冬、枸杞、山萸、熟地黃、製何首烏滋補肝腎，選用淫羊藿、仙茅、巴戟天等溫腎陽，用透骨草、炒骨碎補、補骨脂等壯骨，用青蒿、地骨皮、炒鱉甲、知母等滋陰清熱，用薑天麻、茯苓、陳皮等化痰除濕，用黃芪、炒酸棗仁、紅景天、赤靈芝等補氣養心安神。諸葯合用，達滋補肝腎、溫腎壯骨、化痰祛溼、益氣養心安神等功效。

三、中医药在前列腺癌围手术期的干预研究治疗

（前列腺癌根治术后综合症的中医药治疗）。

前列腺癌根治术后常见的并发症尿失禁的病例不断增多。“肾为水之关，脾为水之制”，故水道膀胱气化功能与肺脾肾相关。气虚不摄，加之肾阳不足，膀胱气化失常，故表现为尿失禁。在常规治疗方案基础上，采取中医益气温阳为主的综合治疗方案，可取得一定的效果。具体方案为：⑴艾灸气海、关元穴，每次30 min，2次/d，10 d 1疗程。⑶电刺激生物反馈盆底治疗。⑷提肛训练[5]。

验案3：中医药治疗前列腺癌术后尿失禁

黎某某，男。70 歲，香港人。患者有前列腺肥大，尿頻急 2 年，服保列治治療有效，PSA6.4。2014 年 1 月檢查發現有前列腺癌，PSA5.4，2014 年 7 月 23 日行手術切除，手術后感倦怠乏力，體位改變易尿自瀝，不能控制，食納可，非常煩惱，舌苔淡薄，脈細。西醫診斷為前列腺癌术后後遺症，尿失禁。中醫診斷為中氣下陷、肝郁腎虧。治宜補中益氣、舒肝補腎。方藥選補中益氣湯、升陷湯和縮泉丸加減：補骨脂 15 克、炙黃芪 20 克、太子參 15 克、沙苑子 15 克、升麻 10 克、金櫻子 20 克、益智仁 10 克、製桑螵蛸 10 克、製山茱萸 10 克、煅牡蠣 20 克、煅海螵蛸 20 克、柴胡 10 克、陳皮 10 克、烏藥 10 克、人參葉 15、桔梗 15、知母 10 克。隨症加減，該案用補中益氣湯和升陷湯、縮泉丸加減治療半年多，諸症好轉。治療后小便基本上可以控制，夜寐時可控制尿，無滲尿，臥位起身無尿自瀝，臥位或白天坐位可以控制尿滲，站立和行走时有滲尿，但較中藥

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治療前有改善，氣力有增。復查 PSA0，現繼續中藥治療。

按：前列腺癌根治术最常见的并发症是尿失禁，給患者的生活帶來極大的不便，影響患者的生活質量。前列腺癌术后患者多為中氣不足，大氣下陷，故治療必須补中益气、提升大氣，兼顧補腎來達到效果，中药治疗以缩泉丸、补中益气丸、升陷湯为基础加減。並加強適當運動，進行提肛训练，逐步恢復膀胱括約肌的功能，改善尿失禁。

四、中医葯治疗前列腺癌放射治疗后综合症。

前列腺癌外放射治疗期间的并发症包括放射性肠炎、放射性膀胱炎和放射性皮肤损坏等，可能伤及神经而导致性功能丧失。中医辨证当属气阴两伤，或气虚血瘀，或热毒内盛。治以扶正祛邪为主，采用益气养阴、清热解毒之法为宜。因放疗导致异常疲倦或脱发者，治宜滋补肝肾，可选用生地、玉竹、沙参、枸杞子、女贞子、太子参、山茱萸、黄芪、补骨脂等；放射性肠炎腹泻者可选用参苓白术散、葛根芩连汤、四神丸等加豆蔻、石榴皮、火炭母、救必应等治疗；放射性膀胱炎治宜清热解毒、利湿通淋，可选用济生肾气丸、五苓散、癃闭散加土茯苓、白茅根、车前草、薏苡仁、瞿麦、扁蓄、灯心草等。

验案4：中医药治疗前列腺癌术后放療后並發症

連某某，男，46 歲，香港人。患者 2011 年 6 月發現有前列腺癌，PSA 為 9，行手術切除，PSA0.03，病情穩定，2014 年 PSA0.04。2014 年 6 月行放射治療，電療后，出現感氣短，大便稍頻，小便稍頻伴灼熱，時尿為淡紅色，坐位轉立位時偶有少許尿滲出，食納好。舌淡紅苔白，脈滑。西醫診斷為前列腺癌术后放射治療后並發症。中醫診斷為前列腺癌，證屬腎虛血瘀、濕熱下注。治宜補腎祛瘀、清熱利溼，方藥為：黃芪 20 克，補骨脂 10 克，五爪龍 15 克，千年健 15 克，太子參 15 克，升麻 10 克，豆蔻 15 克、柴胡 10 克，桑椹 15 克，菟絲子 10 克，金櫻子 10 克，黃芩 15 克，豆蔻 15 克，五加皮 15 克，蘆根 10 克，白茅根 15 克，車前子 15 克、地黃 15 克，牡丹皮 10 克，西洋參 3 克。隨症加減，治療后諸症改善，大小便正常，精神好，食納可，體重正常，性生活可，活動后稍有氣短, PSA0.05。繼續中藥治療。

按;前列腺癌术后放療后多會出現放射性膀胱炎、放射性直腸炎等後遺症。該患者放療后出現大便頻稀，尿頻、尿痛、甚至尿自瀝等副作用，給患者的生活帶來的不便，影響患者的生活質量。放射綫多為熱毒之邪，易傷陰損精，故前列腺癌术后放療后患者多為肝腎虧虛、兼濕熱下注，治療一方面要補中益氣、滋補肝腎，另一方面又要清熱利溼、祛瘀固精。攻補兼施，收效甚佳。

五、中医對前列腺癌患者PSA 升高的治疗是中医药治疗的切入点之五

治疗前PSA 值与治疗后PSA 动态值可预测患者的长期预后及因前列腺癌死亡的风险[6],治疗后肿瘤复发通常是根据PSA 升高来确定,升高值与病死率呈正相关[7]。因此, 目前血清PSA 检测仍是前列腺癌筛选及预测临床局限性前列腺癌预后的指标。中药治疗的关键是辨证辨病相结合,使体内雄性激素(二氢睾酮) 降至最低水平, 方能提高疗效。

验案5：中医药治疗前列腺癌术后PSA升高

翁某某，男，68歲，香港人。患者2013年5月診為前列腺癌，行睾丸切除术，术后用荷爾蒙治療，現無腰痛，不咳嗽，夜尿頻，2小時1次，食納可，有潮熱，2013年3月13日PSA481，术后2013年7月22日PSA為76.2,一直服中藥治療，2014年1月13日PSA降為49.4,后患者停葯，2014年7月3日PSA為188, 患者不願服西藥，要求用中藥治療。現患者夜尿頻，2小時1次，食納可，有潮熱，大便不暢，手腳不溫，腰痠，無腹痛。舌淡紅苔薄，脈細。證屬腎氣不足，痰瘀互結。治法宜溫腎通淋、解毒祛瘀、通絡散結。方藥：黃柏15克、野菊花15克、炒王不留行15克、皂角刺15克、蒲公英30克、黃芩15克、白茅根30克、甘松15、赤靈芝10、路路通20克、瞿麥20克、肉桂粉2克、貓爪草10克、山慈菇10克、九節茶15克、水紅花子10克、金櫻子15克、煅牡蠣20克、益智仁10克、煅海螵蛸20克。葯后好轉，腳轉溫，腰背不痛，每日晨游水，小便較暢，尿頻減，夜尿2-3次，矢氣多，大便稍不暢，時有淡紅血尿。隨診加減：血尿加小薊、薺菜、仙鶴草，大便秘結加肉蓯蓉、大黃，葯后明显好转，2014年11月4日检查PSA為12.7。繼續中藥治療。

按：該患者為前列腺癌术后PSA升高，證屬腎氣不足，痰瘀互結。治宜溫腎通絡、去瘀化痰、解毒散結。選方藥肉桂、黃柏、野菊花、赤靈芝、皂角刺、金櫻子、煅牡蠣、益智仁等溫腎通絡，以白茅根、路路通、瞿麥等通絡利尿，以貓爪草、山慈菇、九節茶、蒲公英等解毒散結，以黃芩、甘松、水紅花子、炒王不留行等祛瘀化痰。全方合用有滋阴溫腎、益气扶正、祛瘀除痰、解毒散結的功效，中药能使患者体内雄性激素降低, PSA下降至正常并维持恒定水平。后期阴精亏耗, 损及元阳, 应阴阳同补。

六、中医葯治疗对内分泌治疗耐药或无效、化疗失败的前列腺癌或者晚期前列腺癌患者是中医药治疗的切入点之六

对内分泌治疗耐药或无效, 化疗失败的前列腺癌患者，当发展为雄激素非依赖性前列腺癌，正气进一步受损，毒邪扩散，导致病入膏肓，出现(脾肾)阴阳两虚的证候为主；中医药治疗要解决的最大问题在于如何减轻患者痛苦, 提高生存质量,延长生存期。

驗案6：中医药治疗晚期前列腺癌骨转移成活2年

梅某某，男，62岁，广州市人。2009年7月6日首诊：患者行前列腺癌根治术
2年，近10天出现双髋节疼痛，活动受限，行走乏力，夜晚痛甚，X片示：髋骨、
坐骨、耻骨多处密度不均和增高，考虑骨盆多发转移癌。食纳可，舌淡红苔薄，
脉细滑。辩证：肝肾亏虚、气滞血瘀、瘀毒互结。治法：温肾壮骨、活血理气、
祛毒散结。方药：补骨脂20g、透骨消15g、骨碎补15g、制川乌10g、细辛3g、防
风10g、姜黄20g、桂枝10g、续断20g、威灵仙15g、寄生20g、牛膝15g、独活15g、

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杜仲20g、羌活10g。同服新癀片、甲地孕酮、金龙胶囊、紫龙金片、安康欣胶囊等。随症加减治疗。病情稳定，下肢有麻痹，感乏力，时有低热，白天不痛，晚上感双下肢隐痛，舌淡红苔薄，脉滑。守方加黄芪30g、太子参30g，随症加减治疗，病情稳定，生活基本自理，不痛时可作家务，痛时则不愿活动，治疗基本不变，治疗至今。

按：患者前列腺癌术后骨转移，行走困难，生活不能自理，先用中药温肾壮骨、活血理气、祛毒散结，继又温肾祛风、散寒止痛、益气固本。在此案治疗中主要以止痛为先，急则治标，缓解后则予温肾壮骨、益气固本，防止出现骨折。中药治疗后存活2年余，没有住院，生活质量较高。

七.不願接受手術和西醫治療的晚期前列腺癌患者是中医药治疗的切入点。

許多年老體弱的晚期前列腺癌患者大多合併有多種慢性基礎疾病、心肺肝腎等功能差等，不願接受手術和西醫治療，這些患者採用中醫藥治療是一种合理的選擇。

验案7：中医药治疗晚期前列腺癌成活2年半

韩某某，男，76岁，辽宁人。2008年1月4日首诊：患者前列腺肥大多年，排尿困难2天。2007年12月7日B超示：前列腺多个低回声团块，考虑前列腺癌。12月19日彩色B超示：前列腺70x63x58mm,其中可见24x20mm边界不清,回声不均匀的低回声结节，考虑前列腺癌。TPSA4390ng/ml,fPSA757ng/ml, cPSA3633ng/ml，PSA(F/T)为0.172。急诊插导尿管排尿。动员患者住院手术治疗，患者和家属坚决拒绝。要求中医药治疗。症见：排尿困难，无尿急尿痛，食纳呆，尿道有刺痛，心烦，夜寐不宁，舌稍红苔薄，脉弦。辩证：毒瘀互结、气机不利、水湿内停。治法：温阳化气、利水通淋、软坚散结。方药：透骨消15g、野菊花20g、仙茅30g、补骨脂15g、淫羊藿15g、路路通20g、王不留行15g、全蝎10g、蜈蚣1条、穿山甲10g（先煎）、生地30g、黄芪20g、肉桂2g（研末冲服）。

药后好转，精神見好，食纳增，已拔导尿管，小便可解，每次约50-100ml，全天尿量约500-600ml，无浮肿，大便可解，腹胀减，腰背痛，舌稍红苔黄腻，脉弦滑。方药：五爪龙100g、千斤拔100g、仙鹤草50g、白七厘15g、藁本10g、天麻10g、炙远志6g、石菖蒲10g、充蔚子15g、山慈菇30g、、猫爪草30g、重楼30g、杏仁15g、白寇仁6g（后下）、薏米仁30g。同服紫龙金片。随症加减治疗。 患者中药治疗1年余，病情稳定，PSA下降，食纳好，小便清，无血尿，时烦躁，易疲乏，大便结，生活自理，舌淡红苔薄，脉滑。

2009年6月19日 患者病情好转，小便清，无发热，精神好，已拔导尿管1周，小便正常，尿量可，无血尿，无尿痛，食纳好，周身乏力，心烦，舌淡红苔薄，脉滑。方药：益智仁30g、瞿麦20g、冬葵子20g、黄柏15g、野菊花15g、路路通20g、王不留行15g、白茅根30g、穿山甲10g（先煎）、金樱子30g、酸枣仁30g、黄芪30g、肉桂2g（研末冲服）。同服紫龙金片、虫草胶囊、甲地孕酮等。随症加减治疗。12月4日 病情稳定，导尿管已拔半年，小便可解，但尿频，尿急，每1-1.5小时1次，尿量尚可，排尿稍感乏力，食纳可，腹稍胀满，夜寐不宁，大便硬，舌淡红苔薄，脉滑。复查彩色B超示：前列腺肿大并弥漫改变，约74x68x65mm，边界不清，膀胱后壁欠光滑。肿块较去年2月明显缩小。治疗基本守方再进。随症加减治疗。

病情緩解后患者不聽勸阻，飲食不節，嗜食膏粱厚味，2010年6月患者病情加重死亡。

按：该患者为晚期前列腺癌高危型，不愿手术及西医治疗，完全选择用中医药治疗，证属毒瘀互结、气机不利、水湿内停。治宜温阳化气、清热解毒、利水通淋、软坚散结。选用五爪龙、重楼、冬葵子、瞿麦、浙贝母清热解毒，用白茅根、大小蓟、车前草、荠菜、仙鹤草利水通淋止血，用黄芪、肉桂、猪苓、泽泻温阳化气利水，用穿山甲、路路通、王不留行、全蝎、蜈蚣软坚散结。治疗期间病情变化复杂，辩证施治，随症加减。全方攻补兼施，疗后肿块明显缩小，PSA明显下降，取得极佳的疗效，插了1年多的导尿管拔去，疾病缓解期达到10個月。中藥治療療后生存期達2年半。

總結：

前列腺癌的治疗必须因人而异，治疗方法的选择应考虑患者的预期寿命、身體狀況、病理及臨床分期、家庭及经济状况等。无论何种治疗方法，因治疗所致的并发症會使部分患者生活质量明显下降。结合西医对前列腺癌分期及治疗方式不同，采用中医辨证治疗辅助西医治疗前列腺癌，可调节机体免疫功能，增强机体抵抗力，提高治愈率，延缓疾病进展。因此，根据中医药治疗前列腺癌的切入点和优势，采用整体辨证治疗或辅助治疗前列腺癌前景是广阔的。

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ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

针灸治疗难治性排卵障碍病人的临床观察

许晋，蔡亚斌，徐莉莉，朱建东，朱少雄

摘要 探讨基层医院妇产科对枸橼酸氯*米芬*（clomiphene citrate，*CC*）反应不良的排卵障碍患者加用针灸助孕治疗的临床观察. 方法:回顾性总结分析 2012.6 至 2014.6 在盛康医疗集团（郑州，盐城和淮安等地医院）接受 CC 促排卵 2-3 疗程无效的排卵障碍患者。符合准入标准共 238 例。分成:1.针灸组：促排卵药物加针灸共 109; 2.对照组：单纯促排卵药物治疗共 129 例。疗程 3-5 月，随访观察是否妊娠。结果: 针灸组促排卵的成功率为 68%, 妊娠率为 53%，而对照组排卵成功为 52%，妊娠率为 30%。 二组相比：针灸组妊娠率明显高于单纯促排卵药物组，具有统计学意义。(53%：31%，p<0.05).针灸疗法对 CC 抵抗+腹腔镜术后, 多囊卵巢综合症和先兆流产患者均有助孕疗效。结论: 本研究初步结果显示对 CC 反应不良的排卵障碍患者采用排卵药物加针灸可提高临床妊娠率。该法简便,安全,易行, 可适合有条件基层医院妇产科开展.

关键词 针药同治 排卵障碍 克罗米芬（clomiphene citrate, CC)抵抗 妊娠率 药物

The Observational Study on Acupuncture in Combination with Drugs in Treatment of CC-resistant Patients with Ovary Dysfunction

Xu Jin, et al.

Objective: To report the clinical outcome of combination of drugs with acupuncture together in treatment of patients with CC-resistant for improving pregnancy rate

Methods: From June 2012 to June 2014 patients with ovary dysfunction after CC treatment for 2-3 cycles at Zhengzhou，Yanchen and Huai'an Hospitals were selected and total 238 patients with CC-resistance met our study criteria and were included into the study. 238 cases were divided into two groups. Group 1 is acupuncture group (n=109) combining acupuncture with drugs together, and Group 2 as control group (n=129) in which only drugs were used. The ovulation induction regimes were performed and success rates of pregnancy were assessed.

Results：The result showed that the success rates of ovulation induction and pregnancy are 68% and 53% in acupuncture group compared with 52% and 31% in drugs-only group. The patients receiving acupuncture with drugs together had the better result in pregnancy rate than drugs-only group (P<0.05). The result also showed it was a useful method to conceive in some clinical difficult cases with CC-resistance PCOS and post-laparoscopic operation.

Conclusion: Acupuncture is safe, easy and useful method to combine drugs together to improve the pregnancy rate in some CC-resistant patients with ovary dysfunction

Key wards: Acupuncture, PCOS, Ovary Dysfunction, CC-resistance, Pregnancy rate.

前言

近年来，随着全世界范围内不孕症发病率呈上升趋势，在发达国家其发病率为 5%～8% [(1)]，在中国发病率约为 10% [(2)]。WHO 提出不孕症，心血管疾病和肿瘤已经并列为当今影响人类生活和健康的三大疾病。不孕症严重影响家庭和社会。不孕症的原因复杂，女方约占 40%-55%,男方占 25%-40%. 其中,女性一半以上的不孕由排卵障碍引起.目前,常规治疗排卵障碍的方法有药物,手术 和辅助生殖技术.均取得较好疗效.但中国临床广泛使用促排卵药物（枸橼酸氯*米芬*, clomiphene citrate，*CC*）和基层部分医务人员的不规范使用,导致 CC 不敏感或不反应病例增多,疗效欠佳。使患者花费较多时间,精力和开销，增加怀孕难度。

本研究选择 CC 反应不良的排卵障碍病人作为对象，按照中华医学会生殖分会 2012 年推荐不孕症病因初筛临床路径，并结合我国基层医院妇产科的现状，采用常规助排卵药物加针灸的针药同治法进行助孕治疗。取得令人鼓舞的初步结果，现报道如下。

1 材料和方法

1 对象资料来源

按照中华医学会生殖分会新推荐的不孕症病因初筛临床路径, 回顾性总结分析 2012.6 至 2014.6 在郑州华山，盐城协和和淮安中山等医院接受 CC 促排卵 2-3 疗程无效的排卵障碍患者。符合准入标准共 238 例。分成:1.研究组：排卵药物加针灸的针药同治共 109 例, 年龄 20 至 38 岁，不孕年限 2－4.5 年。 2.对照组：单纯药物治疗共 129 例。疗程 3-5 月， 年龄 19－37 岁。不孕年限 2－4 年。观察是否排卵和临床妊娠。

1.2 诊断标准：参照《中药新药临床研究指导原则》相关标准及《女性不孕症的中西医结合诊断标准》拟定。月经周期＞35 天或＜25 天；B 超连续监测至少1 个月

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

经周期提示卵泡生长缓慢，无优势卵泡，生长过程中卵泡萎缩、停育、卵泡不破，子宫内膜过薄

1.3 纳入标准：符合排卵功能障碍性不孕症诊断中的卵泡不破者，且无严重并发症。接受 CC 促排卵 2-3 疗程无效的患者。

1.4 治疗方法

1.4.1 治疗组 予针药结合治疗。针灸方法：取穴神阙、中极、关元、子宫 （双侧）、足三里（双侧 ）、内关（双侧）、三阴交（双侧）。常规消毒，应用4、7号针“*华佗*”*牌针灸*针（中国苏州医疗用品厂有限公司）刺入约1寸，患者有得“气”感。 针刺得气后接电极线(双侧子宫、内关，三阴交，足三里分别接一对正负极)，用6805- D 电针仪， 疏密波， 频率1～1.2Hz， 电流输出1～2 档，通电30min，每天1 次。*(SDZ-II型，苏州医疗用品厂有限公司)*.神阙穴用艾灸悬灸。配合针灸从第9 d开始。CC *50 mg，Bid，月经周期第3 d起连用5 d； （广州康和药业有限公司，国药准字H44021970），HMG*（尿*促性素*），*75－150iu im， Qd， 月经5天起连用7天*，为1个治疗周期。*(*宁波人健药业集团股份有限公司生产，国药准字：H20033042，每支75IU。*第一次用药者，给予HMG 75IU 每日一次，连续用药7天。如2疗程无排卵，加大HMG用量，给予HMG 150IU 每日一次，连续用药7天)，*超监测下卵泡平均直径≥18mm 时，即给予HCG (*绒促性素*）5 000～10 000IU(宁波人健药业集团股份有限公司生产，国药准字：H33021021，每支2000IU)肌肉注射1 次，同时每天B 超监

1.4.2 对照组 仅予常规CC（ *克罗米芬* ）和HMG（尿促性腺素）用药，方法同治疗组。 *（第一次用药者，给予HMG 75iu 每日一次，连续用药7天。2疗程无排卵，加大HMG用量，给予HMG 150iu 每日一次，连续用药7天。*超监测下卵泡平均 直径≥18mm 时，即给予HCG5 000～10 000IU(宁波人健药业集团股份有限公司生产，国药准字：H33021021，每支2000IU)肌肉注射1 次，同时每天B 超监测。

1.4.3 疗程 2 组均治疗 3~5 个月。

1.5 妊娠标准 停经 10 d 查血 HCG,并于停经 50 d 后 B 超查妊囊，若血 HCG 阳性，见宫内妊娠囊和胎心博动，确诊为临床妊娠。排卵监测方法： B 超 D9 开始监测卵泡发育，≥18 mm 卵泡并破裂、尿 LH 值上升(≥20 miu/mL, 出现双线)为排卵表现，并及时指导同房。

1.6 统计学方法 采用 SPSS 17.0 统计软件进行统计学分析, 计数资料率的比较采用 X^2 检验。

2 结果

2.1 一般资料比较

表 1 两组病人年龄和不孕一般资料对比

组别	n	平均年龄	不孕年限
针药同治组	109	25±2.37	3±1.37
药物促排卵组	129	25±2.07	3±1.09
统计学意义		P>0.05	p >0.05

两组年龄和不孕一般资料对比无明显差异（P>0.05)

2.2 促排卵成功和临床妊娠率的比较

表 2 两组病人促排卵成功和临床妊娠率的比较

组别	n	促排卵率（%）	妊娠率（%）
针药同治组	109	68	53
药物促排卵组	129	53	30
统计学意义		P>0.05	P<0.05

2 组促排卵率及妊娠率比较 治疗组 109 例，促排卵率 68%（74/109），妊娠率 53%（58/109）；对照组 129 例，促排卵率 52%（67 / 129），妊娠率 30%（38 / 129）。治疗组妊娠率高于对照组（53%：30%，*P*<0.05），治疗组疗效优于对照组。

3 讨论

中医学认为， 不孕病因有肾虚，血虚，血瘀，肝瘀和痰湿。诸病因可以单独为患，亦可相兼为病。现代中医认为，不孕最常见病因是月经不调及肾虚。排卵障碍是导致女性不孕的一个主要原因，中医女性不孕病因可能与下列因素有关，（1）心为“五脏六腑之大主”，心藏神主血脉，心神失养，则诸脏失调，不易摄精成孕；（2）督任虚寒：督为阳脉之海，任主胞胎。任督虚寒，胞宫失于温煦发育，因 而不能摄精成孕；（3）肝郁血瘀：冲任气血瘀滞而影响排卵；（4）冲任虚损或失调：气血两虚、肝经郁滞血瘀、痰凝等致病因素作用于机体，造成肾气亏损，气血不足，冲任失养或气郁、痰血互结，冲任失调，造成卵巢功能失常而不能排卵。

现代医学认为，排卵障碍是导致女性不孕症的一个主要原因,占 25-30% [3].可分成 I 型:下丘脑,垂体病变引起;II 型:最常见,是下丘脑-垂体-卵巢轴功能失调,如 PCOS 和月经失调.III 型:卵巢衰竭或不敏感.其根本原因在于下丘脑-垂体-卵巢轴的如何部位发生功能或器质性病变导致暂时或长期排卵障碍.临床常见于闭经, PCOS,功血,高催乳素血症,未破裂黄素化综合症,黄体功能不全,卵巢早衰,甲状腺功能失常和肾上腺功能失常等. 排卵障碍根本原因在于下丘脑-垂体-卵巢轴的部位发生功能或器质性病变导致暂时或长期排卵障碍，故排卵障碍治疗的关键是调节恢复正常下丘脑-垂体-卵巢轴功能，使卵巢正常排卵，从而促进妊娠。

CC 的促排卵机制是作用于雌激素水平(抑制雌激素受体来诱发排卵) 但是由于 CC 具有减少宫颈黏液、弱化黄体功能的副作用。[4] 因此由其治疗的妊娠成功率受到局限。而且常常对 PCOS 患者疗效欠佳.若加大助排卵药物剂量,常引起多个卵泡发育,导致双胎或多胎妊娠,严重时可发生卵巢过度刺激综合症影响患者妊娠过程甚至危及生命.文献报道,针灸有促进下丘脑-垂体-卵巢轴功能动态平衡的作用,如俞瑾 [5, 6] 等对确诊为无排卵患者进行电针前后血FSH,LH 水平及卵泡生长的临床观察,结果促排卵有效者其血 FSH,LH 值在电针后均上升伴随卵泡生长.提示电针通过中枢神经系统调节 FSH,LH 分泌起促排卵作用.排卵成功率为 50%－51%（5 / 10，和 16 / 31）。国内许多作者也报道针灸用于排卵障碍患者的助孕治疗,取得较好疗效, [7, 8, 9]。国外

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

Stener-Victorin E 等的研究也证实电针对无规律排卵的 PCOS 患者促排卵成功率达 38%。[10]

本研究中针药同治组的促排卵成功率为 68%，临床妊娠率为 53%均较单纯药物促排卵为好。提示采用一站式针药同治法诊治,取得较好临床疗效.其作用机理为中西医结合,两种方法作用不同环节,协同互补,增加疗效.电针促排卵可能机理:1 局部刺激作用;2 电流刺激通过下丘脑-垂体-卵巢轴调节变化导致FSH和LH动态的改变,达到调节人体神经内分泌平衡活动,使卵泡易于破裂,从而诱发排卵.同时,针灸也具有减轻压力的临床效果. 具有帮助提高患者术后信心，尽早开始促排卵疗程，调节下丘脑-垂体-卵巢轴功能和神经内分泌平衡活动,使卵泡易于破裂,从而诱发排卵.同时,针灸也具有缓解患者压力的效果. 此外,对于难治性排卵障碍患者,如 PCOS 合并输卵管通而不畅, 有早期流产和 PCOS 者,以及腹腔镜术后患者采用针药同治法,坚持连续治疗 3－5 疗程可帮助提高妊娠机会。另外，我们还观察到难治性排卵障碍者的排卵虽然有时发生在月经周期的 18－22 天，仍可成功受孕。

我们采用针药同治法,规范了不孕患者的诊疗流程,简化了治疗过程,使患者在同一地点不仅接受西医标准的药物促排卵治疗,同时给予针灸的辅助治疗.缩短了患者就诊时间和疗程.节省了部分费用.受到广大基层医务人员和排卵障碍患者欢迎和好评.取得经济效益和社会效益双丰收。 本研究初步结果显示对 CC 反应不良的排卵障碍患者采用一站式针药同治法进行助孕治疗有一定疗效.该法简便,安全,易行,适合有条件基层医院妇产科开展. 但针药同治的详细机理有待于今后进一步研究。

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作者简介 **许晋,** 医学学士，妇产科医学硕士，博士（英），英国中医药学会（ATCM）会员. 1983 年医学本科毕业，1991 年获妇产科医学硕士，曾在三甲医院妇产科工作 20 多年。1999 年作为牛津大学妇产科的访问学者前往英国，2004 年曾针灸促排卵博士，在英国担任高级研究助理，研究员，上海同济－牛津生殖中心经营主任等职。2011 通过英国国际标准化生殖中心质量评审员培训，考试合格获国际标准化生殖中心评审员资格证书 （ISO9001：2008）。

从事妇产科临床工作近 30 年，具有丰富的临床工作经验，擅长中西医结合治疗不育不孕症和妇科疑难杂症等疾病的诊治。精通针灸加强排卵周期的助孕疗法和中药维护，保养保卵巢功能，了解和掌握国内外生殖医学的现状和发展趋势。参与国际 RCT 药物临床试验工作，科研成果发表在美国的《生殖与不孕》（2006）杂志和《英国妇产科杂志》（2011）以及《现代妇产科最新进展》（2012）等国际著名杂志上。

《英国中医针灸杂志》征稿启事

《英国中医针灸杂志》为英国中医药学会主办的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 2016 年 2 月 20 日。

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电针配合刺络拔罐治疗肩关节周围炎

靳勇 孙斌 王爱菊
深圳平乐骨伤科医院， 518010

肩关节周围炎是指肩关节囊和肩关节周围软组织的一种退行性、炎症性疾病。本病可引起肩关节周围软组织粘连，以一侧或双侧肩痛和活动受限为临床特征。笔者2007年至2009年间，采用电针配合刺络拔罐治疗该病，取得较为满意的临床疗效，现总结报告如下。

1 一般资料

43例患者均来自我院门诊，男19例，女24例，年龄40～70岁；右侧肩周炎25例，左侧18例；病程1月～1年。

2 病例选择标准

2．1 诊断标准

参照国家中医药管理局1994年发布的《中医病症诊断疗效标准》中肩关节周围炎的诊断标准[1]：①肩部疼痛逐渐加重，昼轻夜重，不能侧卧于患侧；②肩部活动受限，以上臂上举、外展、后伸、内旋为明显；③肩前、肩峰处有压痛；④X线检查无特殊发现，病程久者可见骨质疏松。

2.2 排除标准

①不符合上述诊断标准者；②颈椎病、冠心病等肩外疾病引起肩痛者；③肩关节脱位、肱骨外科颈骨折、肩关节化脓性关节炎、肩关节结核、肩关节肿瘤等肩内疾病引起肩痛者；④胸廓出口综合征、肩胛上神经卡压综合征、臂丛神经炎、肩-手综合征等周围神经疾病引起肩痛者；⑤患有高血压、糖尿病者。

3 治疗方法

3.1 针灸治疗

3.1.1 取穴

肩三针配合阿是穴。肩三针部位[2]：肩Ⅰ针：即肩髃穴。肩部，三角肌上，臂外展，或向前平伸时，当肩峰前下方凹陷处。肩Ⅱ针：在肩髃穴同水平前方2寸为肩Ⅱ针。肩Ⅲ针：在肩髃穴同水平后方2寸为肩Ⅲ针。阿是穴部位：选取病变部位2或3个痛点为阿是穴。

3.1.2 针刺法

患者取侧卧位，局部常规消毒后，用直径0.30mm，长为1.5寸的毫针，常规针刺，得气后接华佗牌SDZ-Ⅱ型电针仪，电流强度以患者可耐受为度，留针30 分钟。留针同时，用TDP照射病变部位，温度以患者耐受为宜。每日一次，10次为一个疗程，疗程间休息两天，继续下一疗程。

3.2 刺络拔罐

针刺完毕后，稍事休息，进行刺络拔罐治疗。在病变处选取2或3个痛点，以痛点为中心常规消毒，在痛点中心处，用梅花针叩刺微出血，再用闪火法拔罐，并留罐10～15 分钟。此治疗方法隔日1次，5次为1疗程。

3.3 功能锻炼

嘱患者回家后每日做爬墙活动、梳头动作、弯腰晃肩、甩手锻炼各5～10 分钟。

4 疗效判定标准

疗效标准根据《中医病症诊断疗效标准》［3］拟定。①治愈：肩部疼痛消失，关节活动范围正常或接近正常(外展≥85°，前屈上举≥170°，屈肘内旋达T8胸椎以上)。②显效：肩部疼痛及压痛基本消失，关节活动功能明显改善(外展≥75°，＜85°，前屈上举≥150°，＜170°，屈肘内旋达T2以上)。③有效：疼痛及压痛均减轻，关节活动范围有改善，但尚未达到以上标准。④无效：肩部疼痛及压痛无明显改善，肩关节活动范围较治疗前无变化。

5 结 果

43例肩关节周围炎经1～3个疗程治疗，痊愈24例，显效16例，有效3例，无效0例。所有病例经治疗全部有效，治疗次数均在1～3个疗程以内。

6 讨论

中医学称本病为“漏肩风”、“肩凝”等，属痹症范畴，五十岁左右者好发，故又称为“五十肩”。五旬之人，肝肾渐衰、肾气不足、气血亏虚、筋肉失于濡养，风寒湿邪乘虚而入，致经脉痹阻；或跌仆损伤，瘀血留内，气血不行，经筋作用失常而导致本病。肩3针乃是靳瑞老先生多年总结而来，3穴合用，再配以阿是穴，可以祛风除湿，通经活络，活血止痛。肩周炎之所以顽固，缠绵难愈是因为长期风寒湿邪闭阻经脉，气血运行不畅，瘀血内停，风寒湿瘀互结所致，所以针刺治疗后，施以刺络拔罐法，拔除瘀血，风寒湿邪自然也随之祛除，经脉气血畅行，从而达到治疗该病的目的。

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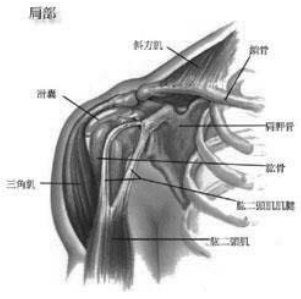

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Skills Required in Cultivating a Successful Therapeutic Relationship in TCM Practice

Guijie Wang(王桂杰), Ph.D. BSc Acupuncture, MD, Associate Professor.
Member of ATCM and BAcC. guijie.wang@yahoo.com

Abstract
高质量的中医行医首先取决于广博深厚的知识，优秀的临床经验。然而，行医者的其它特质，如，尊敬，同情，倾听，清洁的环境，得体的行为举止，提供真心帮助，保证一定的医患界限，良好的语言交流，职业化等，也很重要。本文就一个病例，讲述我是如何应用这些来提高临床服务质量的。

The quality of TCM practice depends on foundational knowledge and good clinical skills. However, other characteristic traits that a practitioner should possess also contribute to a successful therapy. This assay discusses main practical skills required to cultivate a successful therapeutic relationship in acupuncture practice. They are based on: sound deep foundation of medical knowledge, respect to clients, provision of high quality treatment, empathy, attending skills & listening, practitioner's physical and behavioural techniques, offering genuine help, good communication, professionalism, and knowing the bounderies. The application of these skills into my clinical practice is demonstrated in a case study.

A case of my clients:
Stan, a 55-year-old male client, visited my clinic in August 2010. He walked slowly with slight tremor on his left hand, and spoke quietly. Based on his symptoms and examination, clinical history, I thought that he suffered from an earlier stage of Parkinson's disease (PD). He did not recognize it at that time. I simply explained the causes both in biomedical and basic TCM concept and the treatments by Western medicine and complementary medicine, also highlighted there was no good curative treatment for this disease at present. The acupuncture is one of the complementary methods frequently used to support this treatment in China, however, there is no good study to support this. He chose to try it. His symptoms were reduced after several session of acupuncture.

About 2% of adults use acupuncture in the UK each year and most of these treatments are through private clinic (Thomas et al., 2001). The number is increasing dramatically in Western countries due to the lower side effects, natural alternative nature and effectiveness for some diseases, e.g. back pain. Research has shown that the quality of the therapeutic relationship is also an important component in a successful therapy, along with the skills and experience of the therapist. Some studies also state that the good therapeutic relationship is the foundation of a successful therapy of complementary and alternative medicine (CAM).

A successful therapeutic relationship will increase the practitioner credibility (Price et al., 2006) and the clients will accept the treatment and abide by the advice given by practitioners. However, this relationship shared by a practitioner and a client is multiple in nature. Clarkson (2003) stated that there are five types of relationship potentially present in the therapeutic encounter. These are (1) the working alliance, (2) the transference/ countertransference relationship, (3) the developmentally needed/reparative relationship, (4) the person-to-person relationship, and (5) the transpersonal relationship. Many skills should be carefully handled in order to maintain and improve this relationship to generate the benefit to patient. This paper will discuss the key skills required to cultivate a successful therapeutic relationship, and a case study will be used to highlight the application of some of skills.

Skill 1. Sound and deep foundation of medical knowledge is the most important skill for ensuring client confidence and trust and subsequently follow the practitioner's the therapeutic strategy. However, other skills discussed below are also important to maintain and improve the effective treatment process. In the case showed here, the client, Stan, later told me he searched many websites on TCM offered in the UK. He discovered that I had a Ph.D. in neuroscience, a MSc in herbal medicine, completed a 5 year MD course (equal to MBBS) in China, including study of Chinese Medicine; processed relevant practical experience at an affiliated hospital to the world renowned TCM University, and BSc acupuncture. In view of these qualifications and experience, the patient concluded the person with the appropriate knowledge and experience to assist him with his condition. Further, in order to be a good practitioner I am fully aware the need to continually learn and develop to maintain sound and deep foundation of needed knowledge.

Skill 2. Respect clients, put efforts into treatment. Stan initially did not confess he suffered from PD. After a few sessions of acupuncture treatment, his symptoms were relieved significantly and his sleep was improved too. Whenever he visited clinic, I showed some materials on PD to him. With the increase in therapeutic relationship, he gradually told me stories about his stress from his CEO job and his son's drug addiction, importantly, his feedback revealed more detail on the treatments. Based on the evidences he provided, I considered many factors affected both his symptoms and his whole body. I adjusted my therapeutic strategy by using acupuncture, herbal medicine, and also psychological and dietary support. Thanks to the enhanced therapeutic relationship, he referred his wife

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who suffered from IBS and son to my clinic for the treatment.

Skill 3. Empathy. Empathy is the ability to perceive accurately the feelings of another person and to communicate this understanding to him (Burnard, 1992). It is crucial for us acupuncturists to share the sufferings of the clients and put efforts into rebuilding their health. Research showed that patient enablement was positively correlated with perception of their practitioners' empathy. High enablement improves outcome of well-being (MacPherson et al., 2003). With empathy the practitioner can also predicte the positive changes in client's health outcome, e.g., the Measure Yourself's Medical Outcome Profile (MYMOP) (Price et al., 2006). In the whole treatment process, Stan remained at the centre of treatment, gradually, I discussed with him about the mechanism of PD and the treatment developed in both Western medicine and complimentary alternative medicine which could benefit his case. He felt my feelings with a PD patient like him and my willingness to help him. He did feedback every subtle changes in the symptoms, he realised that a good communication between us indeed benefited his treatment.

Skill 4. Attending skills & Listening is a good start for a good communication between practitioner and client, which is based on professional interpersonal skills**.** Listening and attending skills are by far the most important aspects involved in the counselling process (Morrison and Burnard, 1997). Practitioner should pay close attention while listening. This not only helps collect the correct and detailed information required, but also shows respect to the patient and thus improves the therapeutic relationship. The art of 'attending skills' is "the act of truly focusing on the other person, consciously making ourselves aware of what they are saying and what they are trying to communicate" (Burnard, 1992). Attending skills and listening require flexible adaptation to changing circumstances and different people in a range of different situations, in pursuit of clear nursing (therapeutic) goals" (Kagan and Evans, 1995). The goal is clear from the start and constantly aim for it in the development of the therapeutic relationship. Stan's speech was slow, not very clear due to the illness, so sometimes I tried to encourage him to write down some words to make sure I understood him correctly.

Skill 5. Physical and behavioural techniques
The following factors, such as, comfortable and hygienic environment in the clinic, tidy and white coat and explanatory literature and telephone manner of the practitioner, have been highlighted in enhancement the therapeutic relationship in a study (Turner et al., 2007). This cross-sectional patient survey was conducted in 37 CAM practices across nine geographical areas of the UK using a structured questionnaire. Certain behavioural techniques can show that they are interested in what the patient says. Such as, the practitioner maintains his/her concentration on what clients say and also give reflection by head nods, 'yes's et al. During my conversation with clients, or after treatment, most of time, we have a cup of green tea, a good sign to have a light conversation. Other skills like reasonable eye contact show I am listening and understanding the patient.

Skill 6. Offering genuine help
A continuous, strong, and genuine therapeutic relationship is the beginning of a successful treatment. In a two-year follow up study, patients rated the personal interaction with the therapist as the very or extremely most important factor in their treatment (Sloane et al., 1975). Offering genuine help with good personal interaction to clients does improve the health of clients. Professionally, I have to bear in mind of the patient's best interests. However, as a private practitioner, I have to minimize costs which include money, time and emotional costs in order to improve the career professional development training, clinical facilities for myself.

Skill 7. Keep necessary and balanced boundaries: This can be physical, personal and emotional, such as, abiding by the therapist priorities, keeping promise but not making any impropriate promises, no exploitation of patients (http://www.psytx.com/10relationship.html). All these prevent harms to patient and to practitioner themselves. In four randomized controlled trials of acupuncture in patients with chronic pain, results showed that there is twice as likely to respond well to treatment in patients with high expectations compared to those with low expectations (Linde et al., 2007). Positive patient beliefs in acupuncture have been contributed to non-specific effects observed in acupuncture trials (Dincer and Linde, 2003; Lewith et al., 2002). However, another study (Thomas et al., 2006) did not support this hypothesis. Patients in the group with a prior positive belief in the effectiveness of acupuncture fared little better than those randomised to usual care. In contrast, patients with neutral prior belief gained relatively more benefit from acupuncture care. Thus, I do not make impropriate promises in my clinical practice, such as in Stan's case, I explained that acupuncture might not cure PD, due to the neuron degenerative damage in the *substantia nigra*, but, I did show many clinical evidences of acupuncture in symptom improvement and also acupuncture has been widely used to support treatment of PD in China. This let him decide whether he should give acupuncture treatment a go or not. I also kept my balanced boundary in this therapeutic relationship, as therapists, we can't reveal ourselves to our clients to the same degree they reveal themselves to us.

Skill 8. **Good communication**
Practitioner should control the language skills, and efficiently deal with patients and also help patients to express themselves. It is very important to get a clear and correct history of the disease and also predicate the disease when dealing with patients. A closed questionnaire form will help clarify vague statements made by the patients. For instance, when I enquire about diet, most of the patients respond that they had a 'healthy diet'. However, this is different to my idea of a balanced diet, e.g. reaching the target of 5 a day etc, it will be beneficial to me and client if they fill a simple form about the name and quantity of the food in their daily diet. A study (Busato and Künzi, 2010) shows better patient-reported outcomes of CAM in comparison to conventional primary care in

Switzerland. There is a higher patient satisfaction in CAM, the authors believe this is due to effective patient-physician communication, which may play an important role in allowing patients to maintain more positive outcome expectations. When I explained the TCM concept to Stan, I had to avoid some technical language in order to deliver a simple idea, such as balancing Yin and Yang.

Skill 9. Professionalism

The practitioner must also apply effort in order to possess the latest knowledge and remain professional in order to help the patient efficiently. The practitioner has to avoid throwing himself into each case, but, practitioners also must stand back. I also referred Stan to a GP and got regular check. This benefits him by receiving the best care and I am able to know the treatment progress and hence improve my own skills.

Conclusion

Developing and maintaining good therapeutic relationship is an important component of a successful therapy. There are many skills involved in this process. In this assay, some skills have been discussed. These skills are 1) sound and deep foundation of medical knowledge; 2) respect for clients, put efforts into treatment of disease; 3) empathy; 4) attending skills & listening; 5) physical and behavioural techniques; 6) offering genuine help; 7) keep necessary and balanced boundaries: physical, personal and emotional; 8) good communication; 9)professionalism.

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Case Report: Shoulder Pain and Peripheral Neuropathy Treated by Acupuncture

Student Practitioners: Bob Feng Bing and Amy Jackson-Smith, Belgude Munkhtulga, Donna Marie Saxton,
BSc (Hons) Acupuncture Undergraduates, Lincoln College, UK
Supervisor: Hui Jun Shen

LM is a medium-build, about 5`3`` tall, 79 years old female patient, who presented at Lincoln College Complementary Medicine Clinic for acupuncture treatment in October 2014. Her initial main complaint was severe pain in right shoulder. The shoulder pain occurred after she caught a man about to fall on the day she flew on holiday to Greece two months before. She described the pain was sharp, with pain level being 7 out of 10 when waking up in the morning. The pain is better for heat and pressure. It hurts more putting her arm down than raising it and it is tenderer under her arm, and it radiates down to her elbow. In general she sleeps well. Only when she flips over on her shoulder, the pain wakes her up. Her urine tends to come frequently and her energy level was low.

During her initial consultation, she revealed that she had had pain, tingling and numbness in her feet for nearly 10 years and it was diagnosed as “peripheral neuropathy”.

The feet felt cold but with burning sensation in the evening. The toes were more sensitive. Especially if someone touched her big toe or the middle toe (the third toe), the shock sensation could make her jump. For many years she could not use a tower to dry her feet after bath as the touching would cause a very sharp pain, so she had to leave her feet to dry up by themselves. Other medical histories include hypertension and shingles 20 years ago.

LM had dry mouth. Her tongue presented a thin white tongue coating with slightly red tip. The tongue body had dark pink colour. Overall her pulses were thin and choppy.

Diagnosis

- Qi and blood stagnation in local channels
- Spleen and Kidney Qi deficiency

Aetiology and Pathogenesis

Severe local shoulder pain with the history of injury indicates Qi and blood stagnation. Acute pain is caused by a sudden injury to the muscles and ligaments. Since LM's shoulder pain has lasted for more than 2 months, it could develop into chronic pain. Spleen dominates the muscles and four limbs. Slow recovery from muscle or ligament injury results from Spleen Qi Xu.

Peripheral neuropathy (PN) is caused by the impairment or inflammation of the peripheral nervous system. Depending on the type of nerve affected, the malfunctions may occur in either sensory nerves, motor nerves or autonomic nerves (NHS, 2014). In LM's case, the condition develops in her extremities of the body, in particular her feet. Although 60% of diabetes patients may suffer from PN, in Western Medicine, the real cause of PN remains difficult to define (NHS, 2014, Schröder et al., 2007). Some main symptoms of PN, such as pain, numbness and burning sensation, are considered to be Bi syndrome in TCM. Qi and blood stagnation contribute to Bi syndrome.

Treatment Principles and results:

- Unblock local channels
- Move Qi and blood
- Tonify Spleen and Kidney

A block of 5 sessions of acupuncture were recommendation. The early treatment was focused on her main complaint – shoulder pain. The acupoints used for the initial treatment were SI3, SJ5, LI15, SJ14, LI14, SI9, SI10, ST36 and GB34. SI3 (Houxi) is not only shu point but also yuan point of the Small Intestine meridian. It is the Confluence point crossing with Du meridian. SI3 was used as it relieves Qi stagnation, alleviates stiffness and pain of the shoulder. SJ5 (Waiguan) is Luo-Connecting point of the Sanjiao meridian and Confluence point to Yangwei meridians. SJ5 was used to unblock the channels and release the pain (Deadman, Al-Khafaji and Baker, 1998). LI15 (Jianyu) and SJ14 (Jianliao) were used to release the shoulder pain. LI14 (Binao), SI9 (Jianzhen) and SI10 (Naoshu) were used as local points. ST36 (Zusanli) was used primarily to strengthen the spleen and tonifying the Qi and blood; GB 34 (Yanglingquan) was for relaxing the tendons and relieving the spasm. Tuina massage on shoulder area was also used to release the local pain after needling session.

The patient did not notice any changes regarding the pain on her shoulder during the first two treatments, but pain was a lot better after the third treatment. And there was a whole day she was almost pain free, but the pain came back the next day. With two more treatments, her shoulder pain was 80% better already.

When the second block of 5 sessions started, although LM still felt a little discomfort on the right shoulder, she started to ask for treatment focusing on her PN. Therefore the treatment plan was amended with ST41 and Bafeng points added to release the PN symptoms on feet. Ba Feng helps the Qi and blood flow to the feet resulting in a decrease in numbness and pain (Wong and Sagar, 2006). Other selected points included BL23, BL25, BL40, BL57, BL60, BL54, KI6, SP3, SP4 and BL62 trying to boost the functions of her spleen and kidney and help nourish the collaterals. BL23 (Shenshu) and KI6 (Zhaohai) were used as they are effective points to strengthen Kidney. BL40 (Weizhong), BL57 (Chengshan) and BL54 (Zhibian) were mainly used for releasing painful obstruction of the lower limbs. BL60 (Kunlun), BL62 (Shenmai), SP3 (Taibai) and SP4 (Gongsun) were used to treat local. SP3 and SP4 are Yuan and Luo point of the Spleen meridian. They are very important points to treat the pain resulting from Qi stagnation and blood stasis (Deadman, Al-Khafaji and Baker, 1998).

After the first session of new treatment plan, her PN symptoms were significantly improved already. She was amazed as she could use a tower to dry her feet after bath for the first time in many years. More improvement was achieved with ongoing treatment and the pain and tingling/numb sensation on her feet eventually disappeared altogether. On the fourth treatment of the latest block booking, LM said she didn't expect any treatment this time. She just wanted to come back to tell us that her shoulder had completely gotten back to normal and her feet were getting better and better. She was very happy with the result.

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ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

疑案治疗后的思考

ATCM 会员 何勤

摘要：二型糖尿病并前列腺病患者突发闪电样剧烈左侧耳后枕颞部头痛。西医诊断为神经痛，服用止痛、抗癫痫药物无效。而中医辨证治疗取得较好效果。思考其中病理病机，有经验也有疑问，想交流更想请教。
关键词：糖尿病 **神**经痛 **中医辨**证

患者 L，**男**，1957 **年出生。英籍**华人。居住 LONDON. **就**诊时间：2013 **年** 6 **月** 15 **日** 10:30.

主述：**原因不明**，**突**发闪电样、剧烈左侧耳后枕颞部头痛，持续数秒至十数秒不定；如抓搔左侧腰、腹股沟至足趾任何部位都可立即引发上述头痛。以夜间为甚，此症状持续二周以上。

现病史：二周前，夜间头痛惊醒，觉太阳穴附近及耳后枕颞部头痛剧烈，自服止痛片缓解。经 GP 诊断认为是神经性头痛，给予一般止痛药，症状无改变。后频繁发生足趾，足蹼处发痒，抓搔后迅即出现枕颞部闪电样头痛，停止抓搔后头痛随即停止，再抓再痛。加服消炎止痛药，维生素 B1/B6/B12，**服用二周无改**变。继续发展至凡抓搔左侧大腿至左侧足趾任何部位都可引发头痛，**小便**时也会引起上述发作，夜间头痛常至痛醒。经 GP **介**绍至神经科专家诊断，血常规、肾功能、血糖等相关检查无异常，神经系统体检无异常，但触摸左足至大腿任何部位，都可出现上述闪电样头痛。专家认为可能是糖尿病神经性病变，但无法解释为什么会出现触摸左侧下肢皮肤会引发头痛。给予 NEURONTIN（**加巴**喷丁）300mg,**逐步加量**，**服用二周**，**开始**头疼略有改善，之后仍然发作如前。因为频繁发作，影响睡眠，觉疲乏，紧张、焦虑。另有夜尿增多，每夜 1-2 **次**，**每次量** 500-800ml,**有明**显尿不净感觉。

过去史：患二型糖尿病近五年，一**直服用二甲双胍**（500mg，**日二次**），**血糖控制**较好。自觉可能有前列腺增生，未作相关检查。否认其它慢性疾病。否认有偏头痛。

家族史：**母**亲有家族性高血压。父亲因肺心病，心肌病去世多年。相关检查：空腹血糖在 5.7-6.8 **之**间，餐后血糖在 9。5-10.7 **之**间。一天前自查空腹血糖为 5.7（**晨** 8:30）。**血**压一直正常，在 110-70mmgh **左右。心、肺、肝、**肾、脑、眼底检查完全正常，无血管病变。血脂胆固醇基本正常。轻度脂肪肝。

望闻问切四诊要点：中年男性，中等身材，体重 70kg，**身高** 174cm.**全身皮肤**颜色正常，头发花白，眼神略显抑郁，神气不足。其它体检望、闻无异常发现。轻轻触摸左侧足底、足趾、足背、踝部、腓肠肌，大腿肌任何部位，都可引发其头痛，尤其在内侧更为明显；如在某部较重扼压，开始有反应，之后反不引起头痛。脉微沉和缓，一息四至（每分钟 72 **次左右**），规律，双尺脉重按略感不足；舌体微胖；舌苔微黄，腻，舌根苔偏厚，舌中有竖纹；舌下脉络无明显肿胀，但舌系带根部静脉略显粗大，色偏深红。饮食正常，有时口渴；喜浓茶，喜饮酒。小便略黄，有时较浑浊，排尿不净，余沥，夜尿增加；大便多稀溏，饮食稍有不慎就会腹泻。

西医诊断:1.**二型糖尿病** 2.**神**经性头痛？3.**糖尿病神**经并发症？4.**前列腺增生**（轻度）

中医诊断：1.**二型糖尿病**（**脾虚湿滞**，肾精亏损）2.头风（少阴头痛，肝肾不足）3.**前列腺增生**（肾气亏虚，气血淤滞）

中医治疗：中药水煎剂内服. 处方如下：当归 9g **川芎** 9g **白芍** 12g **生地** 12g **枸杞** 15g **石决明** 15g 钩藤 15g **三七粉**（**每次** 3g,**冲服**）**每天一**剂，先服三天。（因其糖尿病，嘱不要停止降糖药）

19 **日复**诊：服上方后，夜间头痛改善，局部抓搔引起闪电样头痛减轻，睡眠改善。夜间出现 1-2 **次腓**肠肌痉挛（抽筋），脉舌如前，饮食二便如前。上方有效，守方再用，略加化裁。处方二: **上方加山茱萸** 9g。**用法同前**，**三**剂。

22 **日三**诊，效果明显，夜间头痛基本消失，刺激反应性闪电样头痛偶有发生，气色精神明显好转，脉象无明显变化，舌体如前，舌苔微黄，舌根苔变薄，舌系带颜色明显改变，基本正常色泽。**症状改善**，**但舌脉**变化不大，应是标证缓解，本证仍存，脾湿肾虚，气滞血瘀非短期能有较大改变，继续标本兼理。处方三：当归 6g **川芎** 9g **白芍** 9g **生地** 12g **枸杞** 12g **制首**乌 15g
山茱萸 6g **茯苓** 6g **石菖蒲** 9g **三七粉**（**另冲服**，**每次** 3g),7 剂。

7 **月** 2 **日**电话告知，夜间头痛完全消失，肢体刺激引发的头痛消失，肢体皮肤发痒抓搔不再出现头痛。因天气炎热，将外出度假，暂停服用中药。后跟踪二周没有反复，确定了此次治疗效果为临床治愈。

诊后思考：

- **关于**诊断:

一、本案诊断分两部分，一是原发病，有：1.**糖尿病**（**二型**）2.**前列腺增生。**诊断依据是临床症状和相关检查。这部分比较明确。二是本次主述的头痛，特点是夜间头痛和肢体刺激激发的闪电样头痛。是继发症状还是独立疾病是颇费思量的。头痛的特点具有神经性头痛的特点，发作迅速，剧烈，刺激。是糖尿病的继发症状还是独立的神经疼痛？糖**尿病后期有**较多并发症，主要有心脑血管疾病、眼底病变、肾血管病变、神经病变。神经病变是因为糖代谢失常，远端神经营养失常，导致远端肢体如足趾的感觉迟钝，逐步加重甚至感觉丧失，并可出现足趾溃疡。该患者没有感觉迟钝，反而反应过敏，这与糖尿病的神经病变不同；而且临床表现，相关检查，其血糖控制良好，多次检查眼底，心、脑、肾无异常，单单发生神经病变可能性较小。且头痛可因抓搔左侧腰以下皮肤即可引发，其神经管理部位节段毫无关联，无法用糖尿病并发神经病变解释上述症状发生的机理。因此可以认为是神经性头痛，但与原发糖尿病是否有关无**法确**认。

二、中医诊断，病名病位是明确的，二型糖尿病，前列腺增生，头风痛。辨证为脾湿肾虚，瘀血痹阻。脾湿依据是：舌偏胖，舌苔腻，神气不足、易疲劳，常有便溏，容易腹泻。

ATCM, Suite 12 Brentano House, Unit 5, The Exchange, Brent Cross Gardens, London NW4 3RJ
Tel/Fax: 020 8457 2560, Email: info@atcm.co.uk Website: www.atcm.co.uk

肾虚依据：小便余沥，夜尿增多，双尺部脉重按不足；瘀血依据：剧烈头痛，夜间为甚，舌根部厚苔，舌下系带静脉粗大变形，色泽红紫；前列腺增生。

三、病机演绎：病理特点为本虚标实。本虚涉及脾肾肝、标实为血瘀痹阻。糖尿病初多热邪伤阴，多先及肺胃，口渴多饮多食尿多，久病必波及脾肾，累及气血，而致肺脾气虚，肝肾阴虚，血脉痹阻。本次标证为主要矛盾，剧烈头痛为瘀血**痹阻特点**，**而局部刺激引**发具头风特点，这两个特点为制定治则确立了方向，那就是活血化瘀，柔肝祛风。

- **关于治**疗：

按理，**神**经性疼痛服用止痛药物，适当配合营养神经药物如 B **族**维生素，效果应是肯定的，但是本案服用止痛药和 B **族**维生素无效，加用较强抗癫痫药物也没有达到预期效果。接受此案，再按原来思路必难取效。中医治则，急则治标，缓则治本，解除头痛为当务之急。病机明确，拟方不难。

方一以四物汤补血活血为基础，当归补血柔肝，生地滋阴柔肝，芍药敛阴柔肝，川芎行气疏肝，加枸杞补肾柔肝，石决明潜阳镇肝，钩藤止痉平肝，再加田三七增**强化瘀止痛**。诸多药物，均以活血为基础，以柔肝为标的。补血行气则血流加速而瘀阻易解，滋阴柔肝则水能涵木而肝风得平，正所谓，治风先活血，血活风自灭。组方简单明了，直达病所，收到预期效果。

方二守方不变，效不更方，继续理血柔肝思路，因夜间腓肠肌痉挛，仍为肝经内风为患。故在原方加山茱萸增强补肝肾解痉挛作用。

方三之意，标证缓解，本证变化不大，须在本证上下功夫以防标证反复；改善糖尿病的肝脾肾之亏损，改善其脾湿肾虚血瘀，冀取得长期效果。仍以四物汤基础，加三七加强化瘀止痛；加制首乌枸杞子山茱萸加强补肝益肾；入茯苓石菖蒲渗**湿健脾安神通**窍，亦补亦泻，补中有通，补中有攻，立足长远，着手眼前。

本案治疗时间不长，近期效果好，在西药治疗未能见效的情况下迅速取效，说明中医中药也能对急症有效的治疗，只要辩证正确，用药对症，是可以取得较好效果的。

- **存疑**请教：

本案虽然取得较好近期疗效。但是诊断中的疑点总是不能让人释怀。尤其是触摸抓搔左侧腰以下任何部位皮肤都可引发耳后枕颞部闪电样剧烈短暂头痛，到底是什么病理机制，现代医学未能解释，那么中医理论能否解释呢。

可以认为，本病现病史及主症与肝经关联紧密。能否从肝经循行路线找寻线索呢。经考，足厥**阴肝**经，起足大趾爪甲后丛毛处，沿足背至内踝上行过膝，沿大腿内侧入阴毛中，绕阴器，至小腹，夹胃，属肝，络胆，向上过膈，布于胁肋，沿喉咙后，向上入鼻咽，连目系，出于额，上行与督脉会于头顶部。……

足少阳胆经起于目外眦瞳子髎穴，上至头角，向下到耳后，再折上行，经额部至眉上，又向后折至枕部，沿颈下行至肩上，左右交会并与督脉相会于大椎穴，前行入缺盆。其分支……**深入体腔**，过膈肌，络肝，属胆，沿胁里浅出气街，绕毛际，横向至环跳穴处。……**回穿**过爪甲，分布于足大趾爪甲后丛毛中，经气由此处与足厥阴肝经相接.

足厥阴肝经与足少阳胆经互为表里，经脉相连，经气相通，病理机制可以互相影响。肝风内动，厥阴头痛，如按经脉循行部位核比，确实可以出现耳后枕颞部的特殊头痛，虽有些牵强，但还是能自圆其说的。而制方以活血化瘀、柔肝镇潜收到较好效果也可为佐证，好像可以从脏腑经络学说来解释本案特殊头痛之病机。

不过，至此，有一个很关键的细节无法解释，那就是为什么刺激性头痛仅仅只发生在左侧，刺激左侧腰以下皮肤引发左侧耳后枕颞部头痛，而右侧肢体同样有肝胆经脉至循行啊。

百思不得其解，**故**请教于同道师长，望予释疑解惑。

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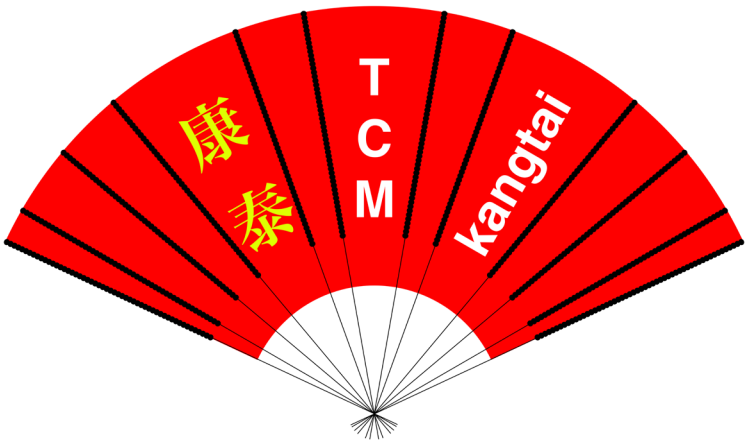

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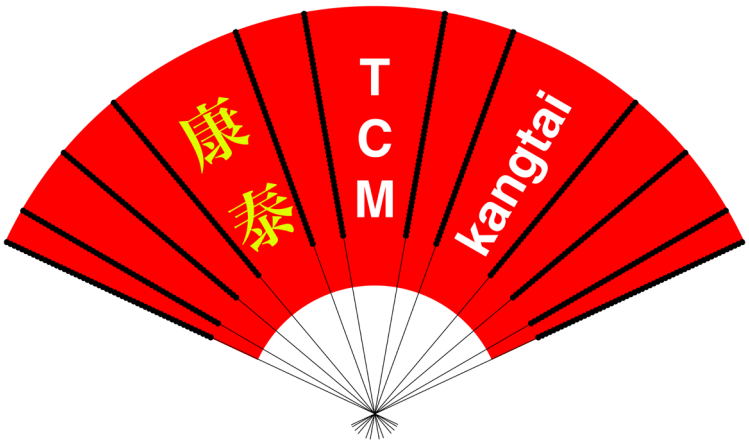

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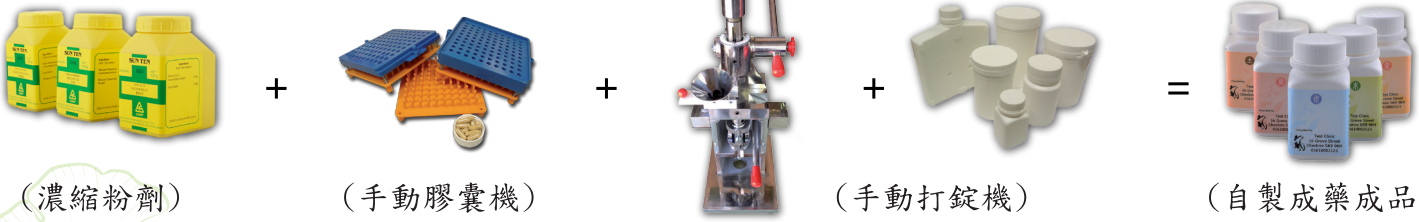

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