ISSN: 1745-6843
Volume 26 Issue 1
第 26 卷 第 1 期

英国中医针灸杂志

The Journal of Chinese Medicine And Acupuncture

An Official Academic Journal of
The Association of Traditional Chinese Medicine and Acupuncture UK

30th April 2019

英国中医药学会会刊

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地址 Address: ATCM, Suite 10 Brentano House, Unit 5 The Exchange, Brent Cross Gardens, London NW4 3RJ

电话/传真 Tel/Fax: 0044 (0)20 8457 2560　　微信 WeChat：ATCM-OFFICE

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Gout and Acupuncture Treatment

Gulshinder Johel
BSc (Hons) Acupuncture, Lincoln College

Abstract:
This paper reviews the diagnosis and treatment of gout in both Western Medicine and Traditional Medicine. It concludes that accurate diagnosis, personalisation and continual review are at the heart of effective treatment in both Western and Eastern treatment.
Key Words: gout, arthritis, Bi syndrome, Tong-Feng

Gout is the most common form of inflammatory arthritis in the UK, affecting 2.5% of the population (Arthritis Research (AR), 2016). The condition develops in those with hyperuricaemia (Arthritis Foundation, 2018) and occurs in men more than women (Tausche et al., 2009). Gout is a hereditary condition and strongly associated with numerous metabolic-diseases (Tausche et al., 2009). This paper will review treatment of gout in both Western Medicine and in Traditional Chinese Medicine.

In Western Medicine primary gout is the reduced ability to excrete urate or increased urate production. Secondary gout occurs with conditions such as diuretic treatment or kidney-failure (Waugh and Grant, 2014). Chronic tophaceous-gout, where tophi form years earlier, is found in areas previously affected by acute-gout (Suresh, 2005).

Uric-acid is the waste product created when the body breaks down purines, a protein found within our cells and within foodstuffs (UK Gout Society (UGS), 2018). Build-up occurs when the kidneys are not able to remove it efficiently, a genetic abnormality is present or there is increased purine intake. Persistent hyperuricaemia leads to needle-like crystals, in the form of sodium-urate, collecting in cartilage (UGS, 2018). These are usually engulfed by leucocytes

The condition leads to severe, sudden pain in the joints, particularly the big toe, knees, wrists and fingers with erythema, swelling and heat (NHS, 2017). Collection of urate crystals outside the joint result in small white lumps called tophi. Tophi can appear on the tissues surrounding joints, the ear lobes and may deposit in the delicate kidney tissue (Stephenson, 2017,399).

Humans, unlike other mammals, lack the enzyme Uricase which speeds the oxidation of uric acid to allantoin (Shannon and Cole, 2012) so acute attacks develop quickly, often overnight, and peak within 12-24 hours of the first inflammatory attack. They usually subside within 1-2 weeks (AR, 2016).

Ageing, male-gender and the menopause increase the risk of gout (Hui et al., 2017). Other aetiological factors include genetic inability to remove uric acid, central obesity, hyperlipidaemia, Type-2-Diabetes and kidney disease (AR, 2016). Injury to the area, illness, overconsumption of alcohol and dehydration can also trigger an attack.

Treatment with Western-Medicine

Western diagnosis comprises physical examination and medical-history evaluation to guide differentiation (Badlissi, 2018). The British Society of Rheumatology (BSR) guidelines for Management of Gout state the diagnostic gold standard is arthrocentesis of joint synovial-fluid revealing urate crystals in the tissue (Hui et al., 2017). However, joint-fluid microscopy is rarely performed in primary care due to cost, despite being the most specific, diagnostic test available (Hui et al., 2017). Differential diagnosis is the epitome of effective gout management. Septic, Osteo, Rheumatoid and Reactive arthritis (Suresh, 2005) need exclusion before diagnosis. Polyarticular gout can be confused with rheumatoid arthritis with tophi being mistaken for rheumatoid nodules and both having symmetrical joint-involvement (Wazir et al., 2005).

Sustained hyperuricaemia is the single most important factor in the development and diagnostics of gout (Hui et al., 2017) and is defined as 'Serum uric acid levels of above 408umol/L' (Drug and Therapeutics Bulletin, 2018). However, varied thresholds for maximum uric acid from the American College of Rheumatology (ACR) and the BSR cause some ambiguity (Khanna et al., 2012). Furthermore, whilst gout sufferers usually have hyperuricaemia, not all those with hyperuricaemia will have gout (Stanaszek, 1999). Blood-urate levels, although not diagnostic of gout, are a strong indicator (Suresh, 2015). Interestingly, uric acid is usually raised but there are exceptions so gout-diagnosis is excluded if the serum uric acid level is in the lower half of what is considered the normal-range (Ballinger and Patchett, 2008, 275).

Local physical examination revealing redness, swelling and heat (Suresh, 2005) helps confirm the condition in conjunction with other tests. Radiographs are generally deemed unhelpful with diagnosis of gout as they only show swelling or evidence of osseous destruction which are indicators of recurrent attacks (Suresh, 2015). However, they can be helpful in differentiating conditions such as rheumatoid arthritis. Newer diagnostic tools such as Magnetic Resonance Imaging, Dual-energy computed tomography and Ultrasound, although

expensive, are now offering a non-invasive way of monitoring tophi-dissolution and disease-progression (Dubchak and Falasca, 2010).

Iatrogenic causes of gout include low-dose Aspirin, Thiazide-Diuretics (Dubchak and Falasca, 2010) and the increasing use of Cyclosporin for organ-transplantation (The Drug and Therapeutics Bulletin, 2018). Hypertension-related diuretic use can increase urate levels (Choi et al., 2005) highlighting the need for regular review.

Genetics and individual levels of inflammation are now offering part-explanation for gout (Terkeltaub, 2017). Cysteinyl-Aspartate-Specific-Protease-1 (CASP1) (Dang et al., 2015) and the PYCARD-gene (Dang et al., 2018) may be responsible for the inflammatory response.

Western treatment of gout is hinged on pharmacotherapy with lifestyle advice. The ACR and European-League-Against-Rheumatism (EULAR) recommend a two-pronged approach; treatment of acute attacks whilst preventing future ones. Acute attacks are typically treated with lifestyle advice and non-steroidal anti-inflammatory drugs (NSAIDs) such as Naproxen, Indomethacin and Diclofenac (Stephenson, 2017,399) for 5-7 days with a co-prescription of gastro-protective drugs (Hui et al., 2017).

Corticosteroids in the form of oral, intramuscular or intra-articular depot methyl-prednisolone can be used in difficult cases whilst oral-prednisolone may be a slightly safer than NSAIDs for acute gout (Yu et al., 2018). Moreover, joint aspiration can be effective for monoarticular gout (Hui et al., 2017). If all else fails and physicians are presented with treatment-refractory gout the use of Pegloticase, a uric acid specific enzyme, with its urate-lowering properties may be useful (Shannon and Cole, 2012).

Consumption of purine-rich foods such as offal, meat, seafood and some carbohydrate foods may exacerbate hyperuricaemia and consumption needs modification (The British Dietetic Association, 2018). Furthermore, central obesity leads to increased inflammatory markers in the blood causing metabolic complications (UGS, 2018). Exercise (Williams, 2008) and weight loss can lead to decreased uric acid levels (UG, 2018) and will relieve joint pressure. Conversely, rapid weight loss will increase uric-acid levels so gradual weight loss is more effective. Interestingly, elevated Body-Mass-Index under the age of 40 increases the risk of gout (Choi et al., 2005).

Treatment satisfaction has a notable effect on patient adherence, quality of life and clinical outcomes (Khanna et al., 2015). A bespoke approach to treatment is required with serious consideration to individual constitution and history.

Treatment with Traditional Chinese Medicine

In Traditional Chinese Medicine (TCM) gout is ‘Bi Syndrome’ or specifically ‘Tong-Feng’ meaning painful wind and is caused by unregulated eating and drinking, chronic disease and external-evils (Flaws and Sionneau, 2005, 255). Early literature specifically attributes rich, greasy food to gout formation. Bi-syndrome pathogenesis is Damp, Wind and Heat invasion causing Qi and Blood-stagnation in the channels and collaterals (Jia, 1998). Qi-blockage and fluid movement then cause Damp-Heat and consequently Phlegm-Stasis. The result is hot, swollen, painful joints (Jun et al., 2000). The disease is defined as ‘Hot-Bi’ (Jia, 1998). Severe and fixed pain without the heat would be ‘Painful-Bi’.

In the literature ‘Ge-Zhi-Yu-Lun’ gout is categorised as ‘Phlegm, Wind-Heat, Wind-Wet and Blood-Deficiency’ (Dang et al., 2015). Other categories include obstruction-of-dampness-and-heat, intermingled-phlegm-stasis-blood, Pi-deficiency-induced-dampness, and Qi-blood-deficiency syndromes (Dang et al., 2015).

Gout arises from constitutional weakness or ageing, leading to Spleen-Kidney disharmony attributed to heaven insufficiency (Jun et al., 2000). The Spleen’s compromised transforming and transporting function leads to reduced clarity-rising and turbidity-descending whilst the Kidney transports Qi inefficiently (Jun et al., 2000). The disease typically passes through the inner side of the first joint where the Spleen channel passes (Jun et al., 2000) so attacks around the big toe could imply underlying Liver-Spleen disharmony. An underlying Kidney-Yin Deficiency could also be implicated (Stephenson, 2017,399).

Constitutional weakness of the Earth element can put the patient at higher risk of Spleen-deficiency and Dampness (Maciocia, 2015,27). Whilst Damp is attributed to Heat and Damp-Bi (Stephenson, 2017:399) tophi are described as a form of Phlegm/Fire. Conversely, Cold-Damp can be endogenous or exogenous (Flaws and Sionneau, 2005,255).

Maciocia (2013,28) describes swollen, painful joints as Fixed-Bi -syndrome with the tongue having a sticky, yellow coating with a red body colour. It’s also called Painful-Obstruction-syndrome which is distinguished by local joint heat caused by Damp-Cold lodged for prolonged periods. Heat or Yin-deficiency constitution can then transform this to Heat (Maclean and Lyttleton, 2010, 659). Diagnostic features are a white tongue coat and a wiry or tight pulse.

Damp-Heat can also be caused by Qi-deficiency manifesting in local stagnation and damp-accumulation (Ross, 1998,38). MacPherson and Kaptchuk (2005,77) support the idea that gouty-arthritis in feet is Damp-Heat in the Lower-Jiao.

Dampness is an external pathogenic factor caused by wet surroundings and clothing. However, it can also form internally with Spleen dysfunction (Kastner, 2009,16). Dampness diseases such as gout are Yin character with qualities such as stickiness, swelling, heaviness and tendency to long-term illnesses due to slowing Qi-flow

(Kastner, 2009,16). Conversely, Heat is Yang and tends to rise thereby interfering with the upper-body harmony, drying out and harming the Yin (Kastner, 2009,16). Heat symptoms aiding diagnosis are irritability, insomnia, red rashes, fever, thirst, dry mouth, sore throat and restlessness (Kastner, 2009,16). The Zheng-Qi and Evil force blood to move and the pulse becomes rapid and strong (Jingyuan,1998).

Damp-Heat stagnation is typically seen at the acute-stage of the disease and presents as joint-pain and swelling which is severe at night. It can be accompanied by fever, headache, cold-aversion, thirst, red tongue and a yellow, greasy coat (Li et al., 2010). Conversely. retention of Cold-Damp often occurs in chronic gout and is characterised by painful joints restricting movement, pale tongue with a white coating and a deep, taut pulse (Li et al., 2010).

Qi and Blood-Deficiency can result from long-term illness and results in joint pain and numbness, deformity and a pale tongue with a white, thin coating. The pulse is a deep and thready. Furthermore, it can be complicated with Blood-Stasis or Qi-Stagnation (Flaws and Sionneau, 2005,254).

Maciocia (2018) describes swelling and pain in the joints as Damp-Painful-Obstruction -Syndrome which can be identified by a slippery, rapid pulse. Cold-Damp on the other hand manifests as severe, acute, joint pain which is fixed and worse with cold with no obvious redness or swelling. The tongue is likely to present as slimy, white tongue coating and a slippery, deep or soggy pulse (Flaws and Sionneau, 2005,254).

Consumption of oily, fatty foods, sugar, fatty meat, bananas and excessive dairy can worsen gout (Kastner, 2009,47) so a diet history is essential. Chilled foods are Damp and Cold producing. Frequent use of cold, bitter medications exacerbates the pattern.

Accurate diagnosis of syndrome-pattern in gout is imperative to successful treatment. Research has shown that patients with obstruction of heat and dampness syndrome are more likely to have kidney damage whilst the phlegm-stasis-blood-syndrome patients had higher risk of cardio-cerebral events (Zhang et al., 2018). Although the study was retrospective in nature the observations were nevertheless interesting.

Effective treatment is dependent on correct diagnosis. Identifying the right pathogenic factor at the right stage will help prioritise treatment principles. Treatment of Hot-Bi can be administered in two ways; selecting relevant points to presenting syndrome-patterns or choosing local and distal points primarily from the Yang-channels supplying the diseased channel thus expelling stagnation whilst promoting Qi and Blood circulation (Needles, 1982). Clearing Damp-Heat has been the traditional TCM gout treatment (Xiao et al., 2018).

During acute gout, external pathogens need to be cleared whilst dredging the channels. Conversely, priority during chronic-gout is removing Phlegm, encouraging blood-circulation, expelling Cold and warming channels (Xiao et al., 2018). Strengthening Wei-Qi, nourishing Blood and Qi whilst tonifying the Kidney, Spleen and Liver would also be required in clinical practice (Li et al., 2010) as Wei-Qi weakness can lead to external pathogen invasion (Needles, 1982). The subjective nature of gout-treatment is evident and cannot be standardised. This makes it difficult to compare in research studies.

The ‘Ben’ is the downward-flowing Damp-Heat pathogen due to Liver-Kidney disharmony. The weakened Kidneys cannot eliminate excess heat therefore transmit it into the Liver where the pathogen is passed to the blood. The heavy pathogen then sinks into the feet creating the Biao, the second phase. This toxic-heat results in Blood-Stasis. As the Kidneys cannot transform Qi harmoniously Damp and Phlegm discharges slowly with Phlegm-turbidity building-up. Both tophi and joint deformities are examples are Phlegm-Stasis which requires long-term treatment (Halevi, 2004).

A meta-analysis showed that Acupuncture could improve the clinical effectiveness rate with gout compared to Western medicine. Furthermore, adverse effects were lower (Lu et al., 2016). Many studies, however, were identified as having methodological deficiency so acupuncture could not be guaranteed as a useful treatment. Furthermore, compliance to treatment may hamper any success (Sheng et al., 2017).

Flaws and Sionneau (2005,254) suggest the treatment principles for Wind-Damp-Cold are to dispel wind, eliminate Dampness and warm the channel using the points LI4 and SP6 with local and distal points. For clearing Wind-Damp-Heat they recommend the use of LI11, LI4 and DU14 with local and distal points. They also recommend herbal medicine as a more effective measure than Acupuncture. For Qi-stagnation and Blood-Stasis types they recommend quickening the blood with LI4 and SP6 whilst SP9, ST40, REN12 and ST36 treat turbid-dampness. Powerful phlegm points to use in practice are ST40, P5 and SJ10 (Al-Khafaji et al.,1992).

Joint-swelling in Bi-Syndrome is caused by Damp accumulation resulting from Spleen-Qi-Deficiency (Pei-Lin and Vangermeersch, 1994). Underlying disharmonies such as Liver and Kidney-Yin Vacuity can be treated with KID3 and KID7 which nourish the kidneys and enrich Yin (Flaws and Sionneau, 2005, 258). Jun et al (2000) conducted a small study using ST36, SP6, ST40, SP2, SP3 to strengthen Spleen function and reduce damp. LIV3 was used to clear blood toxins using electroacupuncture. They reported symptom relief and uric-acid reduction.

A potentially beneficial treatment for gout sufferers is Electro-acupuncture on LI11 (used as a homeostatic point) and SJ6 to rid the body of uric-acid quickly (The Journal of Chinese Medicine, 2014). Although this was a case study and therefore of limited replicability the value is logical. LI11 is an important point for Damp-Heat

conditions with its blood-cooling qualities and is beneficial for joints and sinews arising in Painful-Obstruction and Bi-Syndrome (Maciocia, 2015,967). Establishing the strength of both Dampness and Heat within the affected individual helps forge a priority (Jingyi and Xuemei. 1998,184).

Maciocia (2013,32) states that Damp-Heat can lead to complications such as Phlegm, the ability to injure Yin and toxicity. Furthermore, he states that Damp-Heat easily injures the Stomach and Spleen whilst Heat injures the Stomach-Qi and Yin. This can lead to a vicious circle of the Spleen-damage and further Damp evolving. Maciocia recommends points such as ST28, REN5, BL22, BL39, SP9, SP6 and KID7 for Damp in the lower-Jiao to activate water transformation.

Research shows that TCM reduces CRP, Serum Uric-Acid-Concentration and Erythrocyte-Sedimentation-Rate (Xiao et al., 2018]. However, different practitioners use differing modalities such as Herbs, Acupuncture and Cupping to clear Damp-Heat makes it difficult to compare studies. There are inconsistencies in dose, acupoint selection and techniques used.

Dietary therapy of gout includes heat-clearing foods such as dandelion, tomatoes, cucumbers, watermelon, mung beans and lemon (Kastner, 2009,16). Mung-beans, soy-milk, dandelion, corn-silk tea and seaweed help dry Damp (Kastner, 2009:16). Excessive amounts of fatty, rich foods can congest the body with Dampness and Phlegm (Deadman, 2016,139), especially when fried or roasted as they cause internal-heat which contributes to gout aetiology. Fish-oils and juice-fasting may help some patients (Maclean and Lyttleton, 2010, 664).

Chinese herbal decoctions have shown clinical efficacy comparable to that of Western medicine and have the added advantage of alleviating side-effects (Zhou et al., 2014). However, standard reporting techniques are rare, leading to reduced reliability (Schulman, 2005). Furthermore, limited worldwide regulation of the contents of herbal decoctions can pose health risks (Edwards, 2002).

Blood-letting-cupping could relieve gout pain, remove toxic heat and damp whilst improving blood circulation (Zhang et al.,2010) and acupuncture may help protect against renal damage associated with gout although studies are methodologically flawed (Xiaoping, 2004)

Patients need to avoid over-fatigue, cold and wind during treatment and modify their lifestyle whilst reducing alcohol and smoking. (Jun et al., 2000). Jun et al used ST36, SP2, SP3, ST36, ST40 and SP6 to strengthen the Stomach and Spleen whilst removing Damp, and SJ5 with LIV3. They used the pinch-skin method and the reducing-method for acute cases. (Jun et al., 2000). Acupuncture is showing some promising results that can be replicated in practice but variable research-quality does not allow a conclusive benefit (Lee et al., 2013).

The British Acupuncture Council (2015) revealed that infra-red radiation, surround needling therapy and electroacupuncture could all offer benefit but further research is needed.

Interestingly some rat studies, although of limited generalisability, have shown success with electroacupuncture in acute gout, mediated through opioid and peripheral receptors to help reduce pain using ST36 and BL60 (Chai et al., 2018).

Conclusion

Diagnosis and treatment of gout in both Western and TCM terms address underlying imbalance and symptoms. Western treatment success is reliant on accurate differential diagnosis and consideration of individual patient need. Standard Western treatment has now evolved to include new diagnostic tests and treatments. They are, however, inaccessible in general due to resource limitations. TCM treatment is also dependent on accurate diagnosis and syndrome pattern differentiation. Accurate diagnosis, personalisation and continual review are therefore at the heart of effective treatment in both Western and Eastern treatment.

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Syndrome Differentiation and Acupuncture Treatment for Hypothyroidism

By Juliet Simpson

BSc (Hons) Acupuncture, Lincoln College

Abstract: The following paper discusses hypothyroidism from both a Western and Chinese medical perspective. Diagnosis, treatment and ongoing management are analysed from both points of view. It concludes that acupuncture treatment must be provided long term for ongoing management of the disorder to control symptoms and balance the body. Further research studies are required to confirm whether acupuncture is cost effective and truly beneficial to individuals with hypothyroidism.
Key Words: hypothyroid, acupuncture, TCM

Introduction

The following paper discusses hypothyroidism from both a Western and Chinese medical perspective. The diagnosis, treatment and ongoing management are analysed from both points of view.

Hypothyroidism is a common condition which affects more women than men. The elderly and Caucasians' are also more commonly affected. Hypothyroidism occurs as a result of an inadequate production of thyroid hormone or the inadequate action of thyroid hormone on tissues within the body. It causes dysfunction of multiple organ systems and the individual's metabolism is altered (Almandoz & Gharib, 2012).

Hypothyroidism can be primary, secondary or tertiary. Primary hypothyroidism is the most common. Worldwide the deficiency of dietary iodine is the most common cause of hypothyroidism. In the Western world, hypothyroidism due to iodine deficiency is uncommon, due to the supplementation of iodine in food items, particularly table salt. The formation of a goitre due to iodine deficiency causes thyroid hormone to be stimulated. Individuals can be hypothyroid or euthyroid. It continues to remain a common condition in India, and as recently as 2000, about two million of the population had cretinism (Kumar & Clark, 2017). Therefore, one of the most common causes of

hypothyroidism is a chronic autoimmune disorder named Hashimoto's thyroiditis.. Again, this is 5-10 times more common in women than men. Goitre may or may not be present. Autoimmune disease is frequently inherited (Garber et al, 2012).

Hypothyroidism can also be atrophic autoimmune thyroiditis. Kumar & Clark (2017) identify this as the most common cause. Hypothyroidism can also occur following treatment for hyperthyroidism or Grave's disease, which frequently involves removal of the thyroid gland or from radioiodine therapy. Figures suggest that this may account for up to one third of all hypothyroid cases. Babies can also be born with congenital hypothyroidism. Currently one in every 3500-4000 babies are born hypothyroid (Okosieme et al, 2016).

Various medications have been linked to causing hypothyroidism. Lithium, amiodarone and the relatively new tyrosine kinase inhibitors which have been found to reduce vascularity in the thyroid gland and cause the induction of type 3 deiodinase activity (Garber et al, 2012).

Signs and Symptoms of Hypothyroidism

Signs and symptoms alone are inadequate to diagnose hypothyroidism. They are often subtle initially. The most common early presentations are fatigue, muscle aches, feeling cold, low libido, impotence, infertility, dry hair and skin, constipation and changes in the voice.

Diagnosis of Hypothyroidism

In primary hypothyroidism serum thyroid stimulating hormone (TSH) will be elevated, whilst serum free T4 (the active part of thyroxine) will be low. In subclinical hypothyroidism, serum TSH will be elevated but serum FT4 will remain normal, often a precursor to overt hypothyroidism. In secondary hypothyroidism, involvement of the pituitary gland or tertiary hypothyroidism, involvement of the hypothalamus, serum FT4 will be low and serum TSH will not be overly elevated. In Hashimoto's thyroiditis, thyroid peroxidase antibodies (TPO) are frequently positive. TPO antibodies are also present in individuals with type 1 diabetes mellitus and Addison's disease (Almondoz & Gharib, 2012).

Western Medicine Treatment of Hypothyroidism

Hypothyroidism is commonly managed in primary care. If hypothyroidism is confirmed following blood analysis, then Levothyroxine (LT4) is commonly prescribed

Secondary or tertiary hypothyroidism should be referred and managed by endocrinologists, as should patients with thyroid cancer. Normally, in primary hypothyroidism a return to health is resumed relatively quickly, after the prescription of levothyroxine is commenced (Allahabadia et al, 2009).
If hypothyroidism is left undiagnosed and not treated, a life-threatening condition called myxoedema coma can occur. This is a condition where hospitalisation is required with ventilatory support. Respiratory depression, hypotension, bradycardia, hyponatremia, hypothermia and infection can all occur (Tandon, 2011).

Foetal neurodevelopment and growth are dependant upon thyroid hormones from the mother until 18 weeks gestation, although thyroid hormones will continue to pass from mother to foetus throughout the pregnancy. TPO antibodies are frequently seen in women of reproductive age and particularly in women who frequently miscarry. Babies born to hypothyroid mothers not appropriately monitored and treated are frequently underweight at birth (Chan & Boelaert, 2014).

Management of Hypothyroidism in Western Medicine

The use of levothyroxine is the main treatment and long-term use is required for the management of hypothyroidism. 80% of oral levothyroxine is well absorbed in the intestinal tract, particularly the jejunum. A once daily dose an hour before breakfast is advocated. After the commencement of levothyroxine, repeat blood tests should be carried out to check the serum TSH levels after two months. This is the minimum amount of time required for the pituitary-thyroid-axis to reset. Dose adjustment should not be carried out before this point. Once a euthyroid state has occurred, TSH levels can then be monitored at an interval of six months. When the hypothyroid individual reaches a stable equilibrium, monitoring of serum TSH levels, on a yearly basis, is sufficient. Extra care is advised for hypothyroid patients who have angina, anxiety or who are, or wish to become pregnant (Tandon, 2011).

Individuals with hypothyroidism who continue to experience symptoms associated with the disease, despite adequate levothyroxine may then turn to alternative and complementary therapies to manage the disease and improve their quality of life. It is these individuals who may use Traditional Chinese Medicine, acupuncture alongside Western Medicine for management.

Traditional Chinese Medicine (TCM) Approach to Hypothyroidism

In TCM, hypothyroidism is classified as Gall-disease. Ancient physicians noted symptoms of hypothyroidism and the formation of nodules in the

thyroid, long before the disease was named using modern medicine (Luzina & Xin, 2011).
Individuals seeking acupuncture these days have mostly had hypothyroidism diagnosed by a medical practitioner. Acupuncture is frequently used along side the use of levothyroxine and regular blood testing. Acupuncture is beneficial in balancing hormone levels, calming the emotions, improving energy levels and aiding sleep and helping to regulate menstruation (Arsovska et al, 2016).

Diagnosis of Hypothyroidism in TCM

In TCM, hypothyroidism must be differentiated, each case is different, and each individual, will present with different signs and symptoms. Hypothyroidism is a systemic disease frequently manifesting as a general deficiency of qi which then progresses if not appropriately treated. Over a period, of time, many of the organs, and their functions are affected. Qi deficiency if unresolved frequently leads on to deficiency of blood, yang, yin and ultimately kidney essence. In TCM the three organs primarily affected are firstly the Spleen, the Kidney and the Heart. The Liver and Lung are also indirectly affected as the disorder progresses. According to TCM hypothyroidism can manifest due to poor diet, over work, chronic longstanding illness, trauma, prolonged emotional stress and from effects of Western medical treatment (Malikov, 2017).

The majority, of hypothyroid individuals, have a body temperature below 36.4 degrees Celsius, indicating a yang deficiency. An aversion to cold is common. The thyroid gland may feel large on palpation. Other symptoms often experienced are constipation, depression and anxiety, a feeling of general exhaustion and fatigue. The skin may be dry and there may be hair loss, often seen with thinning of the eyebrows. The immune system is often deficient, making the individual vulnerable and prone to infection. Hormone analysis may reveal an imbalance, especially of oestrogen and progesterone. Periods are often scarce, and individuals may seek treatment for infertility and impotence (Crowell, 2018).

Women are more likely to have hypothyroidism than men. From a TCM perspective, women are more prone to spleen qi deficiency. During menstruation there is blood loss, pregnancy and breast feeding also have an impact on the spleen, as does a tendency to overthink and worry. The spleen is the central organ involved in hypothyroidism. Facial oedema is caused by spleen qi deficiency as the spleen governs the transformation and transportation of fluids in the body. This form of dampness may accumulate and lead to phlegm formation, seen as general obesity and goitre formation (Flaws & Sionneau, 2001).

Luzina & Xin (2011) define the main cause of hypothyroidism as a deficiency of yang. They classified autoimmune hypothyroidism into four patterns. The first being insufficient yang of the spleen and kidney. Followed by yang insufficiency of the heart and kidney. Yang qi failure and loss and deficiency of the kidney essence. The body's ability to warm and energise is insufficient when yang deficiency is present. Hence the fatigue, mental dullness and cold intolerance frequently experienced by hypothyroid patients.

The diagnosis of spleen and kidney qi/yang deficiency is seen in cases of subclinical hypothyroidism, it can be subacute or Hashimoto's thyroiditis. The tongue is pale with teeth marks and the pulse is weak, deep and thready. Patients will present with a mild sensitivity to cold, they often feel fatigued and have a low mood. They frequently complain of constipation and weight gain. Menstrual cycles are often irregular, night time polyuria and infertility are often present. When hypothyroidism becomes clinical. The diagnosis of heart and kidney yang/qi deficiency is defined in TCM. Complications involving the cardiovascular system frequent. Little or no sweating, a hoarse voice and oedema around the eyes and face are commonly seen. Palpitations may arise with pain and congestion felt in the chest. The tongue, as well as being pale with teeth marks is often swollen. The pulse is frequently slow and difficult to find (Arsovska et al, 2016).

When there is spleen and kidney yang deficiency, patients will also have a lack of blood and qi, both yin and yang deficiency can also arise. Professor Gao-Tian-Shu, through his own clinical experience also discovered that liver qi deficiency is a common pattern seen in hypothyroidism (Panthi & Gao, 2015). When a goitre is present, TCM defines this as phlegm formation, it frequently manifests with blood stasis. The tongue may show a thin white coating and the pulse is often choppy (Flaws & Sionneau, 2001).

If hypothyroidism, is allowed, to progress, without adequate treatment, the kidney essence becomes severely depleted. This is seen in late stage illness. The marrow also becomes depleted, commonly seen in the elderly. Insomnia, poor memory, tinnitus, headaches and general malaise arise. The pulse is weak, deep and difficult to define. The tongue is dry, without coating (Arsovska et al, 2016).

TCM Acupuncture Treatment for Hypothyroidism

Treatment of hypothyroidism depends on the syndrome pattern or patterns diagnosed. Due to the subjective analysis of syndrome patterns, acupoints prescription varies considerably amongst practitioners. Abbate (2001) advocates the palpation of ST9, LI18 and KI3, she has found all these points to be tender in clinical practice, in patients with hypothyroidism.
General acupoints ST36, BL17, LI4, DU4, SP6, PC6,

Ren6, Ren4 and BL23 are advised for hypothyroidism. If the spleen qi is deficient Ren12 can be added. DU20 if both deficiency of qi and blood are identified. Spleen and kidney yang deficiency is a common syndrome pattern where Ren12 and Ren17 can also be needled. When there is heart and kidney yang deficiency, the use of SP3, Ren17 and ST40 are recommended (Malikov, 2017).

Flaws & Sionneau (2001) recommend adding BL23 for spleen and kidney yang deficiency. When liver qi stagnation and phlegm are present, ST12, SJ13, SI16 and LV3 can be needled. SI17, Ren22 and LI17 can be used to rectify blood stasis and soften and disperse the phlegm.

Dependent on the syndrome patterns as previously discussed the first issue to address is to tonify the spleen qi and warm the kidney. The heart may require nourishment and any stagnation within the liver should be moved. Phlegm or blood stasis requires dispersal. Treatment therefore is aimed at strengthening the organs involved. By increasing the yin and yang in the spleen, kidney and heart many of the symptoms associated with hypothyroidism can be resolved. The thyroid hormones can be regulated, and general health can be improved (Zhu et al, 2018).

Maciocia (2008), believes the main presenting patterns associated with hypothyroidism are spleen and kidney yang deficiency, qi and blood deficiency and liver and kidney yin deficiency. For the treatment of spleen and kidney yang deficiency he advises that the spleen and kidney be tonified and the yang warmed. ST36, BL20 and Ren12 are used to strengthen the yang of the spleen. To strengthen the yang of the kidney he advocates the use of Ren4, DU4, BL23 and KI7. If a goitre is present, indicating phlegm, then SP6 and ST40 are added. He discusses opening the Directing vessel, which is useful when menses is irregular. To do this he uses KI6 and LU7. For direct treatment of the thyroid gland Ren22 can be used. When qi and blood are deficient in hypothyroid patients the treatment should be devised to nourish the blood and strengthen the qi in the body. DU20 is the acupoint used to raise the yang qi. ST36, SP6, Ren12 and BL20 strengthen the spleen qi and in turn, the blood is nourished. Also, the use of Ren4 and BL23 can be used to nourish the blood and strengthen the kidney. When there is liver and kidney yin deficiency, the patient's tongue is red with no coating and the pulse is empty and floating. The yin therefore requires nourishment and the liver and kidney require tonifying. Ren4, SP6, ST36 and LV8 are used to nourish the yin of the liver and KI6, KI3 and Ren4 are used to nourish the yin of the kidney. The opening of the Directing vessel using KI6 and LU7 are also used to nourish the yin. Ren22 is advocated in all treatment for hypothyroidism, due to its direct action on the thyroid.

In acupuncture treatment, the root cause of the hypothyroidism must be addressed. Studies have identified how acupuncture stimulates the nervous system to release neurochemical messengers. This results in biochemical changes within the body which alter homeostasis, therefore both mental and physical well being can be greatly improved (Arsovska et al, 2016).

Management of Hypothyroidism in TCM

Due to hypothyroidism being a chronic condition. Acupuncture should be carried out as a long-term therapy. Large scale studies and trials are lacking with regards to the management of hypothyroidism treatment with acupuncture. Although the small amount of evidence available shows many benefits when acupuncture is used alongside levothyroxine therapy for symptom reduction and quality of life improvement. A research study was carried out in Russia, where acupuncture was provided as the primary treatment for autoimmune thyroiditis. 20% of the participants were able to stop taking levothyroxine, whilst 77% were able to reduce their levothyroxine dose three times over the course of the trial. The quality of life in 90% of the subjects was vastly improved. All, of the participants, noted that their depressive and anxiety symptoms were eliminated (Luzina & Xin, 2011).

A study conducted by Zhu et al in 2018, on hypothyroid men found that acupuncture was highly effective at managing the secondary complications of hypothyroidism. The sperm were found to be inferior, but by replenishing the kidney yang qi and improving the function of the thyroid and reproductive system there was a high success rate in terms of improving sperm count, motility and morphology. Those treated could no longer be classed as infertile. The treatment must be continued long term for beneficial results to remain.

Stress both chronic and acute is known to affect the function of the thyroid gland via the hypothalamus-pituitary-thyroid axis and the hypothalamus-pituitary-adrenal axis. Acupuncture has been proven to reduce the body's stress response. One small study on two female patients with subclinical hypothyroidism who received acupuncture, had reduction in their hypothyroid symptoms. There menses improved as well as their bowel motility. TSH levels were also decreased following twelve acupuncture treatments (Tsuda, 2013).

Autoimmune diseases such as hypothyroidism require long term treatment with acupuncture for symptom management as already highlighted. TCM advocates that lifestyle advice be given to hypothyroid individuals attending acupuncture treatment. Eating iodine and selenium rich foods and ensuring adequate

amounts of protein are consumed can benefit the thyroid and improve the immune system. Sunlight stimulates the pineal gland which has positive effects on the endocrine system. Hypothyroid individuals should eat regularly and avoid skipping meals, keep themselves warm, exercise and ensure they have enough rest in order to manage their disease in the best possible way (Crowell, 2018).

Conclusion

To conclude, it has been identified that more women than men are diagnosed with hypothyroidism. It is seen more frequently in the elderly and Caucasians. Primary hypothyroidism is the most common form and autoimmune hypothyroidism is frequently inherited. Hypothyroidism is managed in primary care for the majority. The signs and symptoms can be subtle on commencement of the disorder. True diagnosis is confirmed by blood analysis of serum TSH and serum FT4 levels. Treatment for hypothyroidism involves the administration of regular levothyroxine, a synthetic thyroid hormone. Undiagnosed hypothyroidism can lead to a life-threatening condition: myxoedema coma. The ongoing management of hypothyroidism in Western Medicine is by levothyroxine therapy and regular blood analysis to check the thyroids function.
In TCM hypothyroidism is classified as Gall-disease. Acupuncture is frequently used alongside Western Medicine for symptom relief and quality of life improvement. Diagnosis in TCM is made by identifying the syndrome pattern or patterns. The correct acupoints are then chosen and needled to provide treatment. The most commonly affected organs in hypothyroidism are the spleen, kidney and heart. The liver and lung can also be involved. Acupuncture treatment must be provided long term for ongoing management of the disorder to control symptoms and balance the body. Further research studies are required to confirm whether acupuncture is cost effective and truly beneficial to individuals with hypothyroidism.

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针药助 IVF-ET 技术的研究现状和存在问题 以及提高爱尔兰 IVF-ET 成功率的挑战和对策

文献综述

伍琼娣(爱尔兰),王佩娟（中国）

南京中医药大学, 江苏省中西医结合医院，Shulan College of TCM UK

第一作者：伍琼娣（1963 －），女，QD Chinese Acupuncture & Herb Clinic，爱尔兰。医学硕士，南京中医药大学博士研究生。研究方向 － 中医妇产科。
通讯地址：QD Chinese Acupuncture & Herb Clinic，Oxfordville，76 Wilton Road，Wilton，Cork，Ireland。电子邮箱：qiongdiw@yahoo.ie

通讯作者：王佩娟，女，南京中医药大学江苏省中西结合医院妇产科。教授，主任医师，博士研究生导师，全国名老中医师带徒导师。
江苏省妇产科全国名老中医师带徒导师. 电子邮箱：pjwang8822@163.com

摘要

体外受精-胚胎移植（IVF-ET）技术是目前世界上不孕症患者最常选用的人工助孕手段，但其活产率平均不到 25%，远低于预期。传统中医的针刺治疗能够明显提高 IVF-ET 的成功率，已经成为辅助提高人工助孕的首选。然而，近期的系统评价，Meta 分析，和前瞻性单盲随机对照临床研究结果对针刺治疗辅助人工助孕的效应提出了疑问和争议。爱尔兰女性不孕症的高发生率有其特殊的病因特征，表现为肾阳虚，宫寒，和寒凝血滞。在治疗上应根据补肾，温阳，和暖宫三大原则，采用针药并用提高 IVF-ET 的成功率。

An Overview on Acupuncture and Chinese Herbal Medicine in Assisting IVF-ET and the Challenge in Increasing the Success Rate of IVF-ET in Ireland

By Qiong Di Wu (Ireland), Pei Juan Wang (China)

Abstract

Currently in vitro fertilisation-embryo transfer (IVF-ET), an assisted reproductive technology, is the most frequently selected technique by women with infertility worldwide, but the average rate of live birth following IVF-ET is often <25%, far less than the expected. Adjuvant treatment with the traditional Chinese acupuncture has been shown to improve the successful rate of IVF-ET with enhanced both clinical pregnancy and live birth rates. However, recently published systematic review, Meta analysis, and a single-blind randomised controlled clinical trial have argued and questioned the benefit of acupuncture in improving IVF-ET outcomes. The much higher incidence of infertility in Irish women is linked to specific causative factors and manifested with insufficiency of kidney Yang, uterine cold, cold coagulation and stagnation. Therefore, the principle for treatment should focus on tonifying the kidney, warming the Yang, and warming the uterus by the combined acupuncture and Chinese herb medicine, in an attempt to improve the successful rate of IVF-ET in Irish women with infertility.

世界卫生组织 WHO 将一对有正常性生活的伴侣，在没有任何避孕措施情况下，一年内无临床妊娠定义为不孕症 （Infertility） [1]。不孕症分为原发性和继发性不孕两类。原发性不孕是指女性结婚一年以上，其配偶生殖功能正常，未避孕但未怀孕者; 继发性不孕是指曾生育或流产后，未避孕而又一年以上不再妊娠者。从西医的理念来分析导致不孕的原因包括免疫内分泌激素，基因遗传，生殖器官结构

和功能，下丘脑-垂体和其它全身代谢性疾病，以及精神和环境因素等 [2]。随着现代社会的发展，人们的生活节奏越来越快，工作时间越来越长，工作压力越来越大，加上现代妇女怀孕年龄的不断推迟，育龄妇女不孕症的发病率逐年上升。世界卫生组织流行病学调查表明，不孕症将成为仅次于肿瘤和心脑血管的三大疾病之一 [3]。值得注意的是，尽管不孕症並非致命性疾病，但严重威胁不孕女性的身心健康和家庭和睦，它对广大育龄妇女们及其家庭造成不同程度的心理创伤。目前，不孕症已经成为许多发达国家面临的主要公共健康问题 [1, 2]。

中医学对不孕症的病机分析和诊治

传统中医学 （Traditional Chinese Medicine, TCM）对于不孕症的认识，病机分析以及辩证论治已有上千年的历史和经验。中医认为不孕的主要原因与肾气的盛衰，冲、任脉的气血平衡，天癸的盛竭有关。《内经》曰肾为先天之本，主生殖，肾气盛则天癸至，任通冲盛，月事规律，阴阳平衡而成孕有子。肝藏血，肝气主疏泄条达，肝血充盈，肝气条达，则月经运行有度。脾为后天之本，气血生化之源，脾气健运，气血充足。女子以血为本，冲任起于胞中，冲为血海，任主胞胎，冲任充盈，气血和调，血以时下，月经畅行。唯肝脾肾三脏及冲任二脉功能正常，则月经畅行，正常排卵，易于受孕。在诊治上以“肾主生殖”为重要理论基础，兼顾“肝主疏泄”理念，把握“肾虚、肝郁、血瘀”之核心病机所致的肾精亏虚，阴血不足，胞宫虚冷，以及胞脉、胞络阻滞，着重滋补肝肾、疏肝解郁、和温经活血。

体外受精-胚胎移植 （IVF-ET）

体外受精-胚胎移植 （In Vitro Fertilisation-Embryo Transfer, IVF-ET），又称试管婴儿，是一种人工生育技术。IVF-ET 是在超声引导下抽吸卵母细胞，用准备好的精子进行实验室受精，胚胎培养，以及将所得胚胎经宫颈转移到子宫中。尽管大多数 IVF 程序使用来自患者的新鲜卵母细胞，但冷冻卵母细胞的转移和供体卵的转移也是其中之一的选择。自从 1978 年第一例试管婴儿在英国诞生，10 年后即 1988 年中国大陆第一例试管婴儿在北京医学院临床三院诞生，以体外受精-胚胎移植为代表的辅助生殖技术（Assisted Reproduction Technology, ART） 在人类生殖史上掀起了革命，将福音带给无数不孕症患者。体外受精-胚胎移植技术是目前世界上不孕症患者最常选用的治疗手段。随着各种促排卵方案的优化改进，包括控制性超排卵 （Controlled Ovarian Hyper-stimulation, COH） 以及取卵、受精、和胚胎培养的程序化，使得助孕成功率不断提高，但仍然低于预期，与人们的要求相比，仍然存在着明显的差距。美国疾病控制和预防中心联合美国生殖医学和辅助生殖技术协会在 2017 年发布的最新统计资料表明，全美体外受精-胚胎移植的临床妊娠率（Clinical Pregnancy Rate, CPR） 平均为 29%，活产率 （Live Birth Rate, LBR） 平均为 24% [4]。而澳大利亚体外受精-胚胎移植的临床妊娠率平均为 23%，活产率平均为 17% [5]。同时体外受精-胚胎移植常常伴有流产率高，易患卵巢过度刺激综合征（Ovarian Hyper-stimulation Syndrome, OHSS） 和卵巢反应迟缓 （Poor Ovarian Responder, POR） 等并发症 [6]。由于体外受精-胚胎移植技术的最佳临床妊娠率和活产率均不足 30%，大多数不孕症患者在体外受精-胚胎移植失败后甚至一开始就求助于辅助疗法 （Complementary Therapy, CT） 以提高其人工助孕的成功率，其中传统中医的针灸疗法和中药处方已经成为辅助疗法的首选。在海外由于寻求中药处方和制剂存在诸多方面的种种不便，国外女性不孕症患者往往容易接受和采用针灸疗法辅助体外受精-胚胎移植的成功。

针刺治疗辅助 IVF-ET 的研究进展

自 1999 年首例针刺配合体外受精-胚胎移植技术的临床研究报道后 [7]。2002 年德国 Christian-Lauritzen 研究所的 Paulus 和中国同济医院的张明敏同时就针刺治疗对体外受精-胚胎移植的妊娠结局进行了临床研究，结果发现在胚胎移植前后运用体针和耳针针刺干预各一次，能显著提高临床妊娠率，从对照组的 26%增加到针刺组的 43% [8，9]。本研究结果对生殖医学领域产生了重大的影响，其针刺治疗方案被临床生殖医学研究者采用，从此针刺疗法辅助体外受精-胚胎移植成为人工助孕领域中的一个研究热点。随后澳大利亚的 Smith [10] ，丹麦的 Westergaard [11]，德国的 Dieterle [12]，以及美国的 Magarelli [13] 和 Balk [14] 均在其各自的临床研究中证实了针刺治疗能够明显改善体外受精-胚胎移植的成功率，包括提高临床妊娠率，持续妊娠率，和活产率。与此同时，许多学者对针刺改善体外受精-胚胎移植成功率的作用机理进行了深入的研究和探讨。已有结果表明，1. 针刺通过诱导相关神经介质分泌，促进性腺激素释放激素（Gonadotropin-releasing Hormone, GnRH） 释放，平衡黄体生成素 （Luteinizing Hormone, LH） 和卵泡刺激素 （Follicle-stimulating Hormone, FSH） 水平，从而促进卵泡成熟和排卵 [15，16]; 2. 针刺通过抑制中枢交感神经活性，从而增加子宫和卵巢组织的血流血供，改善微循环 [17]; 3. 针刺通过促进中枢内源性阿片肽特别是 -内啡肽的生成和分泌，从而降低和克服体外受精-胚胎移植过程中患者的应激和焦虑反应 [18，19]。

针刺治疗辅助 IVF-ET 的争议和反思

然而随着针刺治疗辅助人工助孕临床研究的增多和深入，针刺疗法是否有助于改善体外受精-胚胎移植的成功受到了一定程度的质疑。美国的 Manheimer 对来自 16 个临床试验的 4,021 病例采用系统评价（Systematic Review, SR） 和 meta 分析 （Meta Analysis, Meta-A） [20]，英国的 Cheong 对来自 20 个临床试验的 4,544 病例采用 Cochtane 评价（Cochrane Review, CR） 和 meta 分析 [21]，该两

项系统评价和 meta 分析均表明，针刺组的临床妊娠率、连续妊娠率、和活产率与对照组比较，差异无显著性 （p＞0.05）。更为重要的是 2018 年 5 月澳大利亚的 Smith 在美国医学会杂志（JAMA）发表了收集共有 878 病例的前瞻性单盲随机对照临床研究的论著，其结果显示针刺治疗组 （N = 424） 与对照组 （N = 424） 相比，未显著提高体外胚胎移植的临床妊娠率和活产率 [22]。尽管上述系统评述和 meta 分析，以及 Smith 的大样本前瞻性随机对照临床研究结果给针刺治疗在体外受精-胚胎移植中的应用蒙上了阴影，对针刺治疗辅助人工助孕的效应增加了不确定性和争议性，国内外生殖医学界的有识之士还是发出了不同的声音和质疑。美国的妇产科专家 Rubin 撰文指出，根据针刺组与对照组之间没有显著差异而得出针刺对提高体外受精-胚胎移植成功率无效的结论尚为时过早，同时也是草率的，首先因为选择的所谓对照组是以针刺“假穴”（Sham）与针刺组的针刺“真穴”（Verum） 相比较，並不能代表真正意义上的针刺对照组，因此在确定针刺组真正名符其实的对照组之前，上述得到的两组间的阴性结果有可能是统计学中的第二型错误 （Type II Error），即假阴性错误 [23]。其次，针刺剂量和次数严重不足，多数临床研究为了追求试验的规范化，胚胎移植前后仅用一次针刺辅助干预，导致临床妊娠率和活产率难以有效提高。第三，针刺组和对照组之间的病例选择难以保证均质性，缺少可比性，导致临床样本异质性过大。Smith 在其发表在 JAMA 的论著中也承认，由于无法解释的原因，其对照组中囊胚胎 （Blastocyte） 植入要显著高于针刺组，而卵裂期 （Cleavage Stage） 胚胎植入则明显低于针刺组 [22]。已经证明囊胚胎植入的临床妊娠率和活产率要显著优于卵裂期胚胎植入，这也可能是 Smith 的研究结果中针刺组和对照组之间无统计学差异的一个重要原因。从针刺治疗是否有助于改善体外受精-胚胎移植成功率的争议和反反复复中，我们至少可以从中学习和汲取到两点。首先，我们必须充分认识到中西医之间有着不同的思维方式，西方医学注重局部治疗和“治已病”，而传统中医学更强调整体治疗和“治未病”。在设计针刺治疗（包括中医其他疗法）辅助人工助孕（包括其他西医治疗方案）的临床研究中，一方面要遵循循证医学 （Evidence-based Medicine, EBM） 的原则，建立大样本前瞻性双盲（或单盲）随机对照的临床试验，同时设立干预治疗的标准方案 （Standardized Protocol, SP），以达到研究结果可被重复的目的，同时也要兼顾传统中医学辩证论治所强调的个体化治疗。其次，单单采用针刺治疗辅助体外受精-胚胎植入的疗效有限，在今后设计该类临床研究时，应当强调和着眼于针药并用，才能真正实现中医对不孕症的三大治疗要素，即滋补肝肾，疏肝解郁，和温经活血，以期提高人工助孕的成功率。

爱尔兰女性不孕症的病因特征

爱尔兰育龄妇女不孕症的发病率在欧洲排名靠前，平均每六对已婚夫妇就有一对夫妇患有不孕症，其不孕不育的高发生率除了前述的共同影响因素外，还有其特殊的五个重要原因。1，育龄妇女怀孕年龄推迟。爱尔兰是一个高度保守的天主教国家，禁止离婚和堕胎。1995 年爱尔兰全民公投以微弱多数通过了修改宪法，允许分居五年以上夫妇离婚，解除婚约，但仍禁止堕胎。直到 2017 年爱尔兰全民公投刚刚通过了有条件的人工流产法，即随意堕胎在爱尔兰仍然是违法的，除非怀孕或妊娠已经危及孕妇的生命。鉴于此，爱尔兰夫妇对于是否怀孕或妊娠常常持非常小心谨慎的保守态度，往往倾向于推迟怀孕年龄。根据爱尔兰的两所著名生殖中心（Waterstone Fertility Centre, WFC 和 SIMS Fertility Center, SMISFC） 的统计资料显示，爱尔兰初产妇的平均年龄为 29.9 岁，在全球最年长妈妈中排名第五。由于爱尔兰育龄妇女因宗教政治的原因推迟怀孕年龄，几乎接近女性生理的晚期，其卵巢功能的不足和衰退往往导致卵子数量和质量的减少和下降。2，长期连续服用避孕药。由于上述禁止离婚和堕胎的同样原因，诸多情侣同居 10 年以上也不结婚，大多数女性仍不希望非婚生子，甚至已婚女性因为禁止堕胎而担心和害怕怀孕，导致爱尔兰的育龄女性长期服用避孕药，服用避孕药的最小年龄可早至 16 岁，连续服用避孕药的最长时间有的可达 10-15 年之久。服用避孕药的年龄偏小，卵巢功能尚未发育完善，服用避孕药时间过长，打破了成年女性自身激素的平衡，引起卵巢功能早衰甚至无排卵，导致患不孕不育症的机率明显增加。3，地理气候因素：阴、冷、寒、湿是爱尔兰气候的主要因素。爱尔兰是一个被海洋包围的岛国，在北大西洋暖流的影响下，四季差异不明显。但以阴冷潮湿，雨多风大，和阳光不足为特征。冬季平均温度 4-7^{o}C，夏季平均温度 11-16^{o}C，长年多雨，平均降雨量在 800-1,000 毫米，光照不足，晴朗天气只占全年五分之一。4，饮食习惯因素：爱尔兰女性喜饮冰冷的啤酒，吉尼斯世界记录就是以爱尔兰的著名啤酒吉尼斯 （Guinness） 命名, 酒吧是爱尔兰文化特征；其次喜吃色拉，冰淇淋，和冷食等，寒冷潮湿的天气加上冷饮冷食，患宫寒不孕的女性大大增加。5，精神因素。爱尔兰是一个岛国，同时也是一个以畜牧业为主的农业国，各个家庭之间多以分隔散居的方式居住，少有公共社交活动，唯一聚会交流的地方就是酒吧，加上恶劣气候影响因素，精神因素性疾患特别是抑郁症的发病率在爱尔兰甚高。据爱尔兰国家统计局（Central Statistics Office, CAO） 2017 年公布的数据表明，爱尔兰因抑郁症引起的自杀率在欧共体国家中排名前四，在仅仅只有四百万人口的爱尔兰每天平均有一例或一例以上的自杀发生。毫无疑问，恶劣的气候因素，社交生活的缺乏，以及精神抑郁和沮丧同样也是影响爱尔兰育龄妇女其不孕症高发生率的重要原因。

中医辩证对爱尔兰女性不孕症的论治要素

以上诸多特殊的因素，导致引起爱尔兰女性不孕的原因多以肾虚尤其是肾阳虚、宫寒、寒凝血滞为多见。《内经-上古天真论》 曰“阳气者若天与日，失其所，则折寿而不彰，故天运当以日光明，是故阳因而上卫外者也”。意思是说阳气与人体的关系，就像天和太阳的关系一样，一旦人失去阳气，就会无意识地缩短寿命。因此，正如天空的运作离不开阳光，人们离不开温暖的阳气一样，阳气既具有太阳的上升性，又具有守护人体的功能，说明自然环境与天气对人体功能的影响。阳气乃生命之本，生命即是阳气之所聚。阴、冷、寒、湿的气候易伤阳， 导致爱尔兰不孕症妇女阳虚尤其以肾阳虚多见。 《金匮要略》 曰“妇人之病，因虚，积冷，结气”；隋代-巢元方编著 《诸病源候论》 其三十九卷把不孕症作为无子候，其不孕的原因分为“月水不利”“月水不通”“子脏冷”“带下”“结积”五种不同的致病机理，但大多与风冷致病、子宫虚冷有关。以上理论提供了最早治疗不孕症以温经散寒、暖宫种子的理论依据。《神农本草经》 在‘柴石英’条下说“女子风寒在子宫，绝经十年无子久服” 也开创了温经散寒, 暖宫种子的先例。

我们根据补肾、温阳、暖宫三大治疗原则，采用针药并用对提高爱尔兰不孕症妇女体外受精-胚胎移植（IVF-ET） 成功率正在进行临床研究。“补肾温阳暖宫法”包括传统的针灸加上复方中药方联合应用。其主要治疗机制是温肾阳、温经散寒、暖宫孕子，增加卵巢血液循环，改善卵子质量，改变子宫内膜容受性 （Endometrial Receptivity, ER），调节性激素平衡。子宫内膜容受性良好，胚泡易于定位，粘附，侵入和植入胚胎 [24]。张景岳著 《妇人归》 曰“妇人所重在血，血能构精，胎孕乃成”。当归为妇科常用 调经中药之一 [25]。当归补血活血调经止痛，为妇科要药，配伍暖宫药，即可补血养血活血又温经散寒，改善子宫内膜血液循环，增加子宫内膜容受性，同时使卵巢血液循环增加，促进卵泡发育和卵母细胞成熟，提高卵母细胞质量。右归丸为张景岳的方剂，具有温补肾阳.填精止遗的功效。Hu 等人 [26] 发现含有右归丸或左归丸成分的大鼠血清能够诱导人孕早期脐带血干细胞分化为卵母细胞样细胞，即右归丸和左归丸具有促进新卵子生成的作用，这一研究结果从细胞和分子水平上证明了应用右归丸或左归丸在治疗人类生殖功能障碍如卵巢早衰的药理作用机制。以活产率 （LBR） 作为评价“补肾温阳暖宫法”辅助治疗提高体外受精-胚胎移植人工助孕成功率的终末指标，我们初步的临床研究结果表明，“补肾温阳暖宫法”辅助治疗对改善爱尔兰不孕症妇女体外受精-胚胎移植成功率较单纯体外受精-胚胎移植和单纯针灸治疗分别提高活产率为 23.3％ 和 15.6％ [未发表资料]，说明采用“补肾温阳暖宫法”在辅助和提高爱尔兰不孕症妇女体外受精-胚胎移植成功方面具有疗效确切的应用前景。

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The Journal of Chinese Medicine and Acupuncture
《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 2019 年 9 月 20 日

穴位割治多向埋线术法治疗胃、十二指肠球部溃疡 119 例的疗效观察

柴振江
【浙江中医药大学国际学院 邮编 310053】

摘要 观察穴位割治多向埋线疗效，采用穴树原理及脊柱相关疾病学说，在穴位平面不同方向埋线，增加刺激强度。

关键词 穴位多向埋线术 穴树原理 脊柱相关理论 胃十二指肠球部溃疡

胃、十二指肠球部溃疡是青壮年常见疾病，病程迁延，上腹痛常有周期性、节律性，伴有反酸、嗳气、呕吐等症状，严重可并发上消化道出血或梗阻等。目前用药物治疗效果并不十分理想，且极易复发。

自 2002 年起，依据脊柱相关理论学说及穴树原理，结合传统埋线疗法，新创一种埋线疗法，为“穴位割治多向埋线术”，对功能性及器质性疾病均可达到较满意的、可靠的治疗效果。如内科常见胃、十二指肠球部溃疡，慢性胃炎，中度萎缩性胃炎等。

1 临床资料：

2002-2017 年均经胃镜确诊的胃、十二指肠部溃疡，其中，男性 68 例，女性 51 例，病程最长 12 年，最短半年，年龄最大 65 岁，最小 25 岁。

2 治疗方法：

2.1 选穴：胃俞、脾俞、胸 7-胸 12 脊柱敏感点。

2.2 操作方法：选准穴位按手术常规严格消毒皮肤，用 1%利多卡因以穴位为中心分别向四周做浸润麻醉，带无菌手套，盖无菌孔巾，做 1cm 纵型切口，深达皮下，用止血钳（小蚊嘴）分离，深达肌层筋膜，向四周做广泛分离，以得气深度为准。用小蚊嘴止血钳夹肌层筋膜，增强刺激强度，患者以胀痛感为度，然后将羊肠线 2-3cm 长，3-4 支植入穴位中心及离穴位四周筋膜同一平面上，敷消毒纱布胶布固定 7 日拆线。一月一次，每月复查胃镜一次。

3 疗效观察

3.1 疗效指标：

痊愈：症状消失，胃镜检查溃疡面全部愈合。

显效：症状好转或消失，胃镜检查溃疡面缩小 50%。

无效：症状无改变，胃镜检查溃疡面无变化。

3.2 结果分析：

本组患者经埋线三次统计：治愈率 79%，有效率 100%，无效 0。

4 典型病例：

王 XX，男 46 岁，某贸易公司职员，初诊 2006 年 6 月。主诉：患胃溃疡十二年，泛酸，呕吐，腹胀，呈节律性，多在午前，或夜间定时发作，偶见柏油便。曾服用泰胃美等药物有效，但停药后症状如前，近两个月疼痛明显，患者面色苍白，舌淡，脉细弱。胃镜检查：胃幽门部可见 1.5*3cm 溃疡，边周充血水肿。穴位割治多向埋线治疗。治疗后症状基本消失，随访 5 年未复发。

5 讨论：

穴位割治多向埋线治疗，得气程度强，作用持久，故比常规埋线方法好。为治疗胃、十二指肠球部溃疡，提供一条新的途径。穴树学说理论认为，人体经穴下血管与神经交合成束，并向皮下以及各层组织结构延伸发出分支，因其状似树枝，故称之为穴树。穴树有深浅之分。膀胱经背部穴位的穴树归类为深穴树，背部神经传导功能，体现背部穴树作用机理，背部穴树为背俞穴结构功能基本单元[1]，亦为割治多向埋线术提供科学相关依据。《灵枢·背俞》定背俞穴为相对位置，更重视压痛点反应，穴树学说以血管神经构成的树状结构说明了穴的性质、功能及其内部联系。以背俞穴穴树的解剖结构和生理功能分析，脏腑疾病反应点与穴树基本一致[2]，在相关穴树的平面植入多条方向羊肠线，使相关穴树相通，形成多向性信息网，通过羊肠线的机械性物理化学刺激产生一定的信息量。经过血管神经束到达病变部位，改变机体病理状态，治疗疾病。胃、十二指肠球部溃疡是一种慢性消化道疾病，病程迁延不愈。虽然有不同学说阐述其病因病机，但是脊源性十二指肠球部溃疡，由于脊柱关节紊乱，产生对交感神经的慢性刺激和压迫。交感神经功能减弱或丧失，使交感神经和迷走神经的协调性发生

紊乱，使交感神经对内脏抑制力减弱，并阻断血管收缩的神经通路，结果产生麻痹性血管舒张和迷走神经兴奋性增高，引发脊源性胃、十二指球溃疡[3]，穴位割治多向埋线是经过多种因素的复合刺激，达到疏通经络气血治疗疾病，即本法通过割治分离，缓解深浅筋膜粘连，产生一种强有力的机械物理作用，羊肠线为一种异性蛋白，当埋入穴位后，经过分解吸收，对机体产生有力的生物化学刺激，通过这样机械物理化学的多重刺激，调动人体本身固有的调节机能，这种刺激为非特异性，它可以使人体免疫力功能得到有效调整提高，更进一步调整病理状态下机体平衡及机体内环境的平衡失调，同样这种多重作用对穴位的长久刺激，可大大激发全身经络之经气及其运动速度，从而调节身体有关脏腑器官活动，使经络保持平衡及旺盛的功能状态，达到治疗疾病的目的。实践证明，疗效满意可靠，也证明脊椎疾病相关理论和穴树原理的正确性。

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【3】董福慧 临床脊柱相关疾病 人民卫生出版社 2009，12：341

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第一次治疗前后照片对比：

治疗前 治疗后

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作者简介：

作者宋志香，英国注册中医师，主任医师。英国伦敦Dr Song Clinic 主诊医生，哈尔滨医科大学学士学位，北京中医药大学硕士学位。曾在北京三甲医院工作及私人中医馆兼职20余年，发表医学论文近40篇。

中医综合疗法对凝肩患者治疗研究

宋志香
英国伦敦宋氏医馆主诊医师
英国注册中医师

摘要

目的 中医针罐灸药并用治疗凝肩患者疗效观察。

方法 20 例凝肩患者进行肩部阿是穴火针点刺、粗针浮刺、细针五行或八卦围刺；拔罐，艾灸；体针予五输穴补虚泻实补母泻子等中医疗法。每周一次治疗，3 次一个疗程，最长 1 个疗程，最短一次治疗。同时每天 12 克左右中药浓缩颗粒冲服巩固治疗，最短服一周最长服 3 周。

结果 治愈 13 例，显效 7 例，有效 0 例，无效 0 例，总有效率 100% 。

结论 凝肩是由于气血虚弱，风寒湿邪乘虚而入，堵塞肩周经络，导致肩周软组织粘连，不通则痛并肩关节活动受限。

中医多种针法针刺治疗，配合拔罐艾灸，达到激发阳气，活络止痛，松解粘连，驱邪固表的功效. 多数病人第一次治疗结束，疼痛消失，关节活动度恢复正常；配合中药治疗，以巩固疗效，固护正气，防治外邪再次侵袭.上述针罐灸中药并用祛邪而不伤正，标本兼顾，取得非常好的疗效。

关键词 凝肩，针灸，拔罐，艾灸，中药。

Observation of the Clinical Effect of Comprehensive Traditional Chinese Medicine Treatment for Patients with Frozen Shoulder

Dr Zhixiang Song BMed, MSc (China)
Dr Song Clinic in London, Full member of ATCM(UK)

This study was to explore the clinical effect of comprehensive TCM therapy including acupuncture, cupping, moxibustion and herbs for frozen shoulder. Twenty patients with frozen shoulder received acupuncture on Ashi points (Tender points) by heated needle pricking, thick needle penetrated into fat layer and five or eight thin needle acupuncture surrounding Ashi points in deep tissue. This was followed by cupping and moxibustion.

The treatment was once a week with 3 sessions per course. In the meantime, the patient took orally 12 grams of Dr Song's herbal powder specifically formulaed for frozen shoulder each day. The longest treatment was just one session of acupuncture per week with daily herbs for three weeks. The shortest treatment was one session of acupuncture with one week of herbs. **Results:** Thirteen cases were cured. Seven cases were obviously improved. There was no ineffective case. The total effective rate was therefore 100%.

In Chinese medicine, there are several causes that lead to frozen shoulder: Yang Qi of the body becomes lower from about 50 years of age; wind with cold and wet pathogens can invade points of shoulder, especially in the night. This can block Qi and blood circulation inside the shoulder. This leads to shoulder pain with restriction of movement.

Various methods of acupuncture treatment combined with cupping and moxibustion can chieve the effects of warming Yang Qi and reinforcing meridians, improving blood circulation and resolve blood stasis, expelling pathogenic factors such as wind cold and damp, as well as releasing tissue conglutination and relieving pain. Hance most patients recovered after the first treatment. Chinese herbs work through consolidating the therapeutic effect of acupuncture, tonifying Qi and blood while improving their circulation, and preventing he invasion of pathogenic factors. Overall, such comprehensive therapy has the successful effect to treat both symptoms and the condition itself.

Key words: Frozen shoulder; Acupuncture; Cupping; Moxibustion; Herbs.

凝肩（西医称为肩周炎），该病多发于 50 岁以上，由于气血虚弱，卫表不固，风寒湿邪乘虚而入，堵塞肩周经络，气血运行不畅，不通则痛；气血痰凝滞日久，筋脉不养，肩周软组织粘连，肩关节活动受限。中医针罐灸治疗配合中药口服，疗效迅速，标本兼顾，笔者将本人治疗的 20 例凝肩患者病例进行分析总结，报道如下。

1.资料与方法

1.1 一般资料

20 例凝肩病人均为本人诊治的病人，其中男 10 例，女 10 例，年龄 35～85 岁,平均年龄 55.3 岁，发病时间 1 个月～20 年，平均病程 2.5 年。

1.2 临床表现

症状：肩部串痛，遇风寒湿痛增，得温痛缓，夜间疼痛加重，肩部有沉重感，手臂无力，持物坠落，肩关节活动受限。疼痛甚至由肩部延伸至远端肘臂手指。

查体：肩前，外，后及三角肌可及压痛点及（或）痛性筋结。膏肓及肩井可触及痛性筋结，病程时间长的高龄患者，可见肩部肌肉萎缩，手部略水肿。肩关节屈、伸、外展、内收、外旋、内旋、环转活动幅度不同程度受限。脉弦，舌红少苔或舌淡苔白腻齿痕。

1.3 诊断：

辩证诊断：风寒湿邪阻滞经络，气血闭阻，筋脉拘急；肝肾阴虚筋骨失养；气虚卫外不固。

辨病诊断：凝肩（肩周炎 ）。诊断依据《中医病证诊断疗效标准》〔1〕:1) 慢性劳损，外伤筋骨，气血不足，复感受风寒湿邪所致; 2) 肩周疼痛，以夜间为甚，常因天气变化及劳累而诱发， 肩关节活动功能障碍; 3) 肩前、后、外侧均有压痛，肩活动不同程度受限; 4) X 线检查多无明显异常。

1.4 治疗方法

1.4.1 中医针刺拔罐艾灸疗法

（1）阿是穴针刺：

*火针：在痛性筋结等阿是穴，用火针轻轻点刺表皮

*浮刺：在阿是穴把直径 0.35mm 左右粗毫针刺入脂肪层，快速旋转扫散约 1 分钟，金属针柄连接电针仪，予疏密波。

*围刺：

以阿是穴为中心作五行或者八卦围刺，针尖直达病所，在筋守筋，在肉守肉，在骨守骨。针的直径为 0.20mm 左右的细毫针。左右快速碾转针柄 30 秒，金属针柄接电针仪器，予疏密波。

（2）体针补虚泻实：采用迎随补泻表里经，实则泻其子，虚则补其母。比如阿是穴在三焦经，予补心包经母穴中冲，泻三焦经子穴天井。针的大小不超过 0.18*13mm。

留针时间为 40 分钟。

（3）拔罐：启针后针孔立即拔火罐。

（4）阿是穴艾灸。

1.4.2 中草药浓缩颗粒口服，主治风寒湿邪滞留筋脉，气血凝滞的标实，兼治肝肾脾之虚。方剂如下：

羌活，桑枝，伸筋草；当归，白芍，骨碎补；元胡，鸡血藤；丝瓜络。黄芪，白术，防风，姜黄，茯苓， 每天约 12 克，分 2 次温开水冲服。最短口服一周中药，最长 3 周。1 克中药浓缩颗粒相当于 7 克原生中药，每种中药浓缩颗粒的具体用量，依据每个病人的具体辩证而不同。

1.5 疗程：每周治疗一次，3 次一个疗程，最短一次治疗，最长 3 次治疗。治疗期间每天口服上述中药浓缩颗粒冲剂.

1.6 疗效判断标准

疗效判定参照《中医病证诊断疗效标准》[1] 判定疗效。痊愈：肩部疼痛消失，肩关节活动范围恢复正常；显效：肩部疼痛缓解明显，肩关节活动范围改善明显；有效：肩部疼痛基本缓解，肩关节活动范围部分改善；无效：症状无改变。

2.结果

治愈 13 例，显效 7 例，有效 0 例，无效 0 例，总有效率 100% 。

3.讨论

“凝肩”属于中医“痹证”范畴，《素问·痹论》曰：“所谓痹者，各以其时重感于风寒湿也”。主要是风寒湿邪阻滞肩臂筋脉，气血闭阻，经络不通，筋脉拘急，导致肩关节疼痛和活动受限。另外老年肝肾亏虚，筋骨失养；气血亏虚围外不固等本虚之证，导致病症反复发作迁延不愈。治予祛风寒湿，温经络，q 行气血，柔筋骨。补肝肾健脾气固卫表。

阿是穴火针振奋阳气；阿是穴浮刺针在皮下旋转，犹如运太极之手伸入水中， 一气周流，瞬间产生巨大能量，激活局部五行，疏通经络；毫针围刺直达病所，轻轻捻转，引气聚阿是穴，围寇歼之。连接电针仪，予疏密波疏通经络。体针主要是泻病变所在经的子穴以泻实，补其表里经的母穴以补其虚。针孔拔罐，将风寒湿邪及血淤痰凝气郁拔而除之。艾灸温通经络，祛寒湿行气血。中药浓缩粉继续祛风寒湿行气血，养肝柔筋补肾壮骨，健脾补气固表。

本组治疗采用针刺拔罐艾灸及口服中药等综合中医疗法，局部与全身同治，内外同调，祛邪而不伤正，取得良好疗效。

凝肩病案举例：

病案 1

Bar，女，60 岁，英国人，初诊日期 2018 年 9 月 29 日

症状：左肩臂痛一个月，夜间加重，活动受限。

查体：双脉旋紧，左舌下静脉曲张，左舌边齿痕。左肩臂大肠经上可触及痛性筋结。

诊断：凝肩。风寒湿邪闭阻筋脉，气滞血瘀，

经络不通

治法：以祛风寒湿邪，温经通络止痛为主；兼以滋养肝肾，柔筋壮骨，补气健脾。

中医治疗一次：左肩臂筋结阿是穴针刺，包括火针点刺、粗针浮刺、细针围刺；拔罐，艾灸。针刺补肺经母穴太渊，泻大肠经子穴二间。一次治疗完，左肩臂疼痛消失，活动自如。

口服中药浓缩颗粒一周：一周量共计 90 克，每天 2 次热水冲服，方剂如下：

羌活 7，桑枝 7，伸筋草 7；当归 5，白芍 5，骨碎补 5；元胡 7，鸡血藤 7；丝瓜络 7。黄芪 7，白术 7，防风 7，姜黄 5，茯苓 7。

治疗前后照片对比：

治疗前 治疗后


病案 2

Val，男，57 岁，英国人，初诊日期 2018 年 8 月 16 日。

症状：一个月前外伤后右肩骨折，西医予外固定一个月，右肩臂仍剧痛难忍，活动严重受限，遂复查 X 光片显示骨折不愈合，遂来到我诊所，寻求中医治疗。

查体： 左脉弱，左寸不足；右脉粗大旋紧，舌右边齿痕；舌下静脉曲张。右肩臂心经区可触及条索样痛性筋结。

诊断：右肩骨折，凝肩。血瘀筋骨，风寒湿凝滞，气血虚弱。

治法：行气活血化瘀，疏风散寒化湿，温经通络；补肝肾健脾气。

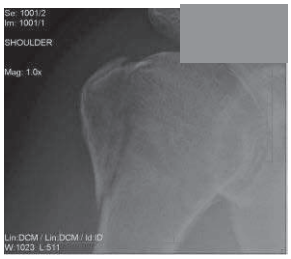
中医治疗 3 次：右肩臂阿是穴针刺，包括火针点刺、粗针浮刺、细针围刺；拔罐，艾灸。针刺补小肠经母穴后溪，泻心经子穴神门。治疗 3 次。

口服中药浓缩颗粒 2 周：一周量共计 90 克，每天 2 次热水冲服，方剂如下：

羌活 5，桑枝 5，伸筋草 7 ；当归 7，白芍 7，骨碎补 9；元胡 7，鸡血藤 7，丝瓜络 5。黄芪 7，白术 5， 防风 7，姜黄 7，茯苓 5。每天分 2 次冲服。

三次治疗前后照片及放射片对比：

治疗前 治疗后






病案 3

Ste，女，47 岁，英国人，初诊日期 2019 年 1 月 8 日

症状：左肩臂痛 7 月，伴左臂活动受限。既往生育 8 个子女。

查体：左脉旋紧，双尺脉极弱，双舌边齿痕。左肩臂心经及肺经可触及痛性筋结。

诊断：凝肩。风寒湿邪闭阻筋脉，气滞血瘀，经络不通。肾虚，水不涵木。

治法：疏散风寒湿，温经通络；滋养肝肾，柔筋壮骨，补气健脾。

中医治疗：左肩臂阿是穴针刺，包括火针点刺、粗针浮刺、细针围刺；拔罐，艾灸。针刺补小肠经母穴后溪，泻心经子穴神门。补大肠经母穴曲池，泻肺经子穴尺泽。三次治疗完，左肩臂疼痛消失，活动自如。

中药口服：中草药浓缩颗粒巩固治疗三周，每周约 91 克，方剂如下：

羌活 7，桑枝 7，伸筋草 7；当归 7，白芍 7，骨碎补 7；元胡 7，鸡血藤 7。黄芪 7，白术 7，防风 7，姜黄 7，茯苓 7，每天分 2 次冲服。

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多科室协作开展体质干预初探

侯献兵[1] 郑晓丽[2] 林树芬[3] 王海章[4] 李宝栋[5] 韩亚妹[6] 刘志云[7] 高娜[8]
指导：贾春生[1]
（河北省沧州中西医结合医院 1 全国老中医药专家贾春生学术传承工作室 2 体检中心 3 医务科 4 骨科 5 脑内科 6 护理部 7 产科 8 健康教育科 沧州，061001）

【摘　要】：通过整合临床各科室资源，分别从体质教育、体质护理、体质管理、围手术期体质干预、中风后体质干预等多方位入手综合干预偏颇体质，并逐步向一站式健康托管的理念发展，以达到缓解患者病痛、治疗患者病症、改善患者偏颇体质状态、提高患者生活质量、在一定程度上预防偏颇体质易发疾病的形成的效果，从而实现中医“治未病”的目的，现将经验分享给大家，以餍同道。
【关键词】：“治未病”；偏颇体质；杂合以治；

由于人体体质的形成是多种因素长期缓慢综合影响的结果，单一的治疗手段不能很好的改善体质的偏颇状态，我“治未病”中心通过整合临床各科室资源，分别从体质教育、体质护理、体质管理、围手术期体质干预、中风后体质干预等多方位入手综合干预偏颇体质，并逐步向一站式健康托管的理念发展，以达到缓解患者病痛、治疗患者病症、改善患者偏颇体质状态、提高患者生活质量、在一定程度上预防偏颇体质易发疾病的形成的效果，从而实现中医“治未病”的目的，现介绍如下：

1 与健康教育科合作开展中医体质科普讲座

2013 年期间，由健康教育科与社区卫生服务中心、学校、公司等单位联系、安排，由“治未病”中心主讲，开展健康科普讲座总计 52 次，听众总计 6258 人次，听众反响热烈。科普讲座在普及中医及传统文化的同时，又体现了中医未病先防之治未病的功能。

科普讲座分别从避致病因素、调生活起居、学养生技能三方面进行讲述。“避致病因素”是指应该学会避开或者降低外因之六淫侵袭、内因之七情所伤、不内不外因之饮食劳倦及跌仆金刃等“三因”所带来的不良影响。“调生活起居”从情志、膳食、运动等方面进行讲述。“学养生技能”则重点科普刮痧、拔罐、点穴等简便易行的方法[1]。

笔者依据讲座主要内容撰写了一些科普文章发表于中国中医药报、上海中医药报、保健时报、老年日报、沧州日报等，以扩大对体质养生知识的科普力度。

目前亦在进一步计划将体质养生知识系统化、科普化并编写成教材，进而规划入大、中、小学教学中。

2 与护理部合作开展中医体质护理

我中心与护理部合作，依据体质特征、中医基础理论及护理学，针对各种偏颇体质制定了相应的护理方案，对护理人员进行培训并应用于临床。中医体质护理采用因体施护、因症施护相结合的方法，因体施护分别从情志、季节、起居、膳食、运动等方面进行了调护；因症施护则针对气郁体质患者不同的症状及轻重情况，“急则治其标”，首先对有较重症状者实施重点护理，例如：气郁体质失眠者，嘱其每日 11:00（子时）前入睡，因子时一阳初生，在此之前较易入睡，并且养成按时入睡的好习惯，以调养生物钟。另加单耳磁珠埋穴神门、心、肺、脑、内分泌等穴[2]；湿热体质有痤疮者嘱其每周应用我科自行研制的，以野菊花、白芷、薄荷等为主的中药面膜外敷 2~3 次，每次 10~15min，并注意面部卫生以防止感染[3]；阳虚体质腹泻者嘱其少食生蒜、生葱等辛辣刺激食品，并每日沿手阳明大肠经从曲池至合谷及腹部天枢穴进行自我按摩[4]等等诸多调护方法以促进偏颇体质转化为平和体质。

3 与体检中心合作开展中医体质管理

我中心与体检中心合作，将体质辨识做为常规的检查项目之一纳入体检套餐之中，并依据偏颇体质特征、传统中医理论结合现代医学理念对偏颇体质人群从先天禀赋及后天的饮食、起居、运动、心理等健康危险因素进行全面监测、分析、评估、预测、预防和维护从而实施对偏颇体质人群的健康指导、跟踪服务和体质管理。[5]

在体质干预方面采用针刺、灸法、中药、拔罐、火针、刺络、微针、刮痧、耳针、电针、熏蒸、穴位贴敷、膏方、揿针等多种中医疗法，优势互补的“杂合以治”方案。依据病邪的特异性、中病层次、体质的特异性及刺灸法的特异性配合使用，以期能达到良好疗效，可发挥 1＋1＞2 的作用。[6]

2010 年我中心应用“杂合以治”的方案干预 53 例气郁体质患者，得到了很好的疗效，临床显效： 46 例，有效 5 例，无效 2 例，总有效率为 96.2%[7]。2011 年，我治未病中心对 128 例单纯气郁体质患者临床观察，观察组应用针刺、刺络、拔罐、体质护理、体质教育等多种方法“杂合以治”；对照组采取空白对照。70 天后采用《中医体质分类与判定表》进行判定，并应用统计学分析治疗前、后体质量化积分有无显著性

差异。研究结果显示：干预前，两组体质转化分均值无统计学意义（P＞0.05）；经过一个对照观察周期 70 天后，观察组与对照组相比转化分均值明显降低，差异有统计学意义（P＜0.01）。观察组干预前、后各条目体质量化积分均值均有显著性差异（均 P＜0.01）。[8]

4 与临床相关科室，如产科、骨科、康复科、脑内科、肿瘤科等合作开展围手术期、中风后体质干预

围手术期患者一般多虚实夹杂，术前一般多以邪实为主，术后可因术中损失气血转化为体虚为主，这种情况对体质的影响较为特殊，短时间内可引起患者体质类型发生较大变化，且对患者体质类型有较长远的影响，这与生活起居等长期作用于患者而导致体质类型变化有很大的不同，临床中应予重点辨识。目前，我中心与产科、骨科、康复科、脑内科、肿瘤科等科室[9-11]已经初步合作干预部分偏颇体质患者，并正在进一步计划大样本临床观察。

5 讨论

中医学理论体系的基本特点就是整体观念、辨证论治等，讲究因人、因地、因时三因制宜，其中因人制宜是最重要的，王琦教授提出“九种体质”并颁布《中医体质分类与判定标准》之后[12]，体质理论在临床各科室中得到了广泛的应用。 王利平[13]等应用于妇科，治疗排卵障碍性不孕症，在患者未行经期间均给予补肾丸口服以调经助孕；气郁体质者口服补肾丸加王不留行、青皮、陈皮等；结果 184 例患者中，痊愈 71 例，好转 96 例，无效 17 例，有效率 90.80%；曹慧[14]等应用于脾胃科，采用体质调节法干预气郁质肠易激综合征，给予逍遥丸口服，配合针刺，取穴足三里、太冲、百会等；据观察证明，采用体质调节法调理患者的体质，治疗气郁质腹泻型 IBS 轻症患者具有一定的疗效；马瑞[15]应用于肿瘤科，其课题研究结果显示气郁体质是乳腺癌患者主要体质类型之一，气郁体质约占 19. 5%。

王琦教授在《中医体质学》中指出：体质是人类在生长、发育、过程中所形成的与自然、社会环境相适应的人体个性特征。并进一步概括出体质的遗传性、稳定性、可变性、多样性、趋同性、可调性六大生理特征[16]。所以说偏颇体质是单种或多种病邪长期作用于人体综合所呈现出的一种低状态平衡，其复杂、多样、多变，这些特点也正是临床各科室广泛应用的基础。近十年偏颇体质的临床干预研究越来越多，也取得了不俗的成绩，中医药通过调节机体整体功能在干预偏颇体质上发挥了独特的优势。但是总的来看，偏颇体质的干预多限于提出原则性指导思想，干预方法单一，尚没有规范，具体的干预措施、实验研究等缺乏具体准确的数据指标。所以笔者认为多学科协作研究、干预对于体质及临床治疗均有很好的优势，可以在临床中进一步规范推广。

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New Development in Western Medicine on the Diagnosis and Treatment of Multiple Sclerosis

Jodi Hawkes

Multiple sclerosis (MS) results from demyelination of nerves in the eyes, brain and spinal cord (Berkow *et al.,* 1997, 319), interrupting communication between the brain and the rest of the body and resulting in declined bodily functions. Without a cure, 2.5 million people, mainly female, are currently affected worldwide. The trigger is unknown but neuronal damage is considered to be orchestrated by the immune system[1] (Hunter, 2016).

1. Western medicine diagnosis

Diagnosis involves a thorough case history, physical examination and laboratory testing. While there is no specific test for MS, some may indicate or exclude it. For example, MS is characterised by multifocal lesions[2] detected by magnetic resonance imaging (MRI) in white and grey matter of the central nervous system (CNS) (Hunter, 2016).

1.1. Signs & Symptoms

Because lesion location and severity are hugely variable, there is a tremendously broad range of possible signs and symptoms (Hunter, 2016). However, common symptoms include weakness, numbness or tingling in the limbs, tremor, visual impairment, cognitive impairment, abnormal gait, fatigue and dizziness. Individuals may also experience muscle stiffness or spasticity, paralysis, speech impairment, depression and urinary or bowel dysfunction (Hao and Hao, 2012). Onset is sudden for the vast majority. Though the disease is generally progressive, patients may experience relatively good periods of health (remissions) alternating with flare-ups (relapses) (Berkow *et al.,* 1997, 319).

The four classifications of MS are based on the nature of relapses and disease progression. 70-80% of patients are initially diagnosed with relapsing-remitting MS (RRMS), characterised by distinct relapses with limited disease progression in between[3] (Hunter, 2016).

1.2. Relapses

Relapse is defined as an acute inflammatory demyelinating event in the CNS lasting for a minimum of 24 hours, without signs of fever or infection (Ross, 2013). Relapse duration averages about three months, during which time new symptoms often emerge (Hart and Bainbridge, 2016). Again, signs and symptoms vary depending on the location of demyelination (Ross, 2013). Determining whether a patient is having a relapse may be challenging due to the possibility of pseudo-relapses, in which neurologic symptoms unrelated to MS may manifest due to fever or infection (Hart and Bainbridge, 2016). Between relapses, neurologic function seems to stabilise, but it is common for individuals to experience fatigue or heat insensitivity (Hunter, 2016), which could worsen symptoms and be mistaken for relapse (Hart and Bainbridge, 2016).

1.3. MRI

MRI has revolutionised MS diagnosis. It is essential in detecting multifocal lesions in the CNS, which are then linked to patient signs and symptoms to support a diagnosis. Lesions must be disseminated in both time and space. Lesions occurring in discrete neuroanatomic areas within the CNS qualify as 'disseminated in space' (DIS).[4] For lesions 'disseminated in time' (DIT), at least two separate sets of damage must have occurred at least one month apart to differentiate between damage caused by recurrent inflammation in MS and unrelated damage (Hunter, 2016).

1.4. Biomarkers

Though MRI is regarded a powerful tool in MS diagnosis, it has been suggested that scans are only useful for observing the damage caused. Therefore, the further development of biomarkers to reflect current disease activity has been proposed (Tomioka and Matsui, 2014).

Cerebrospinal fluid (CSF) drawn from the CNS, where the pathological process occurs, may provide more accurate information on current disease activity than peripheral blood samples. However, as CSF is drawn via lumbar puncture, it cannot be conveniently obtained on a regular basis (Tomioka and Matsui, 2014).

Three biomarkers indicating B-lymphocyte activation in the CNS have been put forward. The most important of these is oligoclonal IgG bands (OCBs), as they appear in over 90% of MS patients from Western countries, with a diagnostic specificity of

94%. However, it appears Asian populations do not exhibit these bands in as great a number. Therefore, while highly suggestive of the presence of MS in individuals from Western countries, this diagnostic tool may not be as accurate in other areas of the world (Tomioka and Matsui, 2014).

Although OCBs are the best-established CSF-based biomarkers for MS diagnosis, CSF immunoglobulin (Ig) free light chains (FLC) have more recently been found by some researchers to have greater sensitivity and specificity for MS diagnosis (Rathbone *et al.,* 2018).

A recent study of 271 participants investigated the diagnostic value of neurodegenerative biomarkers. Although inflammation is known to dominate the early stages of MS pathogenesis, signs of neurodegeneration have also been observed. Patients of all MS classifications were found to exhibit significantly higher levels of the neurodegenerative marker neurofilament light chain (NFL) compared to controls ($p<0.001$). Furthermore, it was found to be among well-established MS biomarkers, like OCBs[5], leading the researchers to state that the additional use of NFL could improve diagnostic sensitivity, as demonstrated by an increase from 93% to 97% (Novakova *et al.,* 2018).

1.5. Diagnostic criteria

The McDonald criteria for MS diagnosis were most recently revised in 2017. Changes increased the chance of early and accurate diagnosis, allowing patients to start treatment sooner. The criteria crucially re-emphasised that their application was meant for individuals presenting with typical clinically isolated syndrome (CIS) (Carroll, 2018), the first episode of neurological symptoms (Garg and Smith, 2015), which in itself increases the likelihood of MS occurrence.

The 2017 McDonald criteria were set out using the latest understanding of MRI technology and OCBs to reduce the rate of misdiagnosis without decreasing diagnostic sensitivity. The criteria specifically lay out the conditions under which clinical attacks may warrant a diagnosis:

The possible substitution of DIT for CSF-OCBs as fulfilment of the criteria was a change instilled in the latest McDonald criteria and highlights the significant role that CSF-OCBs now have in MS diagnosis (Carroll, 2018).

Number of clinical attacks	**Number of lesions implicated by clinical presentation or detected by MRI**	**Additional data required to give a diagnosis of MS**
≥2	≥2	None
≥2	1 (plus history of a previous attack)	None
≥2	1	1 clinical attack demonstrating DIS
1	≥2	1 clinical attack demonstrating DIT or presence of CSF-OCBs
1	1	1 clinical attack demonstrating DIS and 1 clinical attack demonstrating DIT or presence of CSF-OCBs

2. Western medicine management and treatment

Due to its complexity, MS management is multidisciplinary (Ross, 2013). Treatment is an ongoing process and falls into three categories: relapse treatment, disease-modifying therapies and symptomatic therapies (Hart and Bainbridge, 2016). Management is tailored to each individual patient based on their circumstances, MS type and likelihood of adherence (Ross, 2013).

2.1. Patient education

Education is essential in achieving the best possible outcome and includes teaching patients the importance of treatment adherence and how to recognise and manage relapses (Ross, 2013). Lack of treatment adherence is linked with higher relapse rates, disease progression, more emergency department visits and increased medical costs (Hart and Bainbridge, 2016). A 2007 review showed that most patients who discontinued their treatment did so because they believed it provided little benefit. Therefore, it is vital that expectations are managed as part of patient education (Ross, 2013).

2.2. Symptom management

Symptoms and complications interfering with daily life are managed to give patients the best possible

quality of life. Management is based on individual patient needs and involves both pharmacologic and nonpharmacologic interventions. Unfortunately, many prescription medications are not officially approved for use.

Occupational therapy and the provision of various aids keeps patients mobile and independent (Hart and Bainbridge, 2016). Physical therapy is thought to be important in limiting the deconditioning process (Halabchi *et al.,* 2017). It improves overall health and physical strength while reducing pain, spasticity and fatigue (Hart and Bainbridge, 2016). For example, aerobic exercise reduces fatigue in those with mild to moderate disability (Halabchi *et al.,* 2017). Several studies have demonstrated that strength training significantly improves muscle strength and fatigue. As fatigue is believed to affect between 33% and 75% of MS patients, physical therapy should be considered an important part of symptomatic management (Cruickshank *et al.,* 2015).

2.3. Relapse treatment

The need for additional treatment during relapses is highly debated. If relapse is suspected, the decision whether to provide treatment should be based on the extent of the impact on quality of life. Relapses are usually managed with a short-term, high dose of oral or intravenous corticosteroids (Ross, 2013), which provide symptomatic relief, improve motor function and shorten relapse duration[6] (Hart and Bainbridge, 2016). However, steroids lack target specificity and consequently induce notable side effects (Danikowski *et al.,* 2017).

2.4. Disease-modifying therapies

The most significant progress in MS treatment has been made with the development of immunomodulatory disease-modifying therapies (DMTs) (Garg and Smith, 2015) for long-term management[7] (Hart and Bainbridge, 2016). DMTs broadly suppress the autoimmune response with the aim of decelerating disease progression and reducing relapse frequency (Garg and Smith, 2015). They should be provided as early as possible to limit disease activity in the early stages, which is believed to contribute to long-term disability (Hart and Bainbridge, 2016). While they have been helpful to some extent, they ultimately fail to treat the underlying causes of MS (Danikowski *et al.,* 2017). Their success rate in RRMS is estimated to be just 35% (Quispe-Cabanillas *et al.,* 2012). Furthermore, they have demonstrated little benefit in progressive forms of MS (Hart and Bainbridge, 2016) and often come with serious side effects (Danikowski *et al.,* 2017). They are often prescribed on a trial-and-error basis and a balance between efficacy and tolerability needs to be ascertained (Hart and Bainbridge, 2016).

2.4.1. Self-injected DMTs

Beta-interferons are first-line therapies for patients with persistent relapses[8] (Garg and Smith, 2015). Although higher, more frequent doses are supposedly more effective, patients are also more likely to produce antibodies which attenuate the drug's efficacy (Hart and Bainbridge, 2016). Side effects include flu-like symptoms, depression, thyroid problems, leukopenia and anaemia (Garg and Smith, 2015). A 1997 study found that 41% of MS patients reported new or worsened depression within six months of injecting interferon, making them less likely to continue. However, those who received antidepressants or psychotherapy were significantly more likely to continue their medication (86% versus 35%, p=0.003). Researchers therefore suggested that treating depression in MS patients would increase their adherence (Ross, 2013).

Interferons and glatiramer acetate (GA)[9] have a relapse reduction rate of about 30% (Hart and Bainbridge, 2016). Though GA has limited effect on disability progression, its overall efficacy is similar to that of beta-interferon and it has a more favourable side effect profile (Garg and Smith, 2015).

2.4.2. Intravenous dmts

Monoclonal antibodies natalizumab[10] and alemtuzumab are currently the most effective DMTs. However, both are associated with significant adverse events (Hart and Bainbridge, 2016).

Though natalizumab has been highly effective in two phase III trials for reducing relapse rate and disability progression, its use is now restricted due to serious concerns over connected incidents of progressive multifocal leukoencephalopathy (PML)[11] (Garg and Smith, 2015). Unlike with alemtuzumab, there is a risk of rebound disease if the patient stops taking it.

In two trials comparing the efficacy of alemtuzumab and beta-interferon, the relapse rate of patients on alemtuzumab was considerably lower. Nevertheless, alemtuzumab is also associated with serious adverse events[12] (Hart and Bainbridge, 2016).

Mitoxantrone has had success in reducing disability and relapse rate in patients with RRMS and secondary progressive MS. However, its use is also restricted now due to potential risk of cardiotoxicity and leukaemia (Garg and Smith, 2015).

2.4.3. Oral dmts

The efficacy of oral therapies fingolimod[13], teriflunomide[14] and dimethylfumarate[15] in reducing relapse rate, disability progression and MRI lesions has been shown to be comparable to or greater than injectable medications in several phase III trials.

However, they are second-line treatments as they come with a greater risk of dangerous side effects, such as malignancies. This makes their use particularly less favourable in early or mild forms of MS (Garg and Smith, 2015).

3. Future challenges

As MS pathogenesis is considered to be primarily T-lymphocyte mediated, it has been suggested that newer treatments should focus on boosting regulatory T-lymphocyte function. These suppress myelin-destroying effector T-lymphocytes and seem to have reduced function in MS patients, leading to increased production of pro-inflammatory cytokines and the activation of autoantibodies (Danikowski *et al.,* 2017). However, because it is now understood that B-lymphocytes play a pivotal role in MS pathology, newer DMTs are targeting B-lymphocyte activity (Hart and Bainbridge, 2016). Perhaps the key to improving MS treatment is to find out more about MS pathogenesis.

Emerging treatments[16] have demonstrated superior efficacy but are still associated with serious adverse events (Hart and Bainbridge, 2016) and their long-term effects require further investigation (Ross, 2013). It appears that the most effective therapies induce the worst side effects. Thus, balancing the safety and efficacy of MS medications remains a challenge and should be the primary goal of future research (Garg and Smith, 2015).

Conclusion

Though there is no specific laboratory test for MS, diagnosis has been revolutionised by MRI technology and CSF biomarkers. The 2017 revised McDonald criteria increased the chances of early and accurate diagnosis and highlighted the importance of CSF-OCBs. Ongoing biomarker research continues to improve diagnostic accuracy.

MS patients require ongoing, extensive education and support to manage their symptoms and limit relapses. Long-term management with DMTs is still lacking, especially in progressive forms, and finding out more about MS pathogenesis is key in making them more effective. Improving safety profile without compromising on efficacy must be the goal of future research.

Due to unpleasant side effects of MS medication and its lack of efficacy in progressive forms of MS, many patients look into using less harmful alternative therapies such as acupuncture, despite limited advocacy from research. While some successes are apparent, future studies must be better-designed and longer in duration if acupuncture efficacy for MS is to be verified.

Author's Notes:

[1] This distinguishes MS from other neuroinflammatory diseases like Parkinson's or Alzheimer's disease (Danikowski *et al.*, 2017).

[2] Lesions are damage or scarring (sclerosis) (Hunter, 2016).

[3] After 25 years, about 90% of relapsing-remitting MS patients transition to secondary-progressive MS, characterised by an initial relapse-remitting phase followed by disease progression, with or without occasional relapses, plateaus or remissions. Primary-progressive MS entails progression from the onset with occasional plateaus or minor improvements. Finally, the rarest subtype, progressive-relapsing MS, also shows progression from the onset but patient have relapses, which they may or may not recover from (Hunter, 2016).

[4] Lesions are typically periventricular, cortical/juxtacortical, infratentorial or in the spinal cord (Carroll, 2018).

[5] As well as intrathecal IgG production, IgG index and lymphocyte number (Novakova *et al.,* 2018).

[6] For instance, the Optic Neuritis Trial demonstrated that one gram of intravenous methylprednisone per day for three days followed by oral prednisone for eleven days accelerated the recovery of visual loss due to optic neuritis (Hart and Bainbridge, 2016).

[7] FDA-approved DMTs include self-injected therapies beta-interferon and glatiramer acetate, intravenous therapies alemtuzumab, natalizumab and mitoxantrone, and oral therapies fingolimod, teriflunomide and dimethyl fumarate (Hart and Bainbridge, 2016).

[8] Interferons regulate T- and B-lymphocyte function and restrict T-lymphocyte entry into the CNS (where they attack the myelin sheath) (Garg and Smith, 2015).

[9] GA blocks the formation of T-lymphocytes, stimulates anti-inflammatory cytokine production and the expression of regulatory T-lymphocytes (T_{reg}) (Garg and Smith, 2015), which suppress myelin-destroying effector T-lymphocytes (T_{eff}) (Danikowski *et al.,* 2017).

[10] Natalizumab binds to lymphocytes, preventing their entry into the CNS (Garg and Smith, 2015).

[11] Progressive multifocal leukoencephalopathy (PML) is a potentially fatal brain infection (Garg and Smith, 2015).

[12] including the frequent emergence of secondary autoimmune thyroid diseases, autoimmune cytopenias and increased risk of infection (Hart and Bainbridge, 2016).

[13] Fingolimod inhibits the relocation of T-lymphocytes from the lymph nodes into the CNS. There have been reports of severe side effects in individuals taking the drug (Garg and Smith, 2015) and as it can cause

bradycardia and atrioventricular conduction block, its use is avoided in patients with a history of heart problems (Hart and Bainbridge, 2016).

[14] Teriflunomide is believed to have an anti-inflammatory effect in MS patients through its suppression of proliferating T- and B-lymphocytes. Though its short-term side effects are relatively mild, there is major concern regarding its potential to cause abnormalities relating to physical and mental development in children born to women taking the drug (Garg and Smith, 2015).

[15] Dimethylfumarate is the latest oral drug approved for MS treatment and works by inhibiting proinflammatory pathways. Its most common side effects, such as nausea, diarrhoea and abdominal pain, can be minimised by taking it with food. However, there have also been some reports of more severe adverse events (Garg and Smith, 2015).

[16] Emerging treatments include ocrelizumab, daclizumab, laquinimod, masitinib and autologous hematopoietic stem cell transplantation (Hart and Bainbridge, 2016).

[17] Such as reducing inflammation, promoting NT-3 expression for neuronal health, inducing remyelination, relieving pain and reducing muscle and joint stiffness (British Acupuncture Council, 2015).

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Multiple Sclerosis: TCM Syndrome Differentiation and Treatment

Malik Khan, Huijun Shen

Multiple sclerosis (MS) is deemed as Jing Syndrome (痉证, Jing means spasm) or Wei Syndrome (痿证, Wei means muscular atrophy). The causes of MS can be related to environmental factors, poor diet, tensions and emotions (Lee, 1992). Symptoms and signs include weakness, paralysis of legs and arms, impaired vision, imbalance, bladder dynfunction, tremor and lack coordination when walking (Mayor, 2007, 99).

TCM Aetiology and Pathology

External Dampness is a major contributing factor that starts off this disease. It attacks the meridians of the legs and then moves slowly upwards. Living in damp houses, swimming, incorrect clothing, misty weather all contribute to this illness (Maciocia, 2014).

As the main cause of MS, dampness may also be combined with cold, wind or phlegm. Limb numbness is generally the first sign as a result of dampness causing meridian obstruction. Dampness and Phlegm are closely linked. In the middle stages, stomach and Spleen are affected and results in legs becoming weaker and its associated problems. The next stage Liver and Kidney are affected which are responsible for signs of dizziness, urination issues and coordination problems: commonly presenting at the later stages with Liver and Kidney Yin deficiency and Liver wind. In the whole progression of the disease there is always blood stasis resulting in tightness and pain of limbs (Maciocia, 2014).

According to Maciocia (2014), Sun (2010) and Karpatkin et al. (2014), Multiple Sclerosis has 5 stages:

1) Dampness invading the meridians
resulting in numbness, tingling in the limbs and feeling of heaviness. Phlegm may also accumulate, resulting in symptoms such as double vision and poor memory.
2) Spleen and Stomach deficiency:
such as general weaknesn, and starts to have difficulty walking
3) Liver and Kidney deficiency
The bones and tendons become malnourished and the patient's ability to walk becomes greatly impaired. The patient may experience dizziness and vertigo, and urinary incontinence due to Kidney deficiency
4) Liver and Kidney Yin deficiency & Liver Wind
Finally, Liver and Kidney Yin deficiency lead to the development of pathogenic factors such as Liver Wind, causing tremor and spasticity
5) Blood Stasis
Causing limb pain and rigidity.

Syndrome Patterns and Treatment

Generally, there are six patterns that Multiple Sclerosis falls under.

1. Dampness in the Meridians

Clinical manifestations: Limbs are numb, feeling heavy, vision blurred.
Tongue coating is gluey.
Pulse is a slippery type.

Treatment is to expel dampness and energise the meridians. Useful points can include Ren 9, SP 9, 6, BL22, ST28, LI10, ST36. They are primary to remove the Dampness. LI10 and ST36 tonify method (Maciocia, 2014, 1245).

Herbs that are also useful is a formula that is used to expel dampness called Er Miao San (Two Marvel decoction). This contains the herbs Huang Ba, and Cang Zhu

2. Damp-Phlegm with Spleen Deficiency

Clinical Manifestations: Loss of feeling, legs difficult to lift or move, pricking feeling, mental confusion, poor appetite.
The tongue is swollen with sticky coating.
Pulse is slippery or soggy type.

Treatment is to clear damp and phlegm, strengthen the Spleen. Points are Ren 12 to strengthen Spleen, BL20, Ren9, SP9, 6, Bl22 to remove the Dampness, ST40 to remove the Phlegm.

Herb treatments that are useful for this condition includes the formula Si Mian San (Four Marvel Decoction) or Liu He Tang (Six Harmonising Decoction). They are good at strengthening the Spleen Qi and removing damp and Phlegm (Maciocia, 2014, 1245).

3. Spleen and Stomach Deficiency

Clinical Manifestations: include legs weak, unable to walk, fatigue, loose stools, weak appetite.
The tongue is pale, with the pulse being weak.

The treatment principle is to strengthen both Stomach and Spleen. Points include ST36, Sp6, Bl21, Ren12 to strengthen the Stomach and Spleen, Li10, St31 to tonify the Yang channels, ST30 to circulate Qi and blood in the legs (tonify) (Maciocia, 2014, 1247).

Herbs that are useful for this condition are the formula called Shen Ling Bai Zhu San. This is an ancient formula used to tonify the Spleen.
The formula contains the following herbs Ren Shen, Bai Zhu, Fu Ling, Zhi Gan Cao, Shan Yao, Bai Bian Dou, Lian Zi, Yi Yi Ren, Sha Ren, Jie Geng (Sun, 2010, 170).

4. Liver and Kidney Deficiency

Clinical Manifestations: This condition steadily becomes worse, more weakness of legs, back and knees, vertigo, memory issues, urination problems.
The tongue is pale. Pulse is weak and empty.

The treatment principle is to tonify the Liver and Kidney. Points useful are KD3, Ren4, Bl23, Sp6, LV8, BL18, Si3, BL62, GB20 (moxa useful if Yang deficiency) (Maciocia, 2014, 1248).

A Herbal formula that is useful for this condition includes Liu Wei Di Huang Wan (Six ingredients pill). The formula contains the following herbs that are designed to benefit the Liver and Kidney and benefit the essence: Shu Di Huang, Sha Zhu Yu, Shan Yao, Fu Ling, Mu Dan Pi, Ze Xie (Sun, 2010, 123).

5. Liver and Kidney Yin Deficiency & Liver Wind

Clinical manifestations: These are the later stages of the disease of MS, unable to walk, dragging feet, tightness of legs, loss of muscle, sweats at night.
The tongue has no coating and pulse is floating.

The treatment principle is to tonify the Liver and Kidney Yin and extinguish Liver Wind. Useful points: LV8, ren4, Ki3, SP6, LV3, Du16, GB20, Si3, BL62 (tonify first four, reduce rest) (Maciocia, 2014, 1250).

The herbal formula for this condition: Herbal formula Zhen Gan Xi Feng Tang (Sedate the Liver and Extinguish Wind Decoction), which contains 12 herbal ingredients: Huai Niu Xi, Dai Che Shi, Long Gu, Mu Li, Gui Ban, Xuan Shen, Tian Men Dong, Bai Shao, Yin Chen, Chuan Lian Zi, Mai Ya, Gan Cao.

6. Blood Stagnation

This is a chronic and final stage of MS, great difficulty all round with legs, joints and pain in legs.
The tongue is purple, and the pulse is wiry.

The treatment principle is to circulate blood and remove stagnation. Points useful include Sp10, BL17, PC6, LV3 (Maciocia, 2014, 1250).

The herbal formula that helps with Blood stasis is called Huo Luo Xiao Ling Dan (an Amazing pill to invigorate the channels). The aim of this formula is to promote Qi and Blood movement and flow. It contains the following herbs: Dang Gui, Dan Shen, Ru Xiang, Mo Yao.

Discussion

MS as a chronic progressive disease due to the impairment of central nerve system, with its complexity in aetiology and pathogenesis, is a difficult disease to treat. In TCM syndrome differentiation, MS can be excess or deficiency. Clinically, most MS patients have mixture patterns of excess and deficiency together. In terms of heat and cold patterns, more MS present cold syndrome due to the nature of damp as a Yin pathogenic factor which often impairs Yang Qi of the body, although some patients can develop Yin deficiency leading to heat at a later stage.

Disagreeing with other scholars, the authors of this article believe that blood stasis exists in the whole progression of the disease, from the very beginning to the later stage. Even in the early stage once the damp invasion causes meridian obstruction, the circulation of Qi and blood is already affected, leading to the formation of blood stasis. In some cases, patients may already have blood stasis as a constitutional syndrome so they are prone to damp invasion and meridian obstruction. Therefore in the treatment, the intervention to activate blood circulation and remove blood stasis should be included even from the early stage.

Although not mentioned by other scholars, we believe that blood deficiency also plays an important role in the development of MS. This is because firstly in TCM pathology, the deficiency of Spleen, Liver and Kidney is often associated with poor production of blood, and secondly the common symptoms of MS such as numbness, tingling sensation and stiffness of the limbs are the evidence that tendons and meridians are lack of nourishment from blood. For the tremor, as Liver blood deficiency can also cause liver itself and limbs less nourished, which in turn can lead to Liver wind syndrome. Clinically, if a MS patient does not respond to routine TCM treatment, consideration should be given to tonify and nourish blood.

In TCM treatment for MS, both Chinese herbal medicine and acupuncture are used more commonly, together with some other therapeutic options such as moxibustion, tuina massage and cupping, which can be combined with acupuncture to speed recovery. More TCM practitioners would agree that Chinese herbal medicine tends to be more effective than acupuncture for MS to modify the imbalance of the root or primary with a long term benefit, while acupuncture is more effective for a quick relief of symptoms such as pain, stiffness, etc.

However, due to financial and other factors, most MS patients refer acupuncture to Chinese herbal medicine.

We support the opinion raised by Hao *et al.* (2013) that regular acupuncture treatment has a positive therapeutic effect on the recovery of movement and reducing abnormal sensations of the limbs. Similarly as for stroke rehabilitation, commonly used points for MS are GB34, Liv3, KI3, *Ba Feng* (Extra Point) for lower limbs and LI11, LI4, SJ5, and *Ba Xie* (Extra Point) for upper-limb (Chan, 2007). Electrical stimulation is very helpful if the practitioner has difficulty performing the needle rotation more than 200 times per minute. Hao *et al.* (2013) suggested that no more than two of the scalp needles be stimulated at any session so the brain does not become too confused to respond. Moxibustion can enhance the therapeutic results of scalp acupuncture, especially for older or weak patients. Recommended points are ST-36, SP-6, CV-4, KI-3 and UB-23 (Maciocia G, 2014).

As stated by Hao et al (2013), like treating other chronic progressive diseases such as Parkinson's, and amyotrophic lateral sclerosis, acupuncture to treat MS also is a slow progress that requests a long term repeated sessions, as its effects are sometimes temporary. Therefore, follow-up treatments will be necessary on an ongoing basis. Practitioners may consider scalp acupuncture as the primary approach rather than as a complementary approach for patients with MS.

Conclusion

In Chinese Medicine, MS is viewed from a multi-perspectives. The root causes are mainly damp obstruction and deficiency of Spleen, Liver and Kidney, both have a large bearing on the disease formation. Other Zang Fu organs such as Stomach and their meridians are key pathogenic respondents along with some others. The treatment from TCM approach would include acupuncture, herbal medicine, diet and lifestyle approaches. In acupuncture, electro and scalp acupuncture are becoming more popular and arguably deemed more effective in benifiting Multiple Sclerosis sufferers.

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A Critical Analysis of Clinical Trials on Acupuncture for the Treatment of Multiple Sclerosis

Jodi Hawkes, Malik Khan, Huijun Shen

Introduction

Many MS patients are discontented by the unpleasant side effects of current MS medications, which also do little to impede disease activity in progressive forms of MS. Consequently, many patients look into using alternative therapies as a means of managing their condition. Though up to one fifth of MS patients are estimated to receive acupuncture (Karpatkin *et al.,* 2014), research on acupuncture for MS treatment is relatively limited. Nevertheless, acupuncture has been shown to help relieve MS symptoms via various mechanisms (British Acupuncture Council, 2015) and is considered safe with few side effects (Foroughipour *et al.,* 2013).

Despite the fairly common use of acupuncture treatment for MS and its widespread anecdotal support, studies investigating its efficacy are limited. They also tend to be small and of poor quality. There is therefore a critical need for well-designed acupuncture studies if its efficacy for MS treatment is to be verified. However, some trials have demonstrated snippets of success.

Manual Acupuncture

MS suffers from central neuropathic pain can benefit from acupuncture and palmitoylethanolamide (PEA) in a multimodal approach treatment. In a study, it looked at the results of acupuncture on its own which provided relief for MS sufferers of pain but for short periods, and the pain would return. The study found when they combined acupuncture with PEA of 600mg daily that the pain reduced remarkably. Therefore, they concluded that together they worked syngenically for the relief of neuropathic pain for MS sufferers (Kopsky and Hesselink, 2012).

Foroughipour *et al.* (2013) explored the use of acupuncture treatment for fatigue in MS patients whose response to conventional medicine was insufficient. 40 patients were administered amantadine, currently used to treat fatigue in MS patients, for two months. 20 patients who did not respond sufficiently were randomly selected and given amantadine as well as acupuncture treatment for a further two months. Acupuncture was carried out every other day at SP-6, SP-9, ST-36, GB-34, KID-3, KID-6, BL-60, BL-62, LI-4 and LI-11, resulting in 25% of the previously unresponsive patients gaining significant reduction in Fatigue Severity Scale (FSS) ($p<0.001$) .

Tajik *et al.* used biweekly acupuncture treatment over six months for chronic pain in 49 MS patients. While they reported significant improvement in Oswestry Disability Index (ODI), they did not state whether patients were using pain medication alongside acupuncture treatment (Karpatkin *et al.,* 2014).

Wang *et al.* (2017) carried out a randomized trial with 42 participants, trying to evaluate the differences in the therapeutic effects on relapsing-remitting multiple sclerosis (RRMS) at remission stage between acupuncture at acupoints (observation group) and shallow needling therapy at the nearby points (control group). In the observation group, acupuncture was applied according to prescriptions of "the empirical ten needles" "thirteen needles of the governor vessel" "twelve needles of hand and foot" as well as the symptomatic points. Treatment was given once a day and 5 days a week for 2 weeks, followed by an interval of 2

weeks, with a total course of treatment being 3 months. The results show that in the observation group, the scores of the expanded disability status scale (EDSS) in 3-month and 6-month follow-up were reduced as compared with those before treatment (both $P<0.05$) and those in the 12-month and 24-month follow-up were increased (both $P<0.05$). The annual recurrent rates after treatment were reduced as compared with those before treatment in the both observation and control groups (both $P<0.01$), and the recurrent interval in the observation group was longer than that in the control group ($P<0.01$). The researchers conclude that acupuncture achieves the significant therapeutic effects on RRMS at the remission stage, as it relieves the symptoms of neural functional deficits, delays the time of occurrence and reduces the annual recurrent rate.

Electro-Acupuncture

Tjon Eng Soe *et al.* used electroacupuncture (EA) on SP6 and SP4 bilaterally for 30 minutes at 20MZ, once a week for 10 weeks, to treat nine MS patients with bladder dysfunction. Questionnaires revealed significant improvements in urge frequency ($p<0.03$) and daytime leaking ($p<0.041$). The results were good for MS patients with mild bladder dysfunction, especially those who were not able to take medication due to side effects (Soe et al., 2009).
However, trial validity could be deemed questionable as no control group was included (Karpatkin *et al.,* 2014).

Quispe-Cabanillas *et al.*(2012) examined the effects of EA at ST-36, SP-6, LI-4, LI-11 and Yin Tang in conjunction with interferon therapy in 31 RRMS patients over six months. Their reasoning for this point selection was based on reports of their stimulation of the immune system. For the sham EA group, needles were inserted superficially, off-channel and not electrically stimulated. After six months, patient mobility in the sham group had deteriorated more than in the treatment group, but the difference was not quite statistically significant ($p=0.055$). However, both quality of life and pain scores in the treatment group significantly improved after six months group compared to the sham group ($p<0.0001$). Interestingly, there was also a statistically significant improvement in quality of life and pain scores in the sham group compared to baseline after three months, but the effect did not last through till the end of the trial (2012). Therefore, a trial duration of just three months might not have shown a significant difference between true and sham EA. This might indicate that acupuncture treatment needs to be administered for longer than three months to obtain significant benefit for MS patients, and may explain why trials with shorter treatment periods have been less successful. Though researchers stated they selected points based on reports of them stimulating the immune system, perhaps it is more likely that the points are immunomodulatory rather than stimulating, with MS being an autoimmune condition.

Scalp Acupuncture

Chinese scalp acupuncture is a contemporary acupuncture technique that combines TCM needling techniques with Western medical understanding of representative areas of the cerebral cortex (Hao and Hao, 2012).

In an investigation of scalp acupuncture for MS, the researchers obtained a success rate of 87%, with 14 of 16 patients showing either significant or some improvement after just one treatment (Hao and Hao, 2012).

Hao *et al.* (2013) presented a case study of a patient diagnosed with MS over twenty years ago. The patient received acupuncture once a week for ten weeks, then once a month for six months thereafter. They performed acupuncture on the motor, sensory and foot-motor and -sensory areas of the scalp. Needles were retained for half an hour and quickly rotated for a few minutes every ten minutes. The patient responded remarkably well. At the initial consultation, the patient had difficulty getting out of his wheelchair and his gait was spastic and ataxic. After ten sessions, he had no problem getting out of his wheelchair and his gait was normal. Finger-to-nose and index finger-to-index finger tests also returned to

normal. His motor strength increased, he had more energy and had not experienced urinary incontinence since the first session.

The researchers claimed scalp acupuncture is far more effective than body or ear acupuncture for CNS disorders (Hao *et al*, 2013), but provided no comparative evidence (Karpatkin *et al.,* 2014). They explained how scalp acupuncture exerts a direct effect on the brain through its stimulation of the somato-topic system, which encompasses the union of the CNS and endocrine system. In this way, they proposed that scalp acupuncture can improve MS symptoms and may even slow down or reverse the advancement of physical deterioration, as well as reduce relapse frequency. Moreover, they argued that scalp acupuncture is more accessible, cheaper, less risky and induces quicker responses. Though their patient showed remarkable improvement after twenty years with MS, the researchers suggested that patients should seek treatment as early as possible to increase the likelihood of a favourable outcome (Hao *et al.,* 2013).

Combination of manual, electro and auricular acupuncture

Study into the integration of acupuncture with a wellness program for MS woman suffers was undertaken. Stress was a large significant factor that triggers MS symptoms to worsen. In this study, they looked at the addition of acupuncture along with other strategies for relief of symptoms. Weekly acupuncture treatment was carried out for 8 weeks using points such as ST36, SP6, KD3, Li4, Li11, LV3, PC6, HT7. On the ear, they used Shemen, Zero points, Sympathetic. Electro-acupuncture was used on ST36 and SP6 with 2 to 4 Hz current. The participants found it relaxing, their sleep improved, with less fatigue and less pain. (Becker et al., 2017).

Discussion

While some trials have suggested that acupuncture is useful in the symptomatic management of MS, most are small and poorly designed. Because MS is a chronic, progressive condition, treatment probably needs to be long-term for the patient to obtain sufficient benefit. Therefore, longer, better-designed trials are needed to reveal its efficacy.

Furthermore, other factors, such as diet and lifestyle, that probably greatly influence disease activity should perhaps be concurrently investigated in both conventional medicine and acupuncture trials, rather than evaluating treatment in isolation. Lack of control of such factors might explain why therapies are successful in some but not others. It might also explain why patients seek acupuncture treatment despite limited research advocacy. In clinical practice, many practitioners look at the patient's diet and lifestyle to maximise treatment efficacy. Considering the whole picture and combining different treatments may therefore lead to greater success.

It would also be interesting to see whether scalp acupuncture trials conducted by different researchers on a larger scale would have the same success as the aforementioned trials, so it could be deemed whether it is indeed more effective than body or ear acupuncture for MS treatment.

Conclusion

Due to unpleasant side effects of MS medication and its lack of efficacy in progressive forms of MS, many patients look into using less harmful alternative therapies such as acupuncture, despite limited advocacy from research. While some successes are apparent, future studies must be better-designed and longer in duration if acupuncture efficacy for MS is to be verified.

Rather than evaluating treatments in isolation, perhaps other factors such as diet and lifestyle should be concurrently investigated to better reflect real life and thereby maximise treatment efficacy.

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简述腠理三焦是人体生命空间

徐广文

摘要：本文根据《内经》“人与天地相应”，“人与天地相参”原则；和《内经》等经典医著医家的相关腠理，三焦理论，简述腠理三焦是人体生命空间。空间孕育生命，自然界的天地空间，阳光的作用，使空气流动，水气上下升降，“地气上为云，天气下为雨。”以滋润大地万物生长，同时净化空气。人体的腠理三焦空间，是气化的场所；是诸气、津液升降出入的通道。阳气的作用，气化水谷精微生成的营卫、气血、津液、元气，通过腠理三焦的通道，运行输布于全身，温潤肌肤皮毛，濡养脏腑、筋骨、骨节、脊髓和脑窍；腠理气化，卫气调节汗孔开阖，使汗液浊气从汗孔渗出；三焦气化，使浊气从肺口鼻呼出，尿液糟粕和矢气由二阴排出，而净化人体。所以，天地空间和人体空间（腠理三焦）极为相似，都主要是“气，水”的调节运行循环。

说明人与天地相参，自然界有天地之空间，而万物生生不息。同样，人体有腠理三焦之生命空间，则生命生生不息。

关键词：基础理论 腠理三焦 生命空间

Brief Introduction to Cou-Li and San-Jiao as the Life Space of Human Body

Guangwen Xu

Abstract: This article relies on the principle from the *Huangdi Nei Jing*: “Human being is correspondent to the heaven and earth” and “The man is the mutual reference with heaven and earth” to further explore the theory of the *Huangdi Nei Jing* and other Classic TCM literatures about *Cou-Li* (interstices) and *San-Jiao* (triple-energizer). The author describes the *Cou-Li* and *San-Jiao* as the life space of the human body. Space breeds life. The space of the nature, with the effect of the sunlight, makes the air flowing, water circulating upward and downward. “The qi of the earth rises up and turns into clouds; the qi of heaven descends and becomes the rain”, in this way it nourishes the earth and makes everything to grow, and purifying the air at the same time. The human body's space of *Cou-Li* and *San-Jiao* are the place for Qi transformation; It is the passage way of Qi and body fluid for their movement of ascending-descending, in and out. The role of Yang qi is to transform the nutrients of water and food to generate *Ying-wei,* qi and blood, body fluid, which are transported to the whole body through the passageway of *Cou-Li* and *San-jiao*, to moisten skin, nourish *Zang-Fu* organs (viscera-and-bowels), muscles, bones, joints, spinal cord and brain. *Cou-li* ‘s Wei-qi regulates the opening and closing of sweat pores, exudates sweat from sweat pores. Qi-transforming of *San-jiao*, makes the turbid gas (carbon dioxide) to be exhaled from the lungs and nose, and the urine and stool are expelled from urethra and anus. thereby purifying human body. Therefore, the space between heaven and earth is very similar to the space of human body (the space is *Cou-li and San-jiao*), which is mainly to regulate the 'qi and water'.

This demonstrates that the human being is the mutual reference with heaven and earth, the nature has space of heaven and earth, and everything is endless. Similarly, the human body has a life space, and life can never stop.

Keword: Basic TCM theory; *Cou-Li* and *San-jiao*; Space of life

遵循《皇帝内经》:“人与天地相应”,和“人与天地相参”,自然界有天地之空间,人体内必有如天地间相似的“空间”。那么,人体的生命“空间”是什么?是腠理三焦,试探讨简述:

空间孕育生命:

天是宇宙空间,天地间的空间孕育了自然界的万物。

如《素问•天元纪大论》说:“太虚寥廓,肇基化元,万物资始。……生生化化,品物咸章。”《素问•阴阳应象大论》:“天地者,万物之上下也。”说明天地之间是自然界万物生长的空间,天地之气上下流动交替而孕育万物。正因为自然界有天这个无穷大的空间,万物才生生不息。

生命人体也一样,如《素问•宝命全形论》曰:“夫人生于地,悬命于天,天地合气,命之曰人。”“天复地载,万物悉备,莫贵于人。人以天地之气生,四时之法成。”《灵枢•本神》:“天之在我者德也,地之在我者气也,德流气薄而生者也。”说明人生活在地球上,由天地之气所生,与天地息息相关,故人与天地相应。又如《灵枢•邪客篇》曰:“地有九州岛,人有九窍。……地有十二经水,人有十二经脉。地有泉脉,人有卫气。地有草莫,人有毫毛。天有昼夜,人有卧起。…… 此人与天地相应者也。”《灵枢•岁露篇》曰:“人与天地相参也,与日月相应也。”《灵枢•刺节真邪》曰:“请言解论,与天地相应,与四时相副,人参天地,故可为解。“ 说明人与天地相参,自然界有天地之空间,而万物生生不息。同样,人体有生命空间,则生命生生不息。

人与天地相应,人与天地相参,探讨人体生命空间

1. 腠理和三焦象“天”,为人体“空间”

1.1. 腠理,上窍似“天”, 为人体“空间”:

《素问•阴阳应象大论篇》曰:“故清阳为天,浊阴为地;地气上为云,天气下为雨,雨出地气,云出天气。故清阳出上窍,浊阴出下窍;清阳发腠理,浊阴走五脏。清阳实四肢,浊阴归六腑。”大自然的清阳之气上升为天,天者自然界的空间。人体的清阳之气出于上窍:清阳宣发于腠理,其上窍者眼耳口鼻七窍,窍者孔窍和腔也,腠理者人体缝隙、间隙也[1]。故孔窍、腔、缝隙、间隙皆为人体“空间”也。清阳充实与四肢,也是以腠理为通道,运行清阳于四肢[2]。说明腠理为人体“空间”。

1.2. 三焦四腑,“其气象天”,为人体“空间”:

《素问•五脏别论》曰:“夫胃、大肠、小肠、三焦、膀胱,此五者天气之所生也,其气象天。”天者宇宙空间,三焦四腑象天,为天气所生,故三焦四腑也犹如天之“空间”。其功能特点就像天气升降运行,而孕育生命万物(化生身体所需的营卫、气血、津液、精髓等营养物质)。

> 《灵枢•玉版篇》:“胃者,水谷气血之海也。海之所行云气者,天下也。”译文:水谷注入胃,所以把胃称为水谷气血之海。由于天气的作用,使海水上升为云,下降为雨。

此经文比喻,胃之水谷气血,津液的化生和升降运行,如同“海之所行云气者,天下也。”天下者,天地之空间也。 故胃和胃之所属食管,肠道皆为人体“空间”。

2. 三焦是人体的空腔、腔隙、孔腔、管道等,为人体最大的“空间”

如:《素问•六节藏象论》曰:“脾、胃、大肠、小肠、三焦、膀胱者,仓廪之本,营之居也,名曰器.”王冰注:“凡虚中受物者,皆谓之器。”六腑为管形中空之器。《素问•六微旨大论》曰:“器者,生化之宇。”《辞海》释:“宇,空间的总称。”

《素问•金匮真言论》曰:“胆胃大肠小肠膀胱,三焦六府皆为阳。”实者属阴,空者属阳,“三焦六腑皆为阳。”故三焦六腑者皆空腔管道也。

《素问•五脏别论》曰:“夫胃、大肠、小肠、三焦、膀胱,此五者天气之所生也,其气象天。”天者宇宙空间,三焦六腑象天,为天气所生,其也如宇宙之空间。三焦“纳五脏六腑”,为“一腔之大腑也。”三焦在“脏腑之外,躯体之内,包罗诸脏。”故三焦为天,是人体内最大的空间。如张介宾《类经·藏象类》中说:“然于十二脏之中,惟三焦独大,诸脏无与匹者,故名曰是孤腑也。……盖即脏腑之外,躯体之内,包罗诸脏,一腔之大腑也。”张景岳《类经•脏象类》对其进行了概括:“三焦者,确有一腑,盖脏腑之外,躯壳之内,包罗诸脏,一腔之大腑也”。

《中藏经》:“三焦者,..... 又名玉海水道,上则曰三管。”三焦者气道水道,三管者空间也,故三焦为空间。

东汉刘熙《释名》之体例,"肓,荒也,言空虚、空隙之间也。""肓,罔也,言空空如野而无有也。"、"肓,腔也,言空腔、空隙之间也。" 张介宾《类经•诸卒痛》注:“膜,筋膜也。原,肓之原也。肠胃之间,膜原之下,皆有空虚之处。”“空虚之处”者,空间也。《素问吴注》:"肓,腔中空虚无肉之处也。膜,鬲膜也。"《类经•痹证》:“肓者,凡腔腹肉理之间,上下空隙之处,皆谓之肓。”

明. 虞传《医学正传•医学或问》说:“人之相火,亦游行于腔子之内,上下于育膜之间,命为三焦。”明·虞

抟《医学正传•医学或问》：“三焦者，指腔子而言，包涵乎肠胃之总司也。”指出三焦是腔管。《笔花医镜》曰：“三焦者，人生三元之气，脏腑空处是也。”脏腑空处，谓空间也。

根据《黄帝内经》等经典医著的记载，和医圣医家对三焦的解释认识，和自己对相关三焦理论的学习、理解，和临证研究总结；及结合现代医学的人体解剖，认为大的腔隙、孔腔、管道和各种膜系、筋膜、腔壁属三焦。

（1）. 空腔、**腔隙、孔腔属三焦的如**：胸腔、胸膜腔、腹腔、心包腔、胃腔、胆囊、盆腔、子宫腔、膀胱、阴囊鞘膜腔、骨髓腔、颅腔、脑室、蛛网膜下腔、关节腔、口腔、鼻腔、鼻窦、耳鼓室、眼房等属三焦。

（2）. **体内管道属三焦的如**：淋巴管、淋巴导管、肠淋巴管、血管（动脉，静脉、毛细血管、门静脉、上腔静脉等）、中脑水管、脊髓椎管、气管、支气管、细支气管、咽鼓管、鼻泪管、胰管、肾盂、肾盏、肾集合管、输卵管、输精管、射精管、输尿管等；和肠道（十二指肠、小肠、大肠、乙状结肠）、胆道系、食道、内耳道、内耳半规管、眼睛的泪道、阴道、尿道等属三焦。

（3）. **各种膜系、筋膜、腔壁等属三焦**：如胸膜、肋膜、膈膜、腹膜、肠系膜、脑和脊髓的被膜（硬膜、蛛网膜、软膜）、子宫内膜、眼结膜、鼻腔粘膜、口腔粘膜、胃粘膜、食道粘膜、气管粘膜、阴道粘膜、阴道内膜、肾的背膜、骨膜、关节腔内滑膜、肌肉筋膜、头部筋膜、胸部筋膜、腹部筋膜、胆囊壁、膀胱壁等属三焦。

3. 腠理玄府是人体皮肤的汗孔（汗空）、毛窍、皮空，是肌肉、骨骼，及脏腑组织的间隙、缝隙、孔隙、纹理、幽微府等，为人体“空间”。

3.1. 玄府即腠理，为人体“空间”

《素问•水热穴论》曰：“所谓玄府者，汗空也。”王冰注：“汗液色玄，从空而出，以汗聚于里，故谓之玄府。”《灵枢•小针解》：“玄府者，汗孔也。”王冰注：“气门,谓玄府也。”

金元.刘完素《素问玄机原病式》说：“然皮肤之汗孔者，谓泄气液之孔窍也；.....一名腠理者，谓气液出行之腠道纹理也；.....一名玄府者，谓幽微府也。”《杂病源流犀烛•筋骨皮肉毛发病源流》：“经言皮肤亦曰腠理，津液渗泄之所曰腠，文理缝会之中曰理，腠理亦曰玄府。”《医钞类编•肢体门》说:“腠理，亦曰玄府。玄府者，汗孔也。”《黄帝内经太素•温暑病》说:"所谓玄府者，汗空。……汗之空，名玄府者,谓腠理也。" 张志聪《素问集注》：“玄府者，乃汗所出之毛孔。”高士宗《素问直解》：“所谓玄府者，乃皮毛之汗孔也。”

汗孔和汗空为玄府，腠理。玄府者谓腠理，腠理亦曰玄府。腠理玄府是气和津液运行的通道，和津液渗泄的孔窍。所以，腠理是人体的空间。

3.2. 腠理是皮空，是肌肉、骨骼，及脏腑组织的间隙、缝隙、孔隙、纹理、幽微府等，为人体“空间”。

《素问•刺要论》曰“病有在毫毛腠理者”；王冰注曰：“皮之纹理曰腠理”。王冰注释《素问•皮部论》说：“腠理，皆谓皮空及纹理也。”《灵枢•九針》：“八风伤人，内舍于骨解腰脊节腠理之間為深痹也。”骨解，指骨缝，骨节腔隙也。《金匮要略•脏腑经络先后病》说：“腠者，是三焦通会元真之处，为气所注；理者，是皮肤藏府之文理也。”《医宗金鉴》注解为“腠者,一身之隙,血气往来之处,三焦通会真元之路也;理者,皮肤脏腑内外井然不乱之条理也”。

金元刘完素《素问玄机原病式》说：“玄府者，无物不有，人之脏腑、皮毛、肌肉、筋膜、骨骼、爪牙，至于世之万物尽皆有之，乃气出入升降之道路门户也”。

说明玄府者腠理也。腠理玄府是人体皮肤的汗孔（汗空）、毛窍、皮空，是肌肉、骨节，及脏腑组织的间隙、缝隙、孔隙，纹理、幽微府等。腠理为“一身之隙, 血气往来之处, 与三焦通会，是运行真元之路也。”腠理外达肌肤毛孔，内至脏腑、骨缝，无处不有，无处不到。为人体之间隙，气机出入升降之道路。

根据《黄帝内经》等经典医著和医家的相关理论，腠理在形态上可知是人体的皮肤、肌肉、骨骼，及脏腑之间的间隙、缝隙、孔隙、纹理、筋膜等。如毛孔（汗空）、皮腠（皮下间隙，皮肤和肌肉的交接处缝隙等）、肌腠（肌肉的纹理间隙），和脏腑纹理等。包括腧穴（经络上的腧穴，“穴”是孔隙的意思）。腠是肉眼所看不见的间隙，空隙；理是肉眼可见的纹理，空间。

结合现代医学解剖，中医的腠理还应包括组织间隙（肝血窦内皮细胞与肝细胞之间的窦间隙、肝上间隙和肝下间隙、心包与心脏之间的间隙、肺泡之间的间隙、肾小球之间的间隙、细胞之间的间隙等）、斜角肌间隙、大脑沟回、骨缝、骨节间隙、椎间间隙、骨膜与骨之间的间隙等属腠理。

腠理三焦可理解为包涵现代解剖和生理学中的各种液体和腺体。

根据腠理三焦的功能：主要是运行津液，通行敷布卫气元气；及主消化吸收，化生营卫、气血、津液、精髓等生命所需物质。主持诸气，温煦肌肤内脏，防御外邪入侵；司人体气化，和气机的升降出入运动，以推动脏腑的功能活动，调节着整个生命活动；和促进新陈代

谢等。结合现代的解剖和生理学可理解为：腠理三焦运行输布的津、气、水、液等，其包涵着：消化液 （唾液、胃液、肠液、胆汁、胰液等）、淋巴液、血液、脑脊髓液、胸膜腔内浆液、细胞内液和细胞外液（组织液）、关节滑液、泪液、 前列腺液、 精液、阴道液、汗液、尿液等；和内分泌腺（甲状腺、甲状旁腺、肾上腺、垂体、松果体、胰岛、胸腺、胰腺、性腺等），和内分泌细胞，以及口腔腺、乳腺、前庭大腺等的分泌液。

诸气和津液在腠理三焦之空间气化，运行输布，以滋养全身，和净化人体。

《素问•阴阳应象大论篇》曰：“六经为川，肠胃为海，九窍为水注之气。以天地为之阴阳，阳之汗，以天地之雨名之；阳之气，以天地之疾风名之 。” 王冰注：“夫人汗泄于皮肤者，以天地之雨名之；阳之气，以天地之疾风名之。” 人体的津汗，就好象天地间的雨；人之气，就好象天地间的风气（气的流动）。人体“六腑象天”，三焦者“六腑之大孤府”“一腔之大府也”，为人体之“天”也。腠理通三焦[3]，则腠理三焦皆为人体之“天”也。故腠理三焦，如同天地之空间。腠理三焦运行诸气，津液升降出入，如同自然界风气，云雾，雨水升降流通一样。腠理三焦的诸气，津液运行，输布循环，如同自然界的雨水空气循环流动。阳光蒸发地面水分上升为云雾，云雾下降则为雨水，灌溉滋润大地，则万物生长。空气的流动，推动云雾和水气流动，无处不到，不但湿润空气和大地，滋养万物，而且净化了空气。

人体的腠理三焦“空间”，是气化的场所；是诸气、津液升降出入的通道。三焦的气化作用如同自然界阳光的作用。三焦气化水谷精微生成的营卫、气血、津液、元气，通过腠理三焦的通道，使津气“若雾露之溉”，运行输布于全身，外温润肌肤皮毛，内濡养脏腑、筋骨、骨节、脊髓和脑窍。腠理气化，则卫气调节汗孔开合，使汗液浊气从汗孔渗出；三焦气化，使浊气从肺口鼻呼出，尿液糟粕和矢气由二阴排出，而净化人体。所以，天地空间和人体空间（腠理三焦）极为相似，都主要是“气，水”的调节运行，输布循环。

结论

根据《内经》的“人与天地相应”，“人与天地相参”原则；和《内经》等经典医著医家的相关腠理、三焦理论，说明腠理三焦是人体生命空间。空间孕育生命。自然界有天地之空间，而万物生生不息。同样，人体有腠理三焦之生命空间，则生命生生不息。

宇宙没有空间，日月星辰无以运转；万物无以生存。人体没有空间，生命将不复存在。

人体的脏与脏之间、脏与腑之间、腑与腑之间、脏腑与四肢百骸、脏腑与脊髓脑窍、和肌表组织之间，及与九窍之间的联系，都是以腠理三焦为通道。

人体若没有腠理三焦之空间，则营卫、气血、津液、元气，无以化生、调节和运行输布。气化没有场所，气机升降出入没有空间，脏腑组织器官就会失去生理功能。所以说，腠理三焦是人体的生命空间。

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经典中医之气化逻辑脉法浅释

韩永刚

关键词：诊断，脉诊，脉素，精准

一、《中医诊断学》28 脉是否适用于临床实际？

在《内经》、《难经》中，脉诊的病脉并不复杂，而是简单明了，容易掌握的。清代医家柯琴曰：“自有《脉经》以来，诸家继起，各以脉名取胜，泛而不切，漫无指归。夫在诊法取其约，于脉名取其繁，此仲景所云，驰竞浮华，不固根本者是也。”但是，自晋代王叔和《脉经》开始，将常见病脉分为 24 种，明代李时珍《濒湖脉学》增加到 27 种，明代李中梓《诊家正眼》增加到 28 种。现行《中医诊断学》将病脉分为 28 种，而且一脉多证，即每种脉象代表几种不同的病证。这样导致在临床实践中必须四诊合参，极大地增加了辨证论治的难度；在脉症不符的情况下，必须“舍症从脉” 或者“舍脉从症”，导致临床医生无所适从，理论和实践无法自洽。对于一个中医师来说，可能终其一生也无法把这 28 种脉象全部摸到并且全部明了于胸。这样的话，临床疗效也就可想而知了。长久以往，以至于很多中医师只能装装样子，把脉诊当作给患者证明自己是中医的一个招牌动作而已。更有甚者，走到了反中医的行列。例如，在美国的一位徐姓中医师，80 岁的时候出版《老中医欺骗病人五十年》一书，直言中医最大的谎言就是“把脉”。

清代周学海《脉简补义·诊法直解》曰：“盖求明脉理者须将位、数、形、势讲得真切，便于百脉无所不赅，不必立二十八脉之名也。” 后世医家在此基础上提出脉诊五要素，即位、数、形、势、律。脉位是指脉动部位的浅深。脉率是指脉搏频率的快慢。脉形是指脉动的形状和性状，具体是指脉形的粗细、长短，脉管的硬度及脉搏往来的流利度。脉势是指脉搏应指的强弱，与脉的硬度和流利度也相关。脉律是指脉动周期间隔时间的规律性。也就是说，脉诊的根本是掌握脉素，这样才能提纲挈领，容易掌握，不会发生王叔和所谓“在心易了，指下难明”的情况，也能更好地为治疗提供客观依据。

二、当代具有代表性的精准脉法

中医脉法，源远流长。当代中国，能够通过脉诊对疾病做出定位、定性、定量精确诊断的脉法，包括以北京的寿小云为代表的寿氏脉法，山东的金伟和安徽的许跃远为代表的微观脉法和以陈云鹤道长为代表的太素脉法。

以上脉法，共同特点是可以做出精确诊断，同时也需要中医师通过较长时间的手法练习才能够掌握。另外，上述脉法只能对疾病做出诊断，并不能进一步指导临床治疗。因此潘晓川老师提出，“诊脉的目的是为了改造脉！”脉诊的精确诊断只是第一步，脉诊必须能够为临床治疗提供客观依据，这样才更有意义。

三、经典中医自洽体系之气化逻辑脉法

潘晓川老师创立的经典中医自洽体系，包含四项临床技术，即针灵、艾魂、药精、琴神，均以脉法为诊断基础，患者的主诉仅供医生参考，治疗基于脉诊结果，穴从脉出，方从脉出，所谓一脉相承。其脉法包括汤液脉法、终始脉法、五藏脉法，统称“气化逻辑脉法”，完美传承《内经》《难经》的 “辨气论治”诊治体系。

气化逻辑脉法具有如下特点：第一，简单易学，短时间可以学会，不需要长期和严格的手感训练。脉诊的第一步只需要把相关的三对脉素摸清楚就够了。第二，客观，不需要猜，一是一，二是二，不模棱两可。脉诊的第二步是逻辑，从这个意义上讲，逻辑比手感更重要，手感不是一时之功，而逻辑则人人可知，脉诊速成的关键在于明了脉中逻辑，才能对常脉和病脉做出正确的判断。第三，脉诊结

果可以直接指导临床，为用针用药提供客观依据，还可以为疗效提供评判标准。最终，精准的脉诊指导精准的治疗，中医师有的放矢，箭无虚发。

四、寸口脉之男左女右脏腑定位

气化逻辑脉法遵循男左女右的规律，男女左右手的脏腑定位相反，即男子左手的寸、关、尺分别代表心、肝、肾，右手的寸、关、尺则分别代表肺、脾、命门；女子右手的寸、关、尺分别代表心、肝、肾，左手的寸、关、尺则分别代表肺、脾、命门。寸口脉区分男左女右，在《内经》《难经》中都有充分的理论依据。不过，关于这一点，目前在中医界内部尚存在争议，限于文章篇幅，我将在以后的文章中予以论述。

五、根据脉素，对比常病，平脉调气，大道至简。

双螺旋的理念贯穿于经典中医自洽体系始终，人的左右手是一个整体，双手同时诊脉是气化逻辑脉法的特点。通过双手六部脉上下左右的比较，寸比寸，关比关，尺比尺，来判断常脉、病脉，并且检验治疗效果。

后世医家提出了脉诊五要素，那么怎样选择脉素就是脉诊的关键。气化逻辑脉法中，汤液脉法主要比较大小，终始脉法主要比较缓急，五脏脉法主要比较滑涩。可见，大小、缓急、滑涩就是气化逻辑脉法中的三对脉素。这样选择在《内经》中有明确的理论依据。例如，《黄帝内经·灵枢·论疾诊尺》曰："黄帝问于岐伯曰：余欲无视色，持脉，独调其尺，以言其病，从外知内，为之奈何？岐伯曰：审其尺之缓急小大滑涩，肉之坚脆，而病形定矣。"《黄帝内经·灵枢·邪气藏府病形》曰："黄帝曰：色脉已定，别之奈何？岐伯曰：调其脉之缓、急、小、大、滑、涩，而病变定矣。" 确定脉素之后，再通过客观、标准的诊察和逻辑判断，医生就能对患者做出精准的中医诊断，即具体指明五脏六腑，孰为太过，孰为不及，接下来用针用药的补泻也就一目了然了。

最后，脉诊的实质就是诊察气机，即五脏六腑之气的升降出入运动。《黄帝内经·素问·六微旨大论》曰："出入废则神机化灭，升降息则气立孤危。故非出入，则无以生长壮老已，非升降，则无以生长化收藏。是以升降出入，无器不有。" 气化逻辑脉法以浮沉分阴阳，部位分五行，完美还原基于《内经》《难经》的阴阳五行脉法，诊查气的升降出入。医生对于气的升降出入了然于胸，然后可以据此对患者进行治疗，或针、或灸、或药。《黄帝内经·灵枢·刺节真邪》曰："用针之类，在于调气。"《黄帝内经·灵枢·终始》曰："凡刺之道，气调而止。"治疗之后，再通过脉诊检查治疗效果，脉平则气调，气调则症消。平脉调气，诊断和治疗一体，大道至简！《易》曰："易则易知，简则易从" ，只有简单的技术才容易为医生所掌握，也更有利于临床实践。

综上所述，气化逻辑脉法的每一个技术环节都源于中医经典，根于《内经》《难经》，传承经典中医阴阳五行脉法的精髓，客观标准，简单易行，容易掌握，适用于临床实践，不但可以做出精准的中医诊断，并且能有效地指导临床治疗以及检验治疗效果。

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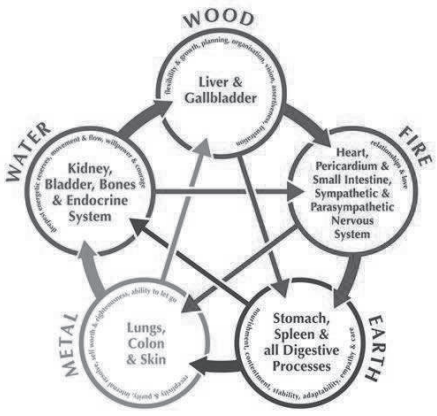
作者简介：韩永刚，男，中医博士，2008 年毕业于中国中医科学院临床医学基础研究所，师从中国工程院王永炎院士和原北京中医药大学校长高思华研究员。2009 年赴英国工作至今。目前是潘晓川经典中医自洽体系学术传承人。



Syndrome Differentiation of Heart Patterns

Huijun Shen

I. The Functions of Heart

In Zang Fu theory of TCM, the Heart has its main functions as:

1. Dominating the blood and vessels: Heart is the motive force for blood circulation, whilst the vessels are the physical structure which contain and circulate blood. Blood circulation relies on the cooperation between Heart and vessels, with Heart being of primary importance.
2. Housing the Shen: Heart Shen has the broad meaning of the outward appearance of vital activities of the whole body, and the narrow meaning as mind, or consciousness, e.g. spirit, thinking and mental activities. TCM holds the theory saying that mind is related to five zang organs, and principally to the physiological functions of Heart. Miraculous Pivot: "Heart is the residential home of the spirit and mind." Therefore, mental activities, spiritual states, consciousness, thinking, memory and sleep are all related to the function of Heart.

The other functions of Heart are related to its close connections with other organs or body tissues – Heat having its opening into the tongue and it's manifesting on the face, as well as its meridian connecting with the small intestine with which it is closely related.

II. Common Syndrome Patterns of Heart

Different etiological/pathological factors can cause dysfunction of heart, therefore give rise to heart. When the functions of Heart become abnormal for any reason, it gives rise to various Heart Syndromes. Heart syndromes can be excess or deficiency. Excess syndromes are usually caused by phlegm, heat, cold, Qi stagnation or blood stasis, while deficiency syndromes are due to long-term illness, congenital reason or emotional/mental factors weakening Heart Qi, blood, Yin or Yang.

Heart system disorders usually affect heart rhythm, blood circulation, mental and spiritual activities, causing palpitation, chest Bi, insomnia, mental or emotional abnormalities, even dementia, epilepsy, etc.

1. Heart Deficiency Syndromes

1.1 Heart Qi deficiency:

heart functions become weakened due to congenital reason, old age, long-term illness, or mental/emotional factors.

Symptoms: palpitation, chest tightness with short of breath, worsened with exertion, pale complexion, spontaneous sweating, pale tongue with white coating, weak pulse.

1.2 Heart Yang deficiency:

further development from Heart Qi deficiency, or severe cold invasion damaging Heart Yang.

Symptoms: symptoms of Heart Qi deficiency usually become more severe, plus, feeling cold, cold extremities, chest pain, swollen and pale tongue with white slippery coating, very weak and thin or irregular pulse.

1.3 Heart Yang Collapse:

very serious and rapid loss of functions of heart Yang, because Yang Qi of the heart suddenly becomes very weakened or collapsed, leading to Yin and Yang separation.

Symptoms: Sudden cold perspiration all over, very cold extremities, very weal breathing, deadly pale complexion with purple lips, heavy palpitation or sharp chest pain, frightened emotion, coma or loss of consciousness, very weak, fast and minute pulse.

1.4 Heart Blood Deficiency:

Weakened blood fails to nourish Heart, usually caused by long-term illness over-consuming blood, congenital

weakness, long-term loss of blood, insufficient blood production, or mental/emotional factors consuming blood.

Symptoms: palpitation, insomnia with excessive dreams, dizziness, poor memory, pale complexion, pale tongue, weak thin pulse.

1.5 Heart Yin Deficiency:

Weakened Yin fails to nourish Heart, usually caused by long-term illness with interior heat over-consuming blood, congenital weakness, insufficient production of Yin, or mental/emotional factors consuming Yin.

Symptoms: palpitation, insomnia with excessive dreams, five palm heat, tidal fever, night sweats, red cheeks, red tongue with little or no coating, weak thin and rapid pulse.

1.6 Notes on Heart Deficiency Syndromes

In the two main functions of Heart, Function 1, dominating blood and vessels, is mainly the function of Hear Qi and Heart Yang, as Yang Qi of the Heart is the power source to generate heart beat and propel blood into vessels for circulation. Function 2, housing Shen, is mainly the function of Heart blood and Heart Yin, as Heart Shen relies on the nourishment from blood and Yin to perform its normal functions.

Therefore, Heart Qi deficiency and Heart Yang deficiency tend to more affect function 1, causing abnormality in heartbeat, heart rhythm, and blood circulation, giving rise to clinical manifestations such palpitation, chest pain, arrhythmias, etc. On the other hand, Heart blood deficiency and Heart Yin deficiency tend to more affect function 2, causing Heart Shen lacking the nourishment hence becoming disturbed, giving rise to poor memory, poor concentration, insomnia, anxiety, panic attack, agitation,

2. Excess Syndromes of Heart

2.1 Heart Heat (Fire) Flaming Syndrome

Excessive Heart heat or fire flaming up and disturbing Heart Shen, usually caused by heat/fire transferred from exogenous pathogens or emotional factors, or overworking, over-intake of spicy food/alcohol.

Symptoms: agitation, mental restlessness, bad sleep or insomnia, red complexion, dry month with thirst, dark urine and dry stools, month/tongue ulcers, red tongue tip, rapid pulse. In serious cases, dementia or delirium, vomiting with blood or nose bleeding.

2.2 Heart Vessel Obstruction Syndrome

he vessel collaterals in Heart are blocked by blood stasis, phlegm turbidity or cold contraction, commonly seen in elderly people, or those with weak constitution, long-term illness.

Symptoms: Palpitation, intermittent attack of chest pain with pressure feeling, radiating pain in upper back/shoulder or arm. Plus:

Chest pain of sharp or stabbing nature, purple marks on tongue, thin and choppy pulse or intermittent pulse – obstruction caused by blood stasis;

Overweight/obesity, excessive phlegm, heaviness in body and fatigue, swollen tongue with white thick coating, deep and slippery pulse – obstruction caused by phlegm;

Sudden attack of severe sharp pain, feeling cold with cold extremities, warmth can help release pain, pale tongue with white coating, deep slow or deep tight pulse—obstruction caused by cold contraction.

2.3 Phlegm Perplexing Heart Orifices Syndrome (Phlegm misting Heart Shen Syndrome)

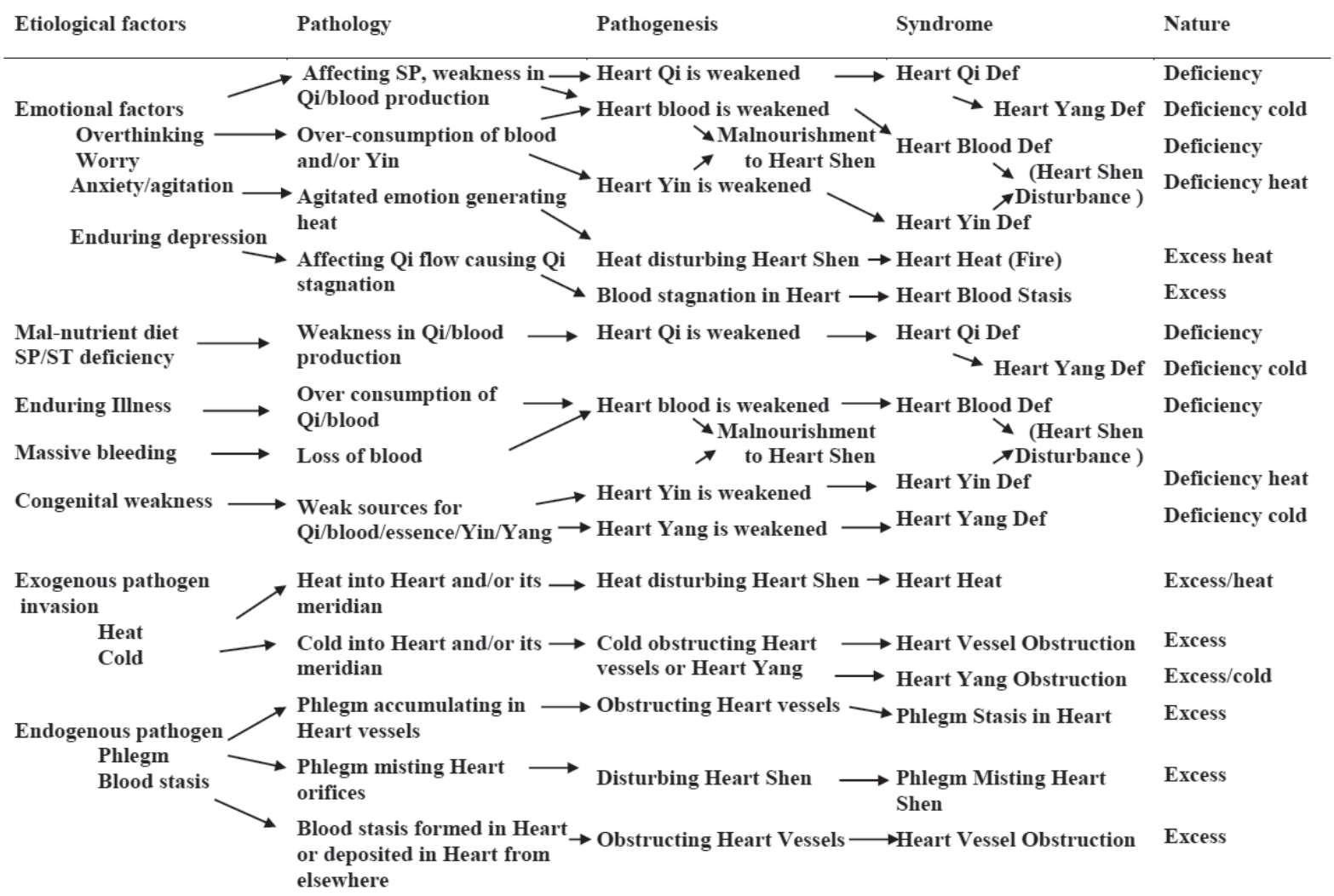
Phlegm turbidity mists and perplex Heart orifices causing Heart Shen violently disturbed. This can be due to damp turbidity from middle jiao being brewed into phlegm, or emotional factors causing Qi stagnation which in turn generates phlegm.

Symptoms: dim complexion and expression, stomach distension and nausea, blurred consciousness, dim speech, phlegm sound in throat, or even coma/ loss of consciousness, meaningless speech/talking, thick white tongue coating, slippery pulse.

In some cases, symptoms can be depressed emotion, dull and dim expression, illusion, idiotic thinking, meaningless speech/talking, bizarre behaviour. ---dementia

Heart Syndromes: Aetiology – Pathogenesis – Syndrome Patterns Diagram

By H. Shen



Or sudden fit, loss of consciousness, foaming phlegm out of month, phlegm sound in throat, convulsion with eyes staring upwards. ---epilepsy

2.4 Phlegm Fire Harassing Heart Syndrome

Phlegm with fire rioting in Heart resulting in Heart Shen turbulence. This is usually caused by emotional factors transferring into fire, fire boiling body fluids into phlegm, phlegm mingled with fire acting on heart; or exogenous heat invasion, mingled with phlegm and invading into pericardium, causing Heart Shen turbulence.

Symptoms: Fever or feeling hot, heavy breathing, red complexion and eyes, yellowish stick phlegm, phlegm sound in throat, meaningless talk, crying or laughing for no reason, idiotic behaviour, or delirium and mania; red tongue with yellow coating, slippery and rapid pulse. – schizophrenia.

III. About Heart Shen Disturbance

- Heart Shen Disturbance is the term used to describe and summarise any clinical disorders affecting the normal function of Heart Shen.
- Heart Shen Disturbance is a secondary syndrome pattern commonly caused by malnourishment of Heart itself leading to dysfunction in housing Shen (mind) or Heart Shen being directly disturbed by pathogens such as phlegm, heat, or the combination of both.
- The reasons for Heart Shen disturbance, or the primary patterns leading to Heart Shen disturbance, can be deficiency or excess.
- In deficiency syndromes, it is mostly commonly seen in Heart blood deficiency and Heart Yin deficiency syndromes.
- In excess syndromes, Heat disturbing Heart Shen is the most common pattern.
- Phlegm, heat (fire) or the combination of both can cause severe disturbance to Heart Shen, giving rise to serious mental disorders such as delirium, loss of consciousness, epilepsy, dementia, schizophrenia etc. in these cases, the syndrome patterns are named as phlegm misting (perplexing) Heart Shen, heat harassing Heart Shen, etc.

IV. Heart Syndromes: Etiology/Pathogenesis Outline

See the diagram on the last page.

V. Multiple Patterns Involving Heart and Other Zang Fu Organs

- Heart and Spleen Dual Deficiency
- Disharmony between Heart and Kidney
- Heat Flaming in Heart and Liver
- Blood Deficiency of Heart and Liver
- Yang Deficiency of Heart and Lung
- Yang Deficiency of Heart and Kidney.

(Continued from page 47)

Since a TCM technique was also included it is not an example of an FSN treatment on its own therefore further research is necessary to explore further the use of FSN in mental and emotional issues. Looking at the practical results however, both patients experienced an immediate positive effect and one patient has enjoyed a lasting recovery.

Acknowledgements:

The author would like to thank the team at the FSN Institute, Nanjing, for the information supporting the approach taken with these treatments.

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Two Case Studies on an FSN Treatment for Acute Depression and Anxiety

by Alexander. B. Mearns, Lic. Ac., BSc. (Hons), Dr. Sc
(Member of the FSN Association of Europe)

Private Clinic, Tain, Ross-Shire, Scotland

Abstract:

This paper describes the application of an FSN acupuncture treatment on two people who were suffering from an acute episode of depression. One was a 32 year-old-woman with a history of depression, and the other a 36-year-old man suffering from acute anxiety and paranoia. Upon examination a tightness was found on the rectus abdominus of both patients. FSN was performed on the rectus abdominus which in both cases resulted in an immediate improvement of the patient's condition. It is speculated that there may be a link to serotonin levels and the gastrointestinal tract.

Keywords: FSN, Acupuncture, Depression, Anxiety, Paranoia, Serotonin

Introduction:

Depression can take many forms and medication is often necessary for moderate and severe depression. Major classes of medication include tricyclics and related anti-depressants, selective serotonin re-uptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs). Unpleasant side effects can occur with any of these medications and so many patients will try alternatives.

TCM and Five Element acupuncture have been used extensively for mild to moderate depression and mental-emotional problems. In a recent Cochrane review (Smith CA, 2018), no clear advantage over medication or therapy was shown, but other reviews have found positive effects. (Junghans, 2018) It may also be the case that many individual practitioners may well have clinical evidence of positive results which have never been published.

FSN (Fu's Subcutaneous Needling) acupuncture, also known as Floating Needle acupuncture is an innovation in treatment which does not follow TCM theory, and therefore TCM pattern diagnosis is unnecessary, although FSN does not preclude adding TCM treatment as well. FSN began as a pain treatment but the range of use of the technique has expanded, as well as research into possible mechanisms of operation. (Fu, 2016) On a recent FSN study trip to China, the author observed FSN being applied in cases of depression, and these cases often involved an FSN treatment of the abdomen.

CASE ONE, 32-Year-old Woman

History of Illness and Symptoms:

Patient: The patient was a 32-year-old woman who had a recent history of depression, including post-partum depression after the birth of her only child two years previously. This was treated with sertraline. She thought that she never got over the post-partum depression entirely. Anxiety would return with her periods and worsened if she was under any unusual stress. She later experienced two miscarriages, followed by urine infections which were treated with anti-biotics, and her anxiety returned.

Her anxiety escalated to a point where she couldn't leave her home, and often spent the day in bed crying. Her mother, a psychiatric nurse wanted her to try alternative treatment before taking medication owing to concerns with side effects, so she contacted the author for help.

I travelled to her home with her mother. When we arrived, she wouldn't leave her bed and was rolled up into the foetal position while crying uncontrollably. She consented to an examination and a tightness was found on her upper left rectus abdominus.

Treatment and Outcomes:

First Treatment:

The patient's upper left rectus abdominus was needled twice, with reperfusion and resistance. Resistance was achieved by asking the patient to raise

her head and shoulders to tighten the rectus abdominus. After the muscles felt relaxed, the patient was left to rest for about ½ an hour with the needle retained. After the rest period the muscles were palpitated again for tightness and treated again, but for a shorter time.

During the rest period between needling, her mood began to lift noticeably. Within the hour she was out of bed and did not appear to be suffering from anxiety.

Additional Needling: To relax the patient Four Gates and Yintang were needled with even technique in addition to the FSN treatment.

Second Treatment:

The patient was able to travel to the clinic for her subsequent appointment. She reported that she felt better and better and was enjoying life with her work and family. Her abdomen did not feel tight, so FSN was not performed. A TCM treatment was chosen instead.

Needling: Four gates and Yintang, followed by a tonification of Pericardium 6 as indicated by her pulses.

CASE TWO, 36-Year-old Man

History of Illness and Symptoms:

Patient: The patient was a 36-year-old man who had a long history of anxiety and depression. He was raised by his mother and he said he had only met his father at one brief meeting. His mother was an alcoholic and died by suicide when he was 18. He then went to live with his elderly grandmother who died within a few years leaving him without support. These difficult years were made worse because he became involved in drug and alcohol abuse. He said that owing to his substance abuse there are years of his life he cannot remember. He did manage to pull himself out of his chaotic life-style, achieving employment and a stable relationship with his partner and child.

When he was seen in the clinic he had come through a session of alcohol abuse and he was full despair and regret, and also the fear that he would permanently lose his partner and child who had left him a few days before owing to his behaviour. The episode was triggered by memories of his mother's suicide and a fear that he would lose control and follow his mother into further alcohol abuse and suicide. He came for treatment because he felt that if he broke down further then he would not be able to regain control of himself. He said that alcohol had "released demons inside" and that at present he was not "the person that he really is." He had a long history of medication but said that the side effects were too severe. Owing to his state of mind he was unable to say what his previous medications were.

He was brought to the clinic by a relation who is a psychiatric nurse and was monitoring his situation. When he arrived he was faint, poorly coloured, unable to concentrate clearly and was shaking uncontrollably.

Treatment and Outcomes:

The first step was to listen to what the patient had to say not only in order to understand his situation, but to try to calm him enough so he could be treated. Fortunately, this was achieved, and he was ready for treatment. He lay on the treatment couch and was still shaking strongly. Upon examination a tight band was easily found on his right abdominus rectus.

An insertion point was chosen near his rib cage on the upper right area of his abdominus rectus. Very soon after starting the swaying movement, his shaking stopped. Treatment was continued with reperfusion and the patient was much more relaxed. The points Four Gates and Yintang were added as well for the same reasons as in Case One above, to move Liver Qi and relax the mind. The patient was then allowed to rest with the FSN needle left in place in the rectus abdominus. At this point the patient was told that his shaking had stopped. He apparently hadn't noticed, and he was pleasantly surprised.

After a rest period for 20 minutes or so, the abdominus rectus was re-examined and it was found to be relaxed, so there was no additional reperfusion or additional insertions chosen. The FSN needle was removed. The casing was not left in as it was unclear if it could be left safely given his mental condition. The TCM needles were also removed.

His pulses were taken (previously I considered him too anxious to provide an accurate reading). His pulses seemed in balance, with a weakness in the kidney/bladder position. Owing to his emotional disturbance He 7 (Shenmen) , and Pc7 (Daling) were tonified, as well as Kd 3 (Taixi) to help his overall condition.

At the end of the treatment the patient was far from a well man in body, mind or spirit but he was calm, he was not shaking, his colour was better, and his mind was clear. He talked about being ready to take appropriate steps to improve his situation. At the time of writing he has not been seen for additional treatment.

Discussion:

FSN or Floating Needle acupuncture has been practiced in China for over 20 years although in the UK it is new and practised little outside of the Mandarin speaking community. The application of FSN has been evolving and the range of conditions successfully treated is expanding dynamically. As well, research has been undertaken to better understand its mechanism of operation.

In this particular case, the abdomen was treated. The abdominal region has been important in eastern thought within traditional medicine, martial arts and Tai Chi. Owing to this, it was not a complete surprise in Nanjing to have observed mental-emotional problems being successfully treated through needling the abdomen.

With regard to treating the abdomen for mental-emotional problems, this treatment comes from the 4th category of FSN indications. There are five in all (Fu, 2016):

1 The muscle itself is causing the pain. The symptoms are pain, dysfunction and a lack of power.
2 The tightened muscle affects the surrounding nerves, arteries and veins.
3 The tightened muscle affects neighbouring tissues and systems. This category includes.
   i) Respiratory system smooth muscles.
   ii) The heart muscle.
   iii) Gastrointestinal smooth muscles.
   iv) Urinary tract smooth muscles.
   v) Reproductive urinary tract smooth muscles.
4 The tightened muscles affect mental and emotional issues. This includes symptoms such as mood swings, anxiety, and insomnia.
5 The tightened muscles result in miscellaneous effects. The pathologically tightened muscles can cause the symptoms of an autonomic nervous dysfunction

The first patient in this study was needled with FSN technique in her upper left quadrant, near the intersection of the epigastrium and the hypochondrium regions. The selection was chosen owing to the discovery of tightened muscles in this area of her rectus abdominus. This area covers the area of the stomach and, more internally, the organs of the spleen, pancreas and the left lobe of the liver.
Owing to the proximity of the left lob of the liver, it is easy to speculate that the tightened muscles were related to Liver Qi Stagnation, but it is unclear whether TCM syndromes are helpful to understand FSN techniques other than in the broadest terms, namely clearing Qi Stagnation and Blood Stasis. Therefore, the mechanism which brought about the result in this case study is unclear. An explanation is further complicated by the inclusion of a TCM technique.
The TCM technique, Four Gates and Yintang, was added as an extra to the main treatment. As a practitioner of nearly twenty experience I consider it unlikely that this TCM technique on its own would have an effect in such a severe case, but it could add to the overall effect. Its inclusion interferes with evaluation of a clear FSN effect, it would be immoral to decline a possible beneficial treatment merely on the basis on research aims. Therefore, the TCM technique was included.
When the patient came for her second treatment she mentioned that the day after her FSN session she had a bath and noticed that her abdomen felt hard and red marks like claw marks were visible. She said they were there for about ten minutes and then disappeared and she was back to normal. I contacted the FSN Institute in Nanjing, and the opinion was that the episode was the result of increased blood flow to the area owing to the FSN treatment. In any event, the episode, although unusual, was short lived and had no ill effects for the patient.
The patient in the second case was also needled in the abdominus rectus, but on the upper right-hand side, lower, but in proximity to the Liver. As with Case One, it is easy to speculate that the tightened muscles were related to Liver Qi Stagnation, but again it is unclear whether TCM syndromes are helpful to understand FSN techniques other than in the broadest terms, namely clearing Qi Stagnation and Blood Stasis. In both Case One and in Case Two, the effect was immediate and obvious, so some mechanism was in operation.
It is hoped that it is not out of place speculate about the possible effect of the FSN treatment on serotonin levels. It is well known that much of the body's serotonin is produced in the gastrointestinal tract. Since the rectus abdominus covers much of area filled by the gastrointestinal tract, it may be hypothesised that FSN on the rectus abdominus may have act on serotonin levels owing to the 4th category of FSN indications, namely, that tightened muscles affect mental and emotional issues. This includes symptoms such as mood swings, anxiety, and insomnia. Clearly, studies designed to investigate any such mechanism are needed to move toward any conclusions, but as a clinic observation there is clear evidence of a positive effect.

Conclusion

This case study provides an example of the application of FSN in two cases of acute depression and anxiety. The treatment is an example of the 4th indication of FSN for its use in mental and emotional issues. There may also have been a beneficial effect on underlying organs, perhaps related to serotonin levels and the gastrointestinal tract.

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车祸引起的毁容、嗅觉味觉丧失兼头痛身痛浮针治疗报道

郭久春 英国 Loughborough

摘要:

体会:浮针治疗与西医及传统针刺治疗方法比较更具见效快，疗程短，效果更好，更经济，病人更易接受.
见证：浮针除了是一有效的治疗方法也可以作为鉴别诊断性的治疗用工具.
学习：浮针治疗的远程灌注法对多个患肌并存时的省时有效治疗；复杂病例中处理胸锁乳突肌的妙用效果.
启发：目前对疼痛和其它已知疾病的治疗范围外浮针治疗是否也可以阔展为外科疤痕组织整容的一种治疗手段？.

关键词：浮针, 头痛，嗅觉味觉丧失，面部疤痕

A Case Study of FSN Acupuncture Treatment for Headache, Pain, Loss of olfaction and taste, and Facial Scarring after a Car Accident

Jiuchun Guo

ABSTRACT:

This case study is on Fu's subcutaneous needling (FSN) treatment for a patient with severe headache, loss of smell and taste senses and facial scarring caused by a car accident 23 years ago. A distance-reperfusion approach was performed during the FSN treatment which was focused on treating the sternocleidomastoid muscle. The treatment outcome was very promising with headache gradually disappeared, smell and taste senses returned and facial scar greatly improved. This demonstrates that FSN could be an effective treatment in a relative short period of time with much enhanced result, even for such a complex case that involves multiple pathological muscles.

In comparison to Western medicine and traditional acupuncture, FSN treatment in this case is more effective even with a shorter course of treatment, and the cost of treatment being less, making it more acceptable to patients. Furthermore, this case raises a hope that FSN may be good in cosmetic therapy for scar tissue while it significantly reduces pain.

Keywords: Fu's subcutaneous needling (FSN), severe Headache, loss of smell and taste senses, facial scar

病史：

女性,54 岁,手工船泊油漆工，英国人

23 年前的一场一死一伤严重车祸，造成如下后遗症：**1**）右侧面部从眼以下的面颊，鼻，致上下嘴唇的开放性损伤，行外科修补术缝合 1080 针，留下右侧面部瘢痕，嘴唇瘢痕致嘴唇闭合不全，每遇天寒风吹时疼痛;**2**）面部伤后致嗅觉完全丧失，味觉大部份丧失，咀嚼食物如橡胶；**3**）留下身痛及多处关节和肌肉疼痛，随后行左髋关节置换术，每遇气温变化，尤其寒冷时疼痛加重，近年被医生诊断为风湿痛；**4**）因车

祸遗留下头痛长期服用止痛片，尤以工作紧张或强迫性体位后头疼痛更甚.三年前因为身痛尤以头部的疼痛，以右侧的偏头痛为主，致不能承受的程度到我处求治.

三年左右的间断性治疗主要分为四个部分，直致目前除嘴唇疤痕还未恢复完全外，其他症状已基本正常，病人满意。希望继续治疗能达到最大效果.

第一阶段治疗：

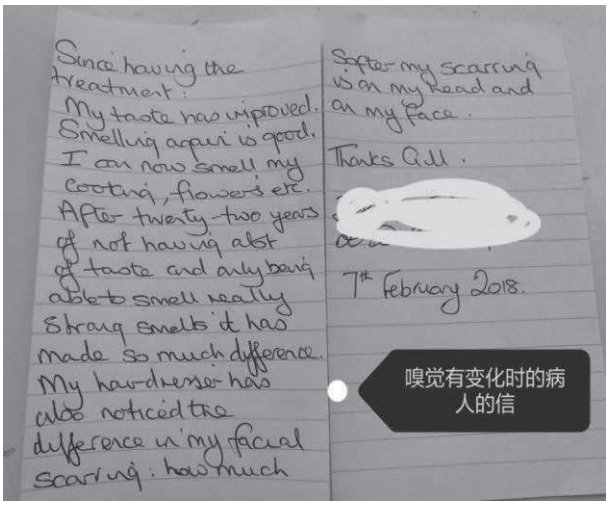
间断性地治疗两年，用传统毫针+火罐。身痛，头痛 有效，使能坚持日常工作和生活，因全身多处关节仍疼痛，被诊断为风湿病长期服用止痛药（病人有风湿病家族史）。

第二阶段治疗：

间断性治疗已一年左右.用浮针，效大显. 头痛完全消失，仅在工作重，气候变化时有颈痛身痛，但程度不重止痛药减少。

第三阶段：

浮针治疗嗅觉和味觉丧失。在用浮针治疗头痛的过程中发现味觉嗅觉似乎有变化，病人提出能否用浮针试试？因为病人曾经被告之，此嗅觉味觉的丧失是由于面部的外伤靠近鼻部加上外科的缝合术造成局部神经的永久性破坏为不可恢复性，病人也接受此诊断，在嗅觉完全缺失味觉大部缺失的生活中过了 23 年的“半残疾”生活. 用浮针治疗两周后嗅觉味觉开始明显改善，之后每二周一次治疗，目前嗅觉味觉已全部恢复，病人讲曾为多年后第一次尝到闻到蔬菜的真正味道，而激动得哭，并也笑话说嗅觉治疗好了的最大好处是知道工棚旁边的公共厕还有气味。



第四阶段：

浮针整容。在治疗前面的嗅觉味觉缺失时，同时病人已经注意到了面部瘢痕的改变，如嘴里不时有缝线断头从嘴里悼出来，瘢痕有变软。因为前面的治疗效果使病人对浮针更有信心. 接下来是每周一次的浮针美容治疗，每周面部瘢痕都有点改变，目前为第 6 后的次治疗如图所示.面部肌肉放松，天寒所致面部肌肤疼痛及瘢痕几乎消失，面部活动正常,已能用粉剂化妆品(之前仅能用液剂品)，病人自己及亲人朋友和顾客已全部注意到她的改变，都以为她整容了. 目前仍嘴唇的瘢痕未消失，还不能完全闭合，但病人讲也比用浮针治疗前好 （因为从未料到浮针可以有此疗效，未曾在治疗之前拍照）。

检查治疗：此病人病史复杂时间长，患肌多，仅列出开始浮针治疗时主要的患肌，

身痛治疗：胸锁乳突肌++++，斜角肌+++斜方肌+++锁骨下肌++竖脊肌+++背阔肌++肱二头肌++肱三头肌++肱桡肌++，乳突 MTrP+,枕下肌群的 MTrP,深一层的肌肉有头颈夹肌+++, 旋转套，腰大肌++臀大肌++腓肠肌++等太多患肌。浮针进针：每次治疗依当时患肌情况选 2-3 个进针部位，局部扫撒+灌注。

头痛的治疗：一般选肱桡肌先远程轰炸，然后作胸锁乳突肌或锁骨下肌或其他颈部肌肉或枕下肌群的 MTrp,交替进针，每次治疗选 2-3 个进针部位，
嗅觉味觉治疗：类似头痛的治疗选择进针点，重点作胸锁乳突肌的扫散和灌注及交替加上颧肌，上唇方肌。
面部整容治疗:每次选 2 个进针部位,先做胸锁乳突肌或锁骨下肌或颈阔肌，加上如颊肌，咬肌，颧肌，额肌等面部肌肉交替。

讨论与总结：

从此病例可以看出以下几点。

一，浮针与毫针及传统治疗的区别：

用浮针以前已经用传统的毫针加火罐间断规律的治疗两年，身痛头痛得以控制病人能坚持日常的生活和工作但仍很疼痛需服用止痛片；嗅觉味觉的缺失无改变；面部及嘴唇的瘢痕组织仍然存在。用浮针也是间断规律地治疗但仅仅一年，身痛仅在天气变化时酸痛，头痛也只在工作强度很重时才有，已停用止痛药片；嗅觉味觉全部恢复；外伤及手术缝合留下的面部疤痕几乎消失，嘴唇瘢痕仍在，但闭合程度也有进步，这

是 4 月底病人因退休关厂，搬家暂停治疗时的情况，按计划今年 9 月会再回来作整容治疗.

如符仲华浮针发明人所讲的，传统针灸能治疗的疾病浮针也一定能治，并且比传统的方法见效快，疗程短，效果更好，更经济。

二，浮针的鉴别诊断治疗：

病人为完全性的嗅觉缺失. 面部外伤在右侧部而左侧面颊，鼻甲部和鼻骨组织未受伤，嗅觉味觉的传导通道应该不受影响，病人也无颅脑损伤史，因此，既是如专科所诊断，嗅觉的缺失是由伤后及手术缝合后引起，也应该只是部份缺失而不是全部缺失. 病人有双侧胸锁乳突肌紧张+++，乳突 MTrp 阳性，双侧头痛史，应用浮针松解肌肉的紧张，解除压迫状态，缓解了与嗅觉味觉有关的肌肉以及末稍神经的缺血状态，逐渐恢复达到了正常的嗅觉味觉功能的，结束了 23 年来这样“半残疾”生活. 由此证实此病例的嗅觉味觉缺失是由相关神经的肌肉暂时的缺血性改变降低了神经牟身的功能，而不是神经自身的永久改变，通过治疗否定了专科的诊断。嗅觉味觉常相通，嗅觉对味觉的影响大于味觉，在味觉神经无大的损伤情况下当嗅觉恢复味觉自然也会恢复.

因此，这个病例告诉我们，正如符仲华所讲，浮针除了是一有效的治疗工具，也可作为诊断性治疗用工具.

三，整容的效果：

同样的理论，对头面部颈部肌肉尤其胸锁乳突肌用浮针治疗改善了这些部位的紧张，缺血缺状况，面部的外伤及手术逢合瘢痕部位从周围致中心开始慢慢的变软到瘢痕逐渐消失到几近正常的面部肌肉皮肤，嘴唇的瘢痕闭合不全是我们的下一步治疗目标. 达到这样快的效果，每次进针也仅 2 处，治疗过程中病人并无特别不适感.，这样永久性的整容效果是开始我们不曾预料到的. 病人非常的满意这种又快又好还省钱的整容方式.

四，头痛与胸锁乳突肌:

此例患者的头痛是由于车祸造成的头颈面部肌肉的过度紧张牵拉引起肌肉缺血形成患肌而引起的，以胸锁乳突肌受损形成患肌后出现的症状为主要表现，嗅觉味觉的缺失也与此有关联。因此有必要简述一下胸锁乳突肌.

胸锁乳突肌是颈侧部两块重要的肌肉，其重要的原因是它的解剖位置与邻近组织关系的复杂性和它功能的多样性及重要性，这使得胸锁乳突肌容易受到损伤及受伤后涉及面广泛，如影响其毗邻的神经（颈丛皮支，面神经、迷走神经和交感神经等）血管（颈内、外动脉、椎动脉等等），而产生许多复杂的症状。这些症状常常被误诊为其它疾病，而忽略了此肌肉损伤的问题，在临床上胸锁乳突肌损伤后所产生的病症涉及神经、内分泌、心血管、呼吸、消化甚至五官、口腔各科。许多病症如从治胸锁乳突肌入手，效果会非常神奇，如本病例。

胸锁乳突肌损伤后其症状特点如下：并不表现出此肌肉的疼痛，而局部的压痛和结节还可能误诊为淋巴结病变, 局部不疼远处疼也就是引起别的的地方疼痛，主要表现为头痛、头晕症状，更多的时候是常常伴有自主神经症状和本体感受紊乱，例如：

1，头面五官症状：头痛头晕、平衡失调、视物模糊、眼胀、干涩流泪、耳鸣耳聋、鼻塞、“过敏性鼻炎”，咽部异物感、口干、声带疲劳、味觉改变、面部麻木、疼痛 2，心血管系统症状：心悸、胸闷、心律失常、血压变化等 3，甲状腺疾患：有表现甲低的，甲亢的，还有甲状腺结节的 4，胃肠道症状：恶心，呕吐，厌食等 5， 其他：多汗，无汗微寒发发热，手指肿胀等

解剖及毗邻：

胸锁乳突肌解剖-起于胸骨锁骨，止于乳突，分为胸骨部和锁骨部所以叫胸锁乳突肌。但他的毗邻关系却非常的复杂。

神经支配-副神经（XI 对脑神经）及颈丛肌支 C2、3。

主要功能-为稳定、旋转和弯曲头部和颈部。

毗邻关系-胸锁乳突肌是颈部分区的标志（依其前后缘分颈前区、胸锁乳突肌区和外侧区），其浅、深层、前后缘都有重要肌肉及神经血管毗邻。

与肌肉的毗邻-浅面中下部被颈阔肌覆盖，前上方有二腹肌后腹，后有斜方肌、斜角肌、头、颈夹肌，深面有头、颈夹肌、肩胛提肌、颈最长肌、斜角肌等，下方有胸大肌

与血管的毗邻有椎动脉，颈动脉鞘等等而颈动脉鞘包绕了颈总动脉、颈内动脉、颈外动脉、颈内静脉和迷走神经。

在胸锁乳突肌的深浅面-全身约 800 个淋巴结中约 300 个位于头颈部

与神经的毗邻，浅面有颈丛的皮支，深面有颈丛深支及膈神经，面神经，迷走神经（为第 10 对脑神经，含有感觉、运动和副交感神经纤维)和颈交感神经干（上至颅底下达颈根部）

Ref：1，浮针医学纲要
2，医学解剖学教科书
3，医学生理学教科书
4，网上下载

基于浮针疗法治疗功能性便秘伴腹痛

刘梦[1]△李奕萱[1] 王曦廷[1] 符仲华[2#]

(1. 北京中医药大学中医学院,北京 100029; 2.南京中医药大学浮针医学研究所，江苏南京 210029）
△作者：刘梦（1992-），女，汉族，北京中医药大学在读硕士研究生，E-mail：liuwanning0610@163.com
#通讯作者：符仲华

摘要：目的：观察浮针治疗功能性便秘伴腹痛的临床疗效。**方法：**基于浮针疗法的“远程轰炸”理论，采用浮针进针器（型号 FSN5.0）对典型功能性便秘伴腹痛患者的腹斜肌、股四头肌、竖脊肌等部位进行治疗，问询并记录病人每日排便情况（排便量、排便次数）及腹痛情况。**结果：**观察浮针门诊典型病例 1 例，本例患者经过 4 周的浮针治疗，功能性便秘与腹痛症状得到显著改善，治疗 4 周后随访结果表明其病症基本达到临床治愈。**结论：**顽固的功能性便秘伴腹痛在临床中属于较为疑难棘手的病症，本案记录了采用浮针疗法改善和治疗功能性便秘伴腹痛典型病案一例，属首次个案报道，其结果表明浮针疗法“远程轰炸”理论在本类病症中疗效良好，值得进一步深入研究与临床应用。

关键词：浮针；远程轰炸；功能性便秘伴腹痛；患肌

A Case Study on Treating Habitual Constipation with Abdominal pain Based on the "Remote bombing" theory of Fu’s acupuncture Therapy

Meng Liu[1]， Yixuan Li[1], Xiting WangXi[1], Zhonghua Fu[2]

(1.School of Traditional Chinese Medicine , Beijing University of Chinese Medicine, Beijing 100029, China; 2. Institute of Fu’s acupuncture medicine, Nanjing University of Chinese Medicine, Nanjing 210029, China）

Abstract: Objective: To observe the clinical efficacy of Fu’s acupuncture therapy in the treatment of habitual constipation with abdominal pain. **Methods:** Based on the theory of Fu’s subcutaneous acupuncture therapy, “remote bombing acupuncture ”, treating the patient with typical habitual constipation with abdominal pain by acupuncturing their abdominal oblique muscle, the four head of the femoris, the erect spinal muscle, etc. using Fu’s needle feeder (FSN5.0). Inquire and record the patient's daily condition defecation (defecation, defecation times) and abdominal pain. **Results:** A case of Fu’s acupuncture outpatient clinic were observed. After treated with a Fu’s acupuncture for 4 weeks, the symptoms of habitual constipation and abdominal pain were significantly improved. Besides, the flow-up results indicated that the symptoms were basically cured. **Conclusion:** Obstinate habitual constipation with abdominal pain is a difficult and intractable disease in the clinic. The case records a typical case of habitual constipation with abdominal pain treated by Fu’s acupuncture therapy, which is the first case report. The result indicates that the Fu’s acupuncture theory of “remote bombing acupuncture” is effective in this kind of disease, and deserves further research and clinical application.

Keywords: Fu’s acupuncture therapy; Remote bombing; Habitual Constipation; The Tightened muscle

功能性便秘是指非全身性疾病或肠道疾病引起的原发性持续性便秘，又称为习惯性便秘或单纯性便秘，表现为反复发生的排便困难或费力、排便不畅、排便次数减少、粪便干结量少的一类疾病，并可伴有腹部胀痛、食欲减退、疲乏无力、头晕、烦躁，部分患者可出现焦虑失眠等症状[1, 2]。流行病学资料显示，在我国功能性便秘的发病率为 4% - 5%，且有逐年上升的趋势[3]。浮针疗法是在《内经》的针刺理论、阿是穴理论和腕踝针理论的基础上发展而来，以治疗软组织疼痛类疾病为主，临床大多用于痛证。浮针疗法自符仲华于 1996 年发明至今，临床已广泛用于治疗各种疼痛类疾病，病种较为广泛[4]。符仲华在完善浮针疗法理论与经验过程中，提出了新的方法理论——“远程轰炸”理论，是指在人体的同一个区域或一条路径上，以减少进针而达到最佳效果的目的，采用在患肌的离心周边处进针，针尖对准患肌群的方法，用以增加肌张力，改善血流量，进而达到治愈疾病的目的。本方法具有方法学创新的意义，扩大了浮针的疾病治疗范畴。本研究即是基于使用浮针新理论“远程轰炸”理论治疗功能性便秘伴腹痛疑难病的临床确效病例的首例报道。

1.病例介绍

袁某，女，67 岁。江苏省南京市联合村村民，痔疮病史伴便秘四十余年，伴有肛门坠胀感，西医诊断为功能性消化不良、胃动力不足、大肠蠕动不足。治疗前大便二到三日一行，质硬，且有便意时肠内容物在直肠端不能自行排出，期间用中药治疗后略有好转，但时间维持不长。影像学检查未发现异常，诊断为不明原因足痛待查而建议进行康复理疗。2017 年 7 月 14 日于符仲华教授研究所就诊，刻下检查腹部肌肉附近，肤温不高，排除感染炎症。腹部外形平坦对称；腹式呼吸运动自如；腹壁静脉不显露；未见到胃肠型和胃肠蠕动波：腹壁无皮疹、无色素沉着；肠鸣音：4-5 次/分钟；无血管杂音、摩擦音、搔弹音；腹部叩诊肝区无肿大，无叩击痛；脾

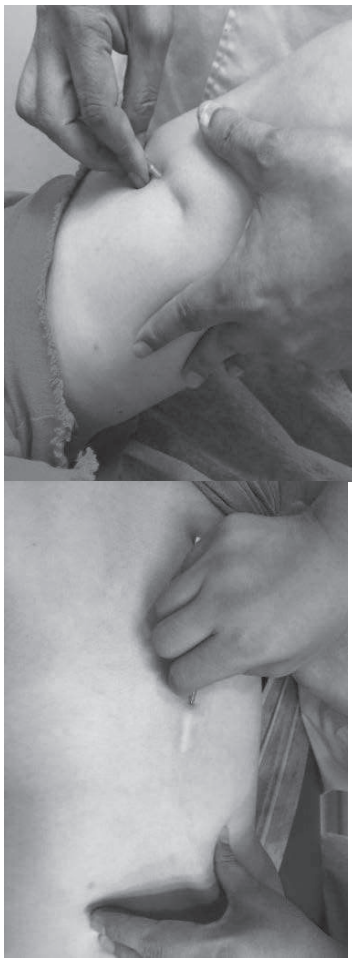
叩诊无肿大；无肾区叩击痛；移动性浊音阴性；腹壁柔软，无压痛及反跳痛。既往无创伤史，无手术史，无高血压及糖尿病史。否认家族遗传病史。

2.诊断与鉴别诊断

中医诊断为便秘——气虚秘[5]；西医诊断为功能性便秘[5]，功能性消化不良。同时，与肠梗阻进行鉴别：肠梗阻临床表现除便秘外，可伴有腹痛、腹胀、呕吐症状。起病急骤者，常因粪石、粪块、肠寄生虫、肠系膜血管栓塞或血栓形成，起病较缓者，可因肿瘤、粘连、巨结肠等导致。通过详细问诊及检查，基本排除上述疾病。

3.治疗方法

分别选取腹部的三块肌肉：腹斜肌、股四头肌、竖脊肌，在对局部皮肤进行常规碘伏消毒后，将针尖朝患肌方向用浮针进针器进针（针器持针角度与皮肤保 持15°左右，以保证浮针刺入疏松结缔组织较浅时发挥浮针的最大效应，同时尽 量减少进针产生的疼痛）。将浮针前端射入皮下后，右手持针柄，并将针身放倒， 稍提起针尖，将剩余针体朝患肌缓缓推入皮下组织。待针身完全刺入皮下组织后， 将软管座上的突起向右旋转并固定于芯座上的卡槽内，固定后进行扫散动作。扫 散过程中尽量最大幅度地进行扫散，时间约半分钟，频次50 次左右，并同时配 合腹部肌肉、腿部肌肉和后背肌肉的再灌注动作（10s/次），小心退出针芯， 将软管留置于皮肤内，继续发挥微扫散作用，待四小时后将软管拔出。肌肉的进 针操作见图 1：



图示：浮针疗法“远程轰炸”肌肉进针操作示意

4.治疗结果

三诊后晨间有气体排出，肠道产生蠕动感。四诊治疗后下午即产生便意，次日晨间便意较浓，并伴有盆底痉挛。辅以灌肠后大便增加。五诊仍继续灌肠，较 之前好转，兼有排气和便意，便质稀疏。九诊后由便秘所产生的腹痛得以缓解， 大便可自行排出，但伴有肛门坠胀感。十诊治疗后进行随访，刻下症状基本痊愈， 现大便日行一次，且便质松软。

5.讨论

祖国医学中的“便秘”与现代医学“功能性便秘”所指相同，即以大便干结、排便困难为首要判断依据。古代医家即对便秘的病因病机有较多的认识。医圣张仲景在《伤寒杂病论》中称便秘为“脾约”、“闭”、“阴结”、“阳结”，并和气滞寒热有关。“金元四大家”朱丹溪《丹溪心法》提出老年便秘的病因病机是由“中气不足”和“阴亏血损”形成。

本研究结果显示，使用浮针对针刺腹部患肌群：腹斜肌、股四头肌、竖脊肌， 疗效显著。功能性便秘是浮针治疗的优势病种之一[7]，本例患者是属于排除器质性疾患的功能性便秘，即西医所指的肠道平滑肌、腹肌、膈肌或提肛肌肌张力减弱所致者，亦即中医所指便秘中的“气虚秘”。浮针疗法可使不蠕动或蠕动力减弱的降结肠下部及直肠蠕动增强，使得患者在排便时肛管直肠周

围的耻骨直肠肌和肛管括约肌呈舒张状态，产生便意并顺利排便。在治疗后，同时嘱患者常规饮食，适当增加水和富含纤维食物的摄入，按时如厕，并可适当增加户外锻炼。

在治疗上，采用“远程轰炸”理论即针对患者的左侧腹斜肌、大腿股四头肌、 竖脊肌，上述肌群均位于人体的同一条路径上，对肠道的蠕动均能产生一定的影响。因此选取治疗肌群时不应只针对局部的患肌群，要在发挥靶向作用的同时结 合远程治疗，以达到以远治近，远近同治，相得益彰。

选取的上述肌群推测可能由于上述患肌群因某些病理因素影响，日久则形成
病理性紧张，使得位于腹腔内的肠道发生传输功能障碍，导致肌张力减弱，不能 及时下传肠内容物，即排便延迟，继而形成一个由里及外的过程。这与患者日常 生活习惯有吻合之处，即久坐久卧、运动少等一些情况导致肠道动力减弱，从而 形成功能性便秘[8]。

浮针疗法是基于现有中西医治疗便秘的理论基础上进行的创新和发展，它将 传统针灸学，现代医学生理学及现代肌肉解剖学，三者相互融会贯通而成，它作为临床治疗功能性便秘的有效手段之一，使用 FSN5.0 (2016 年 3 月生产) 一次性 浮针作用于腹部患肌群（如腹斜肌）、背部患肌群（如竖脊肌）、腿部患肌群（如股四头肌），周围皮下浅筋膜进行手法扫散及再灌注的针刺活动的浮针疗法，可以最大限度地对腹部及腿部肌肉进行舒张放松，增加肌张力，增加血液循环，促进肠道蠕动和新陈代谢，从而达到促排便、改善肠道功能和治愈功能性便秘的目的。

6.结论

通过本次研究，可以看出浮针疗法对于功能性便秘有治疗作用。浮针疗法可
减少对排泄类药物的依赖，从而改变由于停用中西药物后出现的便秘症状反复， 经久不愈或使用灌肠等物理疗法进行的治疗，并增加腹部肌张力，改善血液循环，减轻患者的痛苦和改善患者的焦虑情绪，进而由减轻缓解症状达到最终治愈功能 性便秘的目的。因此，浮针疗法对改善和治疗功能性便秘有一定疗效，值得临床推广。

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消风散加减治疗慢性荨麻疹经验分享病案 1 例

陈伟雄

摘要：慢性荨麻疹有很多病因引起，笔者灵活运用祖国医学中医，立足辩证论治的特色，运用消风散加减治疗临床风毒湿热型慢性荨麻疹疗效满意。
关键词：慢性荨麻疹；消风散加减；清热燥湿、疏风养血

A Case Report of Chronic Urticaria Treated by Chinese Herbal Formula Xiao Feng San

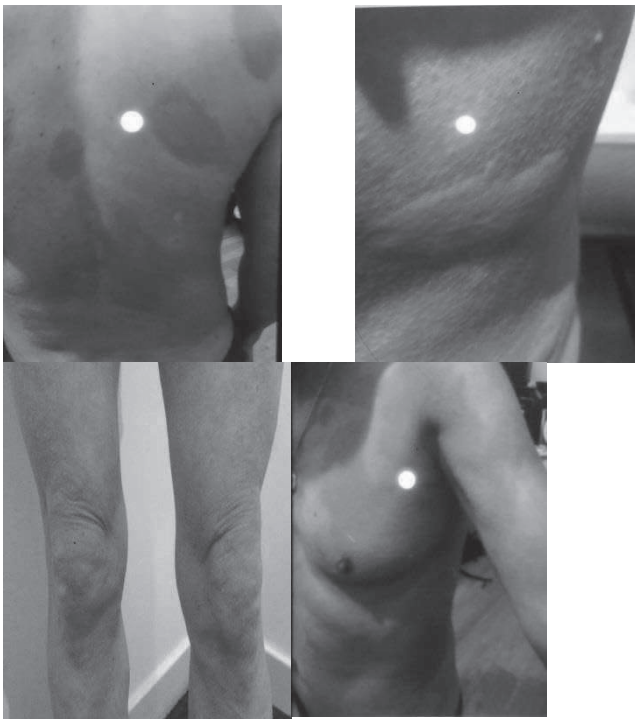
Wei Xiong Chen

Abstract: Chronic urticaria can be caused by various allergens. The author used TCM treatment based on syndrome deferentiation to treat this case with 8 months of recurrent history. The herbal formula used in the treatment was Xiao Feng San (Eliminiting Wind Power) with modifications according to the patient's syndrome patterns. A satisfactory effect was achieved.
Key Words: Chronic urticaria, Xiao Feng San, Clearing heat and draining damp, expelling wind and nourishing blood

慢性荨麻疹是西医的诊断，中医诊断为：风疹。现代医学认为，此病与机体对某些物质过敏，产生变态反应有关。其临床表现为：呈遍布局限性浮肿斑块，颜色红或淡红，边缘有红晕。水肿较重的呈白色，其边缘向周围扩展，凹凸不平，如云片状。中医则认为此病因病机为：禀赋不耐，风邪博于肌肤所造成，内不得疏泄，外不得透达，郁于皮肤之间，邪正交争而发风团。血热会伤阴，阴津不足，水不涵木，会导致血热生风，这都是肝风内生。风为百病之长，它常夹杂其它邪气而致病。

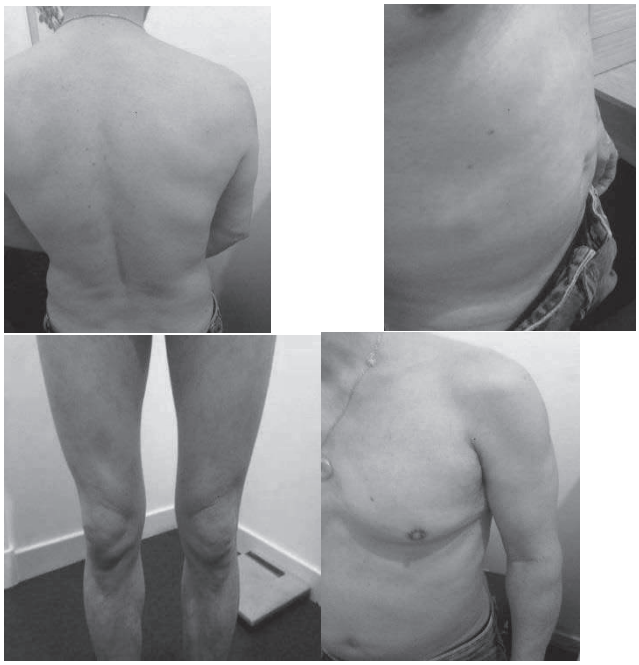
消风散出自《外科正宗》由疏风、燥湿、养血药物组成，具有疏风养血，清热除湿的作用。笔者在临床上善用消风散加减治疗慢性荨麻疹疗效满意，现介绍病案 1 例：

患者 男 59 岁 香港人 患荨麻疹 8 个月，就诊 GP 多次，其 GP 给予抗过敏药内服，仅能短暂缓解，反复发作。经朋友介绍找笔者看病，于 2019 年 2 月 26 日初诊。查体：全身皮肤起红色疹块、大小不一，小如 1P 硬币大，大者成片状（见图），伴有灼热感，奇痒难忍，每天发作，严重影响睡眠，痛苦难受，大便干，小便赤，舌质红，苔白厚，脉数有力。



第一次就诊（图片）

诊断为：风疹 证型：风毒湿盛 治法：清热燥湿、疏风养血 方药消风散加减：防风 6 克、荆芥 5 克、白蒺藜 9 克、苍耳子 9 克、牛蒡子 9 克、地肤子 12 克、山栀子 6 克、白藓皮 6 克、苦参 9 克、连翘 9 克、生石膏 15 克、火麻仁 9 克、生甘草 3 克。每日一剂水煎内服，每日早晚各服一次。五剂后 2019 年 3 月 5 日复诊。患者喜告服完第二剂中药后症状开始减轻而不需要服用抗过敏药，服至第三剂荨麻疹已控制，服完 5 剂获痊愈，四天来风疹未再出现（见图），效不更方，再配五剂以巩固疗效。（注：未配外用中药药膏。）



第二次就诊（图片）

此患者乃风毒之邪侵袭人体，与湿热相博，内不得疏泄，外不得透达，邪于肌肤腠理之间而发，故皮肤疹出色红，奇痒难忍，舌红苔白厚，脉数有力，亦为风毒湿热伤人之侯。其治疗风毒宜疏散，湿热宜祛除，又因风毒湿热之邪易伤人阴血，治又当配养血疏风之法。根据患者证型巧用消风散加减，荆芥、防风、苍耳子为疏风透表，开发腠理，以祛除在表之风邪而止痒，白蒺藜平肝息风，此即“痒自风来，止痒必先疏风”之意。牛蒡子、连翘疏风散热、解毒透疹，以祛风毒，患者舌红苔白厚，脉数有力内兼有湿热，用苦参、白藓皮、地肤子清热燥湿共以祛湿毒。患者大便硬，有湿热伤阴的表现，风毒湿热易伤阴血，所用疏风除湿之品又易伤阴血，而阴虚血燥每每加重身痒，故以火麻仁滋阴养血润燥，即可使已伤之阴血得以补充，又能制约疏风除湿药之温燥，且寓“治风先治血，血行风自灭”之意。患者全身皮肤起红色疹块、伴有灼热感，小便赤，脉数有力，这些都是有内热的表现，所以笔者用石膏、山栀子清热泻火、利湿解毒除烦，生甘草清热解毒，调和诸药为使。全方主要由清热燥湿、疏风养血法则组成，诚为治疗风疹之剂。

上述验案为笔者临证经验之一，充分体现出祖国医学中医，立足辩证的特色。宋朝《三因极一病证方论-癮疹证治》中提到：“内则察其脏腑虚实，外则分寒暑风湿，随证调之，无不愈”。所以笔者在临床上辩证明确，抓主证，灵活运用消风散加减用于临床风毒湿热型慢性荨麻疹取得满意效果。

英国中医药学会

The Association of Traditional Chinese Medicine and Acupuncture UK

地址 Address:
ATCM,
Suite 10 Brentano House
Unit 5 The Exchange,
Brent Cross Gardens
London NW4 3RJ

电话/传真 Tel/Fax: 0044 (0)20 8457 2560
微信 WeChat：ATCM-OFFICE
电子邮件 Email: info@atcm.co.uk
网站 Website: www.atcm.co.uk

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主编：沈惠军
编辑：Alexander Mearns, 佘军, 向阳
本期编辑：沈惠军， Alexander Mearns, 佘军
版面设计：PCL Wollaston Print
Chief Editor: Huijun Shen
Editors: Alexander Mearns, Jun She, Yang Xiang
Editors of this Issue:
Huijun Shen, Alexander Mearns, Jun She
Graphics: PCL Wollaston Print

Traditional Chinese Medicine Accreditation Board UK

The Traditional Chinese Medicine Accreditation Board (TCMAB) was established in 2004 as an independent organisation to accredit institutes that run traditional Chinese acupuncture and Chinese herbal medicine courses. Two purposes for the establishment of TCMAB:

- To ensure that affiliated colleges deliver TCM education and training courses in the UK that meet the requirement and standards comparable to the training standards set up by China's State Administration for Traditional Chinese Medicine;
- To facilitate the discussion on the education of acupuncture, herbal medicine and traditional Chinese medicine with the Department of Health in the UK.

Once the students graduated from ATCM accredited institutes, they could be automatically become a member of the Association of Traditional Chinese Medicine.

Currently there are six TCMAB accredited courses. They are:

Acupuncture Foundation Ireland
(http://acupuncturefoundation.com/courses/acupuncture-tcm)
- Diploma in Acupuncture **(**accredited in **2005)**

Asenté Academy
- Diploma in Chinese Herbal Medicine (accredited in 2016)

College of Naturopathic Medicine (https://www.naturopathy-uk.com/courses-eu/courses-acupuncture)
- Diploma in Acupuncture (accredited in 2009)

Glyndwr University (https://www.glyndwr.ac.uk/en/Undergraduatecourses/Acupuncture)
- BSc (Hons) Acupuncture (accredited in 2007)

Manchester Academy of Traditional Chinese Medicine (http://matcm.co.uk/our-courses/diploma-courses/diploma-in-chinese-herbal-medicine)
- Postgraduate Diploma in Chinese Medicine (accredited in 2017)

Phoenix Academy of Acupuncture and Herbal Medicine
(http://phoenixtcm.org.uk/courses)
- Diploma in Chinese Herbal Medicine (accredited in 2016)