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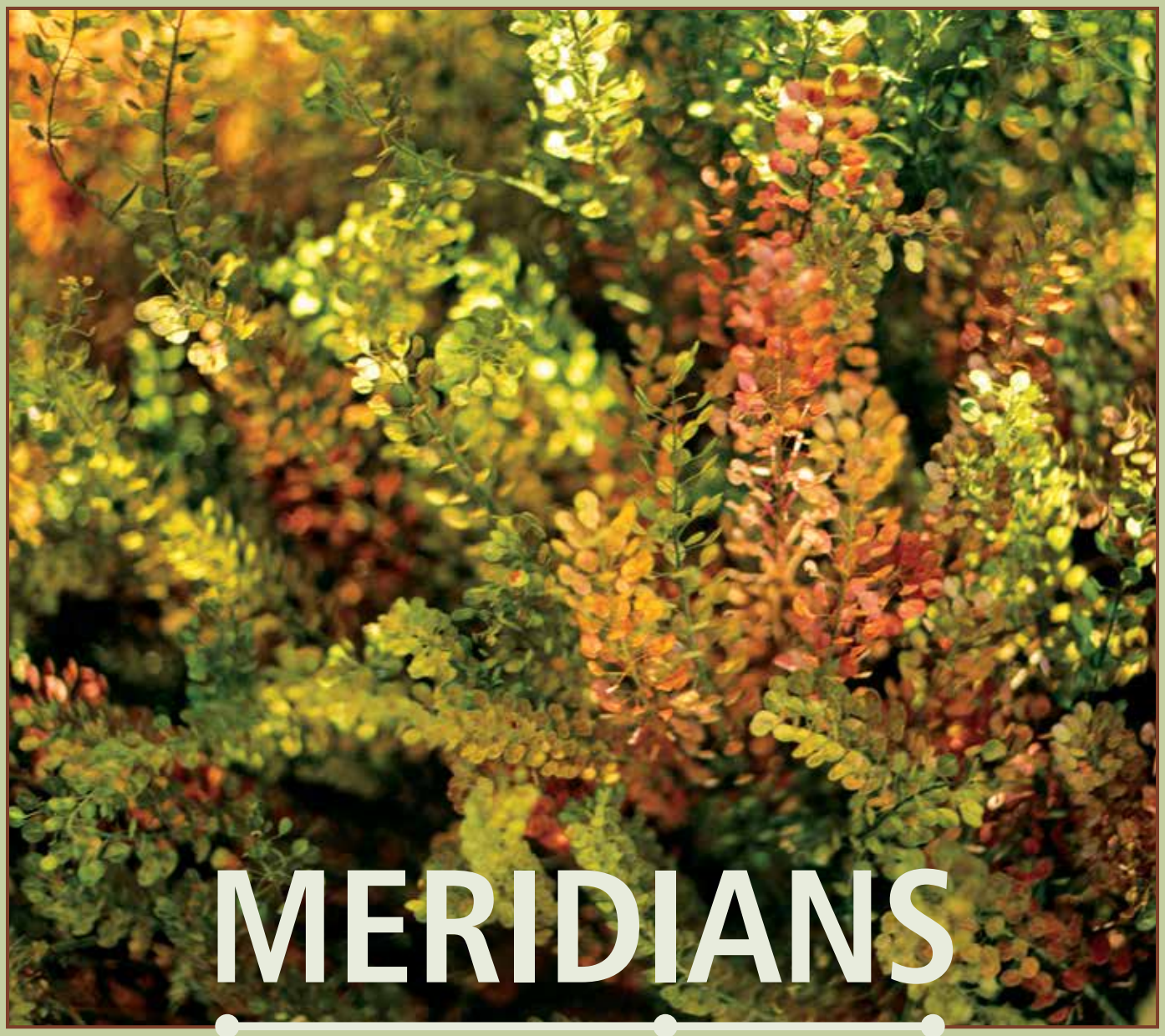

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The Journal of Acupuncture and Oriental Medicine

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MERIDIANS

The Journal of Acupuncture and Oriental Medicine

Letter from Editor in Chief Jennifer A. M. Stone, LAc

I am very pleased to introduce you to the premier issue of *Meridians: The Journal of Acupuncture and Oriental Medicine* (MJAOM). www.meridiansjaom.com Meridians is a quarterly, peer reviewed scientific journal that includes articles by published authors as well as first time authors in all fields of acupuncture and Oriental medicine. We are committed to working closely with DAOM students and other new investigators so as to foster more sources for quality contributions to our profession. Each submission accepted to MJAOM is closely peer reviewed, and each author revises as necessary until their pieces are expertly presented and worthy of MEDLINE indexing.

"Close to 100 people— the core staff, section editors, authors and other contributors, peer reviewers, and advertisers—worked together to turn this concept into a reality. We are all bonded by our dedication to increasing the amount and quality of research and scientific literature in our profession."

For quite a while I have wanted to create from scratch a viable, respected journal for our profession. Starting a new journal with zero seed money is nearly impossible. But through the dedication and enthusiasm of an MJAOM skeleton support staff, working for months without pay, we steadily configured the Journal's goals and its structure. We now have a growing readership, a great website design and maintenance program, a terrific logo, and everything else. I am so proud to say that together our team pulled it off! Close to 100 people— the core staff, section editors, authors and other contributors, peer reviewers, and advertisers—worked together to turn this concept into a reality. We are all bonded by our dedication to increasing the amount and quality of research and scientific literature in our profession. (Dylan Jawahir, LAc even created our Facebook page for us! Hope you all "Like" it soon. https://www.facebook.com/MeridiansJournal)

It takes a village to raise even a journal. Associate Editor Lynn Eder and I have spent many hours on the phone and through emails working together on each detail, step by step. As the journal's character evolved, we invited several people to serve as Meridians' section editors:

Clinical Pearls Editor: Dylan Jawahir, LMT, LAc djawahir@meridiansjaom.com

Public Health Editor: Beth Sommers, PhD bsommers@meridiansjaom.com

Book Review Editor: Terry Courtney, MPH, LAc tcourtney@meridiansjaom.com

Terry Courtney MPH, LAc

Lynn Eder, MFA

Dylan Jawahir LMT, LAc

Elizabeth Sommers PhD, MPH, LAc

MJAOM features a Clinical Pearls section in each issue, managed by Dylan Jawahir, LMT, LAc. Clinical pearls are a valuable tool for all clinicians, particularly recent graduates and new practitioners since they are quick, short pieces culled from peers who each write on the same clinical topic. We hope to publish 3-6 pearls each issue to give readers a variety of perspectives on treatment strategy. In this issue we asked experts to share their experiences with treating frozen shoulder. Please check out our website and Facebook page for information on the next issue's topic: "How Would You Treat Blocked Menses (Secondary Amenorrhea) in Your Clinic?" Submissions are due by or before November 1.

We are very pleased to present our Public Health Editor Beth Sommers, MPH, PhD. Beth is the director of the Alternative and Complementary Medicine office of the American Public Health Association (APHA), and we are grateful to have her on our team. Future MJAOM issues will include a contribution to the profession that relates to a public health topic or perspective. This is being done in an effort to breech gaps in understanding between the AOM professionals and the APHA, the oldest, largest and most diverse organization of public health professionals in the world.

Terry Courtney, MPH, LAc has graciously agreed to keep aware of new and emerging books our readers may value reading. She will match these with AOM colleagues who will share their honest opinions about the book's content, approach, and readability.

I have been practicing AOM in the clinic for over 25 years, but I became a student of research only ten years ago. Because of my affiliation with the Indiana University School of Medicine, I have had the valuable opportunity to work closely with and learn from two mentors who are both NIH-funded researchers, with over 200 publications combined in their names in MEDLINE. Through the years I have been taught to write in the scientific style that MEDLINE requires; I currently have six publications on MEDLINE. For this issue of Meridians, I want to share with you a report of data I collected on postherpetic neuralgia patients when I worked in an integrative pain clinic in Indiana. Please take a look to see the collaborative new treatment strategy that is showing promising results.

In this issue we feature an in-depth exploration of the value of the case report and its contribution to evidence-based medicine. Tim Suh, winner of the 2012 AAAOM/SO research poster contest, has delved into this topic. His perspective on the subject of case reports themselves, entitled "Why Do Case Reports? How These Can Benefit our Profession?" discusses the value of case reports for all AOM practitioners as well as affiliated medical practitioners.

Our inaugural issue presents three case reports:

- Resolution of Erectile Dysfunction in HIV+ Males: A Case Report by Larry Langowski, PhD and Timothy I. Suh, DAOM, LAc
- Acute Dysmenorrhea: Treatment with Electro-Acupuncture: A Case Report by Sara O'Byrne, MAcOM, DAOM, LAc, Dipl OM (NCCAOM)
- A Complex Case Study of Postpartum Facial Paralysis: A Case Report by Lia G. Andrews, DAOM, LAc

In an opinion paper, Dr. Tim Suh offers some possible solutions that may serve to ameliorate the dearth of scientific AOM literature and ultimately increase the evidence of successful use of AOM treatments. Additionally, Dr. Suh prepared a letter to the editor, in which he shares his views on several of our profession's current problems.

Another opinion paper, entitled "Bowel Movements: How Many and with What Frequency?" by Jame'e Brazie'r, DAOM, LAc, DiplOm (NCCAOM), examines both ancient Chinese and modern medical texts in his thorough discussion of this important, yet not widely talked about, topic.

This past summer the Society of Acupuncture Research (SAR) held their annual meeting in Beijing, China. Cynthia Easter's report, "SAR & CAMM 2014 International Symposium on Acupuncture Research: Impact of Acupuncture Research on 21st Century Global Healthcare, Beijing, China," provides timely information on what the top AOM researchers throughout the world are researching and discussing. She gives us valuable details about their different research passions and their expertise.

The book selected for review is *The Liver* by Claude Larre and Elisabeth Rochat de las Vallee. Reviewer Karen Reynolds, LAc, RN beautifully describes the authors' many translations of related topics and their contributions to the wealth of knowledge we can now gain from these ancient texts. The long-gone writers are truly experts in the spirit of traditional teachings, and it is definitely worth our time to read about them and learn from them.

MJAOM is truly a collaborative effort of an incredible team of an expert, experienced staff, AOM leaders, clinicians, researchers and faculty. Alone we are each talented, but when we work together, combining our talents and expertise, we are dedicated to producing the official journal of acupuncture and Oriental medicine in the U.S. that matches up to MEDLINE's quality.

We invite your questions, submissions, feedback, and letters to the editor. info@meridiansjaom.com On behalf of the team, I present to you *Meridians: the Journal of Acupuncture and Oriental Medicine.*

Enjoy!

Jennifer A. M. Stone, LAc
Editor in Chief, MJAOM

Dear Editor:

During the past nine years I have been in practice I have seen many changes in our profession. I have noticed some core problems with the profession. We are our own worst enemy. Most recently one of the national AOM organizations has been broken apart by these problems as has been reported in *Acupuncture Today*. The problems stem simply from the inability to unify. One person or small group has an agenda and makes it their priority and assumes to know what the whole of the profession needs and wants without surveying them. This will only lead to our demise as our profession is threatened more and more by western medical providers, who are not fully licensed in AOM procedures, taking over more acupuncture, our most sacred modality.

MDs, PTs and DCs do the research we should be doing, and we cannot seem to stop them. Our profession is being trampled upon while these other professions use our modality as their own. They are creating a whole other procedure in the world of medicine by just changing its name. With this sleight of hand, they put down what we practice, but at the same time it is exactly what they practice. They are doing the research and creating their market, which should and can be ours.

How do we fix this dilemma? I have some opinions that might help give us a stand.

I believe that we have to stop taking on faith the reasons that our medicine works. In my humble opinion, there is no western or eastern medicine—there are just different perspectives that are valid and valuable, just as there are no eastern and western bodies or biology. All perspectives are necessary because we cannot know everything, and to ignore any other perspective but our own makes us walk blindly.

Creating the evidence that our medicine does work means we will be sharing the "secrets" that have been handed down from our teachers. Why we keep secrets I have no idea. If we share our secrets with each other and can reproduce them, then we are on the path toward helping each other and the profession as a whole.

The next step is to survey our whole profession and see what can help us grow. We have to ask our profession what is needed. A survey study that I did in 2012 for my capstone project showed such a wide discrepancy of income that it astonished me. Why are some practitioners earning so little? Well, the survey seemed indicate that people lacked skills in practice management. We graduate with a master's or doctorate and know how to treat, but few of us know how to translate this into a consistent income stream.

We learn about different treatment strategies and theories, but we are not taught about the different delivery systems so our medicine can be widely presented to the paying public. Unfortunately, we are only taught the private practice model, which is not the only model today. We sometimes hear about the growing area of hospital or community acupuncture but they are not fostered or taught. We need to learn about the advantages and disadvantages of each of these systems and also how to bill insurance and how to gain an in-network presence. This is also part of our medicine.

I have had several acupuncture students shadow me over the years, and each of them are astonished at the amount I share with them. They are surprised that I even allow them to shadow me. They ask questions and I give them answers. I take them to my private practice clinic as well as the hospital where I practice and also to my integrative medicine office. They can see three separate delivery systems and practice management systems at work. Can we all do this for our students and new practitioners?

Let us teach the value of each of these delivery practice systems in our schools so we can help our profession support us. With more successful practitioners, our profession gains in many ways. We can give monetary support to lobby for our medicine at state and federal levels. We can give back to our schools through providing scholarships. We can ask our state and national associations to give us better continuing education courses. We can pay higher salaries for more qualified professors to teach us relevant skills in our profession.

This is a call for unification on many levels. Write case reports, share information with each other, let interns learn in real-life practice about all the AOM modalities we as professionals can pursue, promote practice management at schools, and give back to our profession. These are some simple ways we can strengthen ourselves. So let us begin now!

Sincerely,

Timothy I. Suh, DAOM, LAc, Dipl Ac, Dipl OM, E-RYT 500
Founder & Clinic Director

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MeridiansJAOM welcomes letters to the editor from our readership. Please send them to info@meridiansjaom.com and be sure to include your full name and any licenses and/or titles, your phone number, and email address.

Public Health Editor:
Elizabeth Sommers
PhD, MPH, LAc

Letter from Public Health Editor

Friends and Colleagues,

With the launch of this new venture, I want to welcome you to *MeridiansJAOM* and give you a quick preview about what you'll be seeing in upcoming issues. All of us share a vision about creating a healthy, nurturing environment that promotes community and individual health and wellness. Meridians are pathways that move and connect energies; this same goal resonates with public health.

The spheres of public health encompass the environment and community wellness, vibrancy, and resilience. Public health is characterized by commitment to access, affordability, and appropriateness of care. These issues form a "big tent" that includes promoting healthcare coverage, service, timeliness and work-force education and training. A singular goal of public health is to remove barriers that prevent citizens from receiving care.

In my role as chair of the American Public Health Association's Section on Integrative, Complementary and Traditional Health Practices, I strive to make connections between clinicians, health educators, researchers, activists, students and policy-makers. By uniting our considerable forces and areas of expertise, we create dynamic synergies that strengthen and enliven the public's health. The trans-disciplinary nature of working in collaboration can help to ensure that the fruits of our visions and labors will be bigger and more robust.

I look forward to working together to create a future that is based on ensuring that healthcare that includes wellness is a right, not a privilege.

Elizabeth Sommers PhD, MPH, LAc
Public Health Editor
MeridiansJAOM

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A Complex Study of Postpartum Facial Paralysis: A Case Report

By Lia G. Andrews, DAOM, LAc

Lia G. Andrews, DAOM, LAc is co-owner of Cinnabar Acupuncture Clinic in San Diego, California. Dr. Andrews is a practitioner and educator specializing in women's health and traditional Chinese medicine. She is the author of *7 Times a Woman*, which discusses women's *jing* cycles, and *The Postpartum Recovery Program*™, which presents modern modifications to traditional postpartum care. She can be contacted through her website: www.LiaAndrews.com

Abstract

Background & Objective: This case study reports on postpartum facial paralysis treated by acupuncture and Chinese herbal medicine. Highlights are: 1) the complexity of adapting treatment within the context of the postpartum month and 2) maternal age and inadequate postpartum care as potential factors in postpartum symptoms. The month after childbirth is characterized by a general drain on kidney energy and a specific tendency towards qi and Blood deficiency and Blood stasis. These imbalances are more prominent in older mothers. Traditional Chinese medicine may offer effective treatment and lifestyle interventions to address these cases. Paramount is the need for the postpartum patient to get rest and receive support from family and friends. The case concerns a 48-year-old mother who experienced a series of postpartum conditions including Bell's palsy, high blood pressure, insufficient lactation, night sweats, excessive lochia, and edema.

Methods: A multi-pronged approach was used, including acupuncture, diet therapy, lifestyle recommendations, and Chinese herbs. The patient was also given guidance on proper postpartum diet and lifestyle.

Results: The majority of the patient's various symptoms responded quickly to treatment. Her facial paralysis symptoms were alleviated within four treatments over a five week period. Symptoms such as insufficient lactation, high blood pressure, and excessive lochia were highly responsive to acupuncture and herbal treatment. Edema and night sweats were slower to respond. The patient demonstrated high compliance during treatment and in taking herbal medicine on schedule. However, she was at times resistant to such postpartum care practices as rest, accepting help, using a postpartum girdle regularly, and diet.

Conclusion: This case highlights the need for postpartum care and also the cultural resistance towards it. Acupuncturists can offer support in both educating patients on proper postpartum care and treating common postpartum symptoms.

Key Words: postpartum care, Bell's palsy, facial paralysis, excessive lochia, night sweats, edema, acupuncture, Chinese herbs, advanced maternal age.

Introduction

Postpartum women are a class of patient that requires special consideration.[1] Zhu Danxi (1281-1358), and later Fu Qingzhu (1607-1684), established the postpartum tendency: *yuan qi* and Blood deficiency and Blood stasis.[2] Other traditional Chinese medicine (TCM) scholars have noted that conception, gestation, and delivery also tax the mother's kidney energy, including her *jing*.[3] Thus the first month postpartum is considered a time to protect and recover a woman's vitality through strict adherence to postpartum care practices, known as *zuò yuè zi* (坐月子). This is standard for healthy women, and is considered more important in mothers over 35 years of age and in case of delivery complications such as C-section.[4]

Advancing age is associated with *jing* decline and increased risk of birth complications. The *Huangdi Neijing* (Yellow Emperor's Inner Canon) was the first TCM text to describe women's seven year *jing* cycles and the decline that tends to occur during the fifth cycle, starting at age 35.[5] Western studies substantiate that there are increased risks for delivery with advancing maternal age including higher incidence of C-section, bleeding, and premature delivery.[6]

Facial paralysis appears to be more prevalent in pregnant and postpartum women, according to a 2010 study.[7] This study also suggests a link between Bell's palsy (a condition of facial paralysis, typically one-sided, caused by a dysfunction of the cranial nerve VII, the facial nerve that controls facial expressions) and hypertension during pregnancy. The patient's symptoms presented below must be understood within this context in order to provide effective treatment without damaging the patient.

The objective of this case study is to report about these postpartum symptoms as treated with acupuncture and Chinese herbal medicine. The complexity of adapting treatment within this context takes into account maternal age and inadequate postpartum care.

Case Description

Chief Complaint:

A 48-year-old postpartum patient complained of acute onset facial paralysis on the right side with facial puffiness immediately following delivery.

Relevant Health History:

The patient had a history of polycystic ovary syndrome (PCOS) but was free of any known diseases other than occasional colds. She sometimes drank wine and never smoked. She enjoyed her food but favored sweets, leading towards being slightly overweight during her adult life. She was married, with two other children ages five and eight. The patient had required medical intervention (IVF) to conceive her first two children. She did not concern herself with birth control since her inability to conceive naturally had failed in the past.

The patient was therefore upset when she went on a trip to Fiji and came back pregnant. She had a difficult pregnancy and (jokingly) offered to give the baby away to whomever wanted it. She had no morning sickness during the first trimester. However, she developed pre-eclampsia, [gestational hypertension where blood pressure elevates above 140/90 measured on two separate occasions and also proteinuria or elevated protein levels are found in the urine]. She also developed significant edema midway through her second trimester. (In the U.S., pre-eclampsia occurs in 3-6 percent of pregnant women, with advanced maternal age being a significant predisposing factor.[8]) This condition was managed with the anti-hypertensive medication Nifedipine.[9] During her third trimester she developed sciatica and was very uncomfortable, sleeping only an hour at a time.

History of Present Illness

The patient went into labor four weeks early. When the patient's blood pressure skyrocketed during delivery, she underwent an emergency C-section. After the procedure her face became severely swollen, she had lost the ability to animate the right side of her face, and her speech was slurred.

A hospital neurologist ruled out a transient ischemic attack (TIA), commonly referred to as a "mini-stroke,"[10] and instead diagnosed her with Bell's palsy, a condition of facial paralysis, typically one-sided, caused by a dysfunction of the cranial nerve VII, the facial nerve that controls facial expressions, Although her primary physician remained suspicious of this diagnosis, she was prescribed prednisone, an anti-inflammatory corticosteroid, which is standard treatment for the condition. Prednisone was having no effect at all on her condition when she sought acupuncture treatment 1 ½ weeks postpartum.

The patient also complained of night sweats, a common postpartum symptom affecting approximately 29 percent of postpartum women.[11] She also still had significant edema and felt irritable and tired. Her lochia [normal vaginal bleeding that occurs after vaginal delivery] was scanty and bright red with little clots. Her physician had claimed to have "cleaned out" her uterus during the C-section although she suffered minor abdominal pain from the procedure. She had regular bowel movements and her lactation was normal. The patient said her husband had complained that she snored

Examination:

The paralysis was such that the patient was unable to blink or raise the corner of the right side of her mouth or cheek. She had full sensation on both sides, along with clicking and tension in her right jaw. Her speech was slurred, but her tongue was not deviated. Her whole face was swollen, including her nose. Her skin felt rough; she had generalized hyperpigmentation and acne nodules just under the jaw line. Her tongue was puffy and pale, and her pulse was slippery.

TCM Diagnosis:

The patient was diagnosed with *wind phlegm* in the channels with underlying *yin* deficiency. In TCM, Bell's palsy falls under the category of facial paralysis (面瘫, *miàn tàn*). Facial paralysis can be caused by either external *wind* or internal *wind*. Cases of internal *wind* are complicated by *phlegm* and/or *yin* deficiency.[12] The hypertension and longstanding emotional resistance to the pregnancy pointed to liver *yang* rising; a liver excess occurring amidst the backdrop of *blood* and *yin* deficiency. Night sweats were a sign of *qi* and *yin* deficiency.[13]

At the same time she had a history of *qi* deficiency with *phlegm-damp*, which was apparently aggravated during pregnancy and postpartum as seen in the generalized edema, nodular acne, snoring, fatigue, enlarged tongue body, and slippery pulse. *Qi* and blood loss during delivery set the stage for the perfect storm of internal *wind* and *phlegm-damp*. Blood stasis was suspected due to the operation and minor clots in her lochia. Prior to pregnancy the patient had constitutionally tended towards spleen deficiency with *phlegm-damp*, and suspected *jing* deficiency.

Treatment Principle:

Open the channels, resolve *phlegm-damp*, soothe the liver, and nourish kidney *yin*.

Treatment

The treatment of facial paralysis typically calls for strong intervention, such as the use of insects or strongly aromatic transforming herbs to open the channels. These herbs can easily damage a patient who is already convalescing and must be harmonized within the formula with tonifying medicinals. Another consideration is the timing of the symptom. If a symptom suddenly occurs postpartum, it is most likely arising from deficiency. In such cases, strong sedation will exacerbate the condition.

For these reasons, a combined approach was used, incorporating acupuncture, herbs, and lifestyle recommendations appropriate for the postpartum period. Unless otherwise stated, 36 gauge needles were inserted with a guide tube with even technique on the body points until the practitioner felt the qi activate.

On the face, red SEIRIN® J-15 needles (40 gauge) were used for electro-stimulation. The needles were inserted with a guide tube into the muscle until they met with resistance. Dark green SEIRIN® needles were used on other facial points and on the hands and feet. These needles were inserted with a guide tube approximately 1-2 mm deep. The patient was relaxed and did not report feeling significant *qi* sensation. Electro-stimulation was attached to acupuncture needles on key points to strongly stimulate the muscles and open the channels. Continuous current at a pulse rate frequency of 100 Hz and an output current between 0-2 mA, was used for 20 minutes duration.

First Treatment – 1 ½ weeks postpartum

Acupuncture Treatment:

Qianzheng (Ex-HN-16) and Daying ST-5 were needled bilaterally for facial drooping. On the affected side they were connected with electro-stimulation. Taiyang (M-HN-9) and Yu Yao (M-HN-6) were needled bilaterally for drooping around the eye. On the affected side they were connected with electro-stimulation. Jiachengjiang (M-HN-18), Juliao ST-3, and Dicang ST-4 were needled bilaterally for facial drooping. Si Shen Cong (M-HN-1) was needled to calm the *shen* and assist lifting the face. Fenglong ST-40 was needled bilaterally to resolve *phlegm-damp*. Zusanli ST-36 was needled bilaterally to strengthen *qi* and blood and drain *dampness*.

Sanyinjiao SP-6 was needled bilaterally to nourish the kidneys, strengthen the spleen, and regulate urination and uterine bleeding. Zhaohai KD-6 was needled bilaterally to nourish kidney *yin*. 4 Gates (LV-2 Xingjian, LI-4 Hegu) was needled bilaterally to circulate liver *qi* and relieve stress. LI-4 Hegu also served as a distal point for the face. 4 Doors (Ren-12 Zhongwan, Ren-6 Qihai, ST-25 Tianshu) was needled bilaterally to regulate digestion and move stagnant *qi* in the abdomen.

Herbal Medicine Treatment:

In light of the fact that the patient's body was overburdened and she had already been prescribed prednisone and blood pressure medication, no herbal formulas were given. Instead the milder "food herb" *Hong zao* (Fructus Jujubae) was administered in raw herb decoction form to cleanse the liver while gently tonifying *qi* and blood.[15] The decoction was taken for one week at the dosage of ½ cup twice daily.

Home Care:

Diet therapy was used to address the significant Phlegm-Damp and Heat the patient displayed. The patient was advised to use *yi yi ren* (Semen Coicis Lachryma-jobi), *chi xiao dou* (Semen Phaseoli), and raw daikon radish daily in the diet.[16] She was advised to limit sweets and greasy foods, while increasing cooked vegetables and lean protein. This was recommended for the entire postpartum month. The patient was advised to use a postpartum girdle to protect her abdomen and prevent prolapse. She was also advised to get help taking care of her newborn and her other children so she could rest. Her husband was available to help as was her visiting mother. The patient seemed enthusiastic about the recommendations.

Second Treatment - 2 ½ weeks postpartum

Re-evaluation:

The patient developed a full body rash since the first treatment and was treated with Benadryl. Shortly after this her breast milk dried up.[17] The patient reported minor night sweats. Her lochia was scanty and brownish. Her tongue was puffy and her pulse slippery.

TCM Diagnosis:

Wind phlegm in the channels, *qi* and *yin* deficiency.

Treatment Principle:

Open the channels, resolve phlegm-damp, promote lactation, and nourish *yin* and *qi*.

Acupuncture Treatment 1 was repeated with the addition of:

Xiaguan ST-7 was needled bilaterally to address jaw discomfort. Shaoze SI-1 was needled bilaterally to promote lactation. Shanzhong Ren-17 was needled to get *da qi* sensation to increase *qi* to the breasts. Rugen ST-18 was needled bilaterally to promote lactation.

Herbal Medicine Treatment:

Lou Lu San (Rhaponticum Decoction)[18] was selected for its effectiveness in resolving *phlegm-damp* while boosting *qi*. It served the dual purpose of promoting lactation, while addressing the systemic congestion of body fluids. The formula administered was a Brion Herb brand concentrate powder form. Dosage was four scoops (approximately one gram per scoop) twice daily between from meals for the duration of one week.

Home Care:

The patient reported being compliant with food therapy but less so with other recommendations. Though her husband was helpful with housekeeping chores and caring for the older children, she was still burdened with taking care of her newborn and doing most of the cooking. Her mother was of little help. She also had not purchased a girdle.

Third Treatment - 3 ½ weeks postpartum

Re-evaluation:

The patent's face was significantly improved. The swelling had gone down and her expressions were almost normal. The upper lip on the right hand side was still stiff. Her lactation was much

improved and had returned to normal volume. Her baby was growing but agitated. It was discovered that the rash was an allergic reaction to Nifedipine, so instead she was prescribed Labetalol.[19] The prednisone had been masking her symptoms.

The patient complained that she had suddenly developed excessive bright red lochia with no clots that was so heavy she needed to use two to three pads per day. She also experienced heat that would rise up her abdomen and chest, night sweats, and fatigue. These last symptoms indicated growing *yin* deficiency that needed to be addressed. Her tongue was still puffy and reddened in color. Her pulse was slippery.

TCM Diagnosis:

Yin deficiency Heat with Wind Phlegm in the channels.

Treatment Principle:

Open the channels, clear Heat, nourish kidney *yin*, and drain Damp-Phlegm.

Acupuncture Treatment 1 was repeated with the addition of:

Yinbai SP-1 was needled bilaterally to stop excessive uterine bleeding. Stick moxibustion was swirled around the point bilaterally to strengthen this action.

Herbal Medicine Treatment:

The formula *Bao Yin Jian* (Preserving Yin Decoction)[20] was chosen for its ability to nourish *yin*, clear Heat, and regulate uterine bleeding. The formula was administered in Brion Herb brand concentrate powder form. Dosage was four scoops (approximately one gram per scoop) twice daily between from meals for the duration of one week.

Home Care:

The patient continued with food therapy. She sent her mother away, which gave her peace but increased her workload.

Fourth Treatment - 5 weeks postpartum

Re-evaluation:

The patient was happy to report that her primary care physician had taken her off the anti-hypertensive medication. Her lactation remained normal and her baby had gained (a much needed) two pounds. She was extremely satisfied with her face and felt that the paralysis had been cured, however she wanted another treatment "for good measure."

On the down side, the patient reported experiencing flushes of heat up her abdomen and chest, back acne, night sweats, and persistent fluid retention, although the lochia had stopped. She continued to experience tingling in her fingers and jaw clicking on the left side. The patient reported feeling irritable and fatigued. Additionally, she had popped one of her C-section stitches.

Upon observation, her face and skin texture looked better than it had prior to pregnancy. There were no asymmetries in her expressions and she had a youthful glow. She continued to exhibit significant hyperpigmentation but the bumpiness and roughness had gone. Her shoulders were extremely tense. Her tongue was puffy but now was a normal pink. Her pulse was slippery.

TCM Diagnosis:

Yin deficiency Heat with Wind Phlegm in the channels.

Treatment Principle:

Open the channels, clear Heat, nourish kidney *yin*, and drain *damp-phlegm*.

Acupuncture Treatment 1 was repeated, with the addition of:

Xiaguan ST-7 was needled bilaterally to address jaw discomfort. Bilaterally, Xiaguan ST-7 was connected with Jianjing GB-21 with electro-stimulation. Jianjing GB-21 was needled bilaterally with a 36 gauge needle until *da qi* sensation was achieved to address hand tingling and local muscle tension. Bilaterally, Jianjing GB-21was connected with Xiaguan ST-7 with electro-stimulation. Quchi LI-11 was needled bilaterally to clear Heat. Taiyi ST-23 was needled bilaterally to resolve phlegm and calm the *shen*.

Herbal Medicine Treatment:

Zhi Bai Di Huang Wan (Anemarrhena, Phellodendron, and Rehmannia Pill)[21] was chosen as the base formula for its ability to nourish yin and clear Heat. The formula was administered in Brion Herb brand concentrate powder form. Dosage was 4 scoops (approximately one gram per scoop) twice daily away from meals for the duration of two weeks.

Home Care:

The patient continued with food therapy. She had been wearing a girdle "periodically" but stopped after the issue with her C-section stitch.

Result

The patient experienced a significant improvement in her ability to control her facial muscles immediately after the first treatment. She was able to smile and blink on the right side of her face which she had been previously unable to do. The second and third treatments saw equally significant improvements so that when she returned for the fourth visit, her facial mobility looked normal. Skin texture and clarity improved over what had previously existed. She still exhibited significant hyperpigmentation, but the roughness and acne had subsided.

The majority of her other symptoms were quick to resolve. Insufficient lactation resolved after one acupuncture treatment

combined with one week of herbal treatment, and did not recur. Excessive lochia similarly resolved after one acupuncture treatment combined with one week of herbal treatment. Hypertension resolved during the course of treatment. However, the night sweats and edema persisted.

Discussion

This case was significant in that it showed the occurrence and treatment of Bell's palsy within the context of an older woman who was experiencing postpartum complications. Statistically, Bell's palsy resolves spontaneously over a 3 week period in 85 percent of cases.[22] The author treated several cases diagnosed as Bell's palsy that had not resolved spontaneously after several months without intervention but which responded quickly to acupuncture, electro-stimulation, and herbal treatment. The fact that this patient felt and demonstrated immediate improvement after each treatment indicates that the treatments may speed up the recovery process.

However, there was no control group and it cannot be known if the patient's paralysis would have resolved on its own, albeit at a slower pace. It is the author's opinion that it was a combination of strengthening the patient's constitution and providing local stimulus to clear blockages in the face that allowed the patient to recover with greater speed and more completely than she might have had without acupuncture and herbal intervention.

Modifying the treatment according to her postpartum conditions appears to have been a good choice. In hindsight, it might have been better to have given her a modified *Sheng Hua Tang* (Transformation and Generation Decoction). In the author's experience this not only helps discharge the contents of the uterus and nourish blood, it also helps alleviate postpartum edema.

It would also have been helpful to advise the patient to prepare for postpartum care. Lifestyle and nutrition are important in the treatment of any condition, and even more so in the treatment of conditions after childbirth. The details of postpartum care need to be set in place ahead of time. Organizing help, finding the right postpartum girdle, etc. is too much to think about after the baby is born, particularly if there are complications. This patient received more support than many women do, but would have benefited from additional support.

The patient's age, and the likely proximity to menopause, suggests an inherent *jing* depletion, adding yet another level of complexity to this case. The nuance of symptoms the patient experienced throughout the course of treatment was similar to the author's experience treating perimenopausal cases, whereby dwindling *kidney* strength can trigger the emergence of a wide variety of excess and deficiency patterns.

Similar to the treatment of postpartum cases, perimenopausal women require a special awareness on the part of the practitioner—in this case to protect *jing* and avoid aggravating Heat. For example, perimenopausal women may be less likely to tolerate herbs with a strong drying and ascending action, such as *huang qi* (Radix Astragali Membranaceus) or *chai hu* (Radix Bupleuri), without being significantly balanced within a formula. It is common for women to give up red wine and coffee during the menopausal transition for this reason.

In contrast to a younger postpartum woman who most often requires protection from *cold*, an older woman who has just given birth also requires protection from *heat*. This means that a woman delivering a baby in her late 40s must be treated as a special group within a special group, and treatments that often require greater frequency and adjustment.

Conclusion

This case study will hopefully offer insight to practitioners treating Bell's palsy in postpartum patients. The author also hopes that this case will bring greater awareness to the special considerations of postpartum women, particularly in an aging population. More specific information about postpartum cases of Bell's palsy can only be achieved by conducting studies whereby a control group, verification of homecare, and analysis based on maternal age can be utilized.

By including statistically significant number of subjects undergoing acupuncture and herbal interventions, along with an equal number of subjects who were allowed to recover naturally, a clearer picture of the effects of traditional Chinese medical intervention could be determined. Also needed would be some form of monitoring of the subjects' homecare that would affect outcomes, such as nutrition, adequate rest, etc. Additionally, the age of the subjects—not only chronologically but also in terms of sex hormone levels and health of the eggs (evidence of health of *jing*)—should be used in analysis of the results.

In traditional Chinese medicine it has already been established that lifestyle and nutrition are integral to the healing process, particularly after childbirth. A 2011 study suggests that poor sleep during pregnancy may be associated with postpartum depression and a higher incidence of preeclampsia and premature labor (both of which the patient experienced).[23] Studies need to be performed demonstrating the benefits of simple postpartum interventions, such as the importance of sleep to reduce rates of depression and insufficient lactation. This may be anecdotally evident but requires scientific evidence to gain mass acceptance. In the meantime, it is up to acupuncturists to advocate for and provide postpartum guidance to their patients.

Acupuncturists strive to provide preventive care but often are forced into treating a patient as the patient's last resort. As a profession, the opportunity presents us to educate and endeavor to cultural perceptions to minimize many common symptoms in postpartum patients. One example is the increased need for postpartum rest and recovery in modern American society. In 2008 the average hospital stay for women after a vaginal delivery was between 2-3 days and 3-5 days after a C-section.[24] For the majority of women, once they leave the hospital they are expected to resume their normal lives in addition to carrying for their newborn. There is little cultural awareness of the benefits of adequate postpartum rest and recuperation.

This decrease in postpartum rest is occurring, though, as more women wait to bear children and require assistance conceiving. These factors that increase the need for postpartum attention. This case study provides a step in demonstrating the vulnerability of the postpartum month, but more evidence is needed.

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16. The patient was given the options of adding *yi yi ren* (Semen Coicis Lachryma-jobi) and *chi xiao dou* (Semen Phaseoli) to soups or grains or decocting them as tea. The patient was advised to eat a slice or two of raw daikon radish between meals.
17. Her primary care physician blamed Benadryl for the sudden insufficient lactation.
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Appendix 1 Herbs and Formulas

Please Note: All formulas are modified from standard formulas by author.

Ref 14: Herbs commonly used include *di long* (Lumbricus), *jiang can* (Bombyx Batrycatus), and *qiang huo* (Rhizoma et Radix Notopterygii). [From various teachers and books, as well as practical experience by the author. For an example book see: MaClean, W. & Lyttleton, J. *Volume 1: Clinical Handbok of Internal Medicine; The Treatment of Disease with Traditional Chinese Medicine.* (Sydney: University of Western Sydney, 1998), 676-677.]

Ref 15: To make the decoction, seven dates are first rinsed, then scored and soaked in 4 cups of water for 30 minutes in a saucepan. This is brought to a low boil and simmered for 45 minutes. The liquid will have reduced to approximately 2 cups. The liquid is strained and the dregs discarded. The decoction is divided into 4 dosages, to be taken twice daily. [Andrews, Lia. *The Postpartpartum Recovery Program; How to Adapt the Ancient Practice of Zuo Yue Zi for Your Patients*. (San Diego: Alcyone Press, 2014), 167.]

Ref 18: The exact modification of Lou Lu San (Rhaponticum Decoction) administered was: *lou lu* (Radix Rhapontici seu Echinops) 8g, *gua lou* (Fructus Trichosanthis) 7g, *huang qi* (Radix Astragali Membranaceus) 7g, *dang gui* (Radix Angelicae Sinensis) 7g, *fu ling* (Sclerotium Poriae Cocos) 5g, *yuan zhi* (Radix Polygalae Tenuifoliae) 5g, *chuan bei mu* (Bulbus Fritillariae Cirrhosae) 5g, *wang bu liu xing* (Semen Vaccariae Segetalis) 5g, *mai men dong* (Tuber Ophiopogonis Japonici) 7g. [Andrews, Lia. *The Postpartpartum Recovery Program; How to Adapt the Ancient Practice of Zuo Yue Zi for Your Patients.* [(San Diego: Alcyone Press, 2014), 254.]

Ref 20: The exact modification of *Bao Yin Jian* (Preserving Yin Decoction) administered was: *sheng di huang* (Radix Rehmanniae Glutinosae) 8g, *shan yao* (Rhizoma Dioscoreae Oppositae) 6g, *bai shao yao* (Radix Paeoniae Lactiflorae) 4g, *xu duan* (Radix Dipsaci Asperi) 4g, *huang qin* (Radix Scutellariae Baicalensis) 4g, *huang bai* (Cortex Phellodendri) 4g, *sha ren* (Fructus Amomi) 2g, *gan cao* (Radix Glycyrrhizae Uralensis) 2g, *e jiao* (Gelatinum Corii Asini) 4g, *han lian cao* (Herba Ecliptae Prostratae) 4g, *chao di yu* (Radix Sanguisorbae Officinalis, dry-fried) 4g, *dang gui* (Radix Angelicae Sinensis) 6g, *yi mu cao* (Herba Leonuri Heterophylli) 4g. [Andrews, Lia. *The Postpartpartum Recovery Program; How to Adapt the Ancient Practice of Zuo Yue Zi for Your Patients*. (San Diego: Alcyone Press, 2014), 268.]

Ref 21: The exact modification of *Zhi Bai Di Huang Wan* (Anemarrhena, Phellodendron, and Rehmannia Pill) administered was: *zhi mu* (Radix Anemarrhenae Asphodeloidis) 7g, *huang bai* (Cortex Phellodendri) 7g, *sheng di huang* (Radix Rehmanniae Glutinosae) 13g, *sha ren* (Fructus Amomi) 4g, *shan yao* (Rhizoma Dioscoreae Oppositae) 9g, *fu ling* (Sclerotium Poriae Cocos) 9g, *mu dan pi* (Cortex Moutan Radicis) 9g, *ze xie* (Rhizoma Alismatis Orientalis) 7g, *ze lan* (Herba Lycopi Lucidi) 9g, *han fang ji* (Radix Stephaniae Tetrandrae) 9g, *gua lou* (Fructus Trichosanthis) 13g, *huang qi* (Radix Astragali Membranaceus) 9g, *dang gui* (Radix Angelicae Sinensis) 9g. [Bensky D. & Barolet R. *Chinese Medicine Formulas & Strategies*. (Seattle: Eastland Press, 1990), 265.]

Successful Treatment of Postherpetic Neuralgia Using Dermatome Associated Acupuncture

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Abstract

Objective: Although there is extensive evidence that acupuncture is beneficial for chronic pain in conditions, such as migraine, osteoarthritis, and musculoskeletal disorders (Vickers et al., 2012), there are very few systematic clinical trials examining the effectiveness of acupuncture for neuropathic pain, such as postherpetic neuralgia (PHN). PHN a chronic pain disorder resulting from the shingles virus, and, like most chronic pain conditions, individuals with this disorder are treated with addictive prescription drugs, which unfortunately are often ineffective at symptom management. The aim of this study was to systematically assess a novel acupuncture strategy for pain reduction by needling along the specific dermatome associated with the pain.

Methods: This retrospective analysis reports data from 13 PHN patients treated at a Midwestern hospital pain center with acupuncture. All patients were followed by the anesthesiology pain team to manage medication, and all were treated with acupuncture along the path of the affected dermatome. Pain was reported using a visual analogue scale in a specific format, which always included a low scale for allodynia skin pain and a high scale for more severe shock-like pain.

Results: Data were collected from six patients eight to twelve months after treatment. Statistical analysis using a Paired t-test revealed that post-treatment ratings for both measures were statistically significant from pre-treatment ratings ($p < 0.001$), and all patients reported continued relief from pain.

Conclusion: Acupuncture is an effective treatment strategy for PHN pain. More importantly, needling along the affected dermatome is a novel approach to reducing nerve pain PHN and should be considered when treating other types of nerve associated pain conditions.

Key Words: postherpetic neuralgia, PHN, shingles, acupuncture, dermatome, TCM

Introduction

The National Institutes of Health (NIH) reports that up to one million people in the U.S. are affected by herpes zoster (shingles) each year (1)(2)(Niscosa 2007), (3)(Gandi 2006). The varicella-zoster virus (VZV) resides in a dormant state—as a consequence of previous

exposure to the chickenpox (varicella) virus—in cranial nerves and dorsal root ganglia. It can reactivate years later to produce herpes zoster, which manifests as a painful rash over the corresponding dermatome, (4)(Zagaria 2002) Patients report burning, aching, painful itching, electric shock-like pain, and extremely sensitive skin pain (allodynia).

Postherpetic neuralgia (PHN) is the persistence of the pain of herpes zoster which lasts longer than three months after resolution of the rash. One study describing 208 cases of PHN reported that 48 percent of patients continued to have pain one year after onset (Watson 1998). Unfortunately, PHN is very common, affecting 10-15 percent of patients who suffer from shingles (5)(Dubinski 2004). Patients at risk for developing PHN include populations with a weakened immune system, such as cancer patients, those who are HIV-positive, AIDS patients, or those taking immunosuppresant drugs (2)(Nicosa 2007), (7)(Modi 2000), (8)(Lojeski 2000). Also, the incidence and severity of PHN increases with age as a result of an age-related decline in (VZV)-specific cell-mediated immunity (6)(Sadoski 2008).

Clinically, PHN has always been a difficult condition to manage. In 2008 a VZV vaccine became available; however, studies indicated it was only 51 percent effective in preventing zoster (9) (Oxman 2008). Typical treatment regimens often include opiates, sedative hypnotics, and anxiolytics, which have dangerous addiction liability and limited clinical efficacy.

Acupuncture is gaining respect as a valid medical discipline. Bolstered by the 1997 National Institutes of Health Consensus Conference (10)(NIH 1998), and high-profile clinical trials demonstrating efficacy (11,12,13), acupuncture is now increasingly recognized as a valuable adjunct to conventional medical treatments. In addition to providing pain relief for PHN, acupuncture may have beneficial effects on the immune system. Several studies suggest that acupuncture may modulate the immune system and improve T-lymphocyte levels (14, 15, 16). This is especially relevant to the PHN population, given that many PHN patients are immunocompromised. Acupuncture thus offers great promise in the alleviation of PHN and its symptoms and is safe for the patient population which is most vulnerable. (16)

Patients and Methods

At a Midwestern hospital pain center, PHN patients received a multidisciplinary assessment by both the anesthesiologist/pain fellow and the acupuncturist. If the shingles outbreak was more than six weeks prior, the physicians initially managed the pain with medications, but these patients were also given the option to try acupuncture. Patients who received acupuncture were jointly followed by the MD to manage medication.

The data for thirteen patients were reviewed for this retrospective analysis. Demographic data are presented in Table 1. All patients were prescribed antiviral medication within the first seven days of the shingles outbreak. Ten patients presented to the clinic. They were then currently taking anti-seizure medication, gabapentin or pregabalin, and opioids. Three patients were prescribed Metanx (high B-12, B-6, and folate) by the anesthesiology pain team. In addition, some patients had been given topical analgesics, lidocaine 5 percent patch, Aspercream, and capsaicin cream. Ten of the thirteen patients reported high anxiety in addition to pain, and four were additionally prescribed anti-anxiety medication. Details are presented in Table 2.

Pain was assessed using 2 visual analogue scales. The first scale for allodynia and the second for shock-like pain. Allodynia is hypersensitive, irritating skin pain that is associated with the nerve endings. This form of pain is always present and may increase in severity with mild stimuli of the skin along the affected dermatome path. The shock-like pain travels the entire dermatome path from nerve root to the nerve endings and can last for up to thirty seconds.

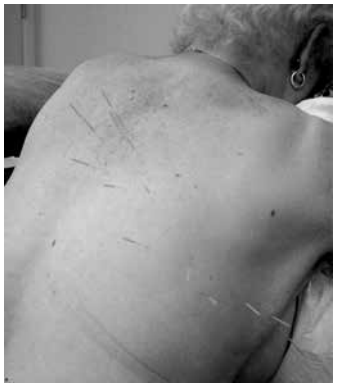
For consistency, a single licensed acupuncturist performed all treatments. The treatment strategy involved a novel and innovative modified "surround the dragon" technique. However, due to the hypersensitivity of the skin and the chance of increasing pain, no palpation was used.

Table 1.

Patient	Age	Duration/ months	Presentation
1	78	8	Thoracic
2	78	24	Thoracic
3	83	10	Cervical
4	84	5	Thoracic
5	59	1	Thoracic
6	72	12	Thoracic
7	80	4	Thoracic
8	78	5	Lumbar
9	87	6	Cervical
10	64	2	Thoracic
11	81	1	Thoracic
12	68	5	Thoracic
13	68	2	Trigeminal

Point regimen was tailored for each patient and consisted of gentle needling along the affected dermatome path from the nerve root to the distribution of nerve endings (Figure 1). No additional classical acupuncture points were used. Twenty to thirty (SEIRIN® J-Type0.20x30mm) filiform needles were inserted at a depth of 1 cm.

Figure 1.



Additional needles were inserted through the supraspinous ligament and into the intraspinous ligaments between the spinous processes of the affected vertebra in the *Du, Governing Vessel* meridian. Needles were retained for 20 minutes. Dose was two times a week for one to two weeks depending on the severity. Frequency was then reduced to one time weekly and every other week until the pain was eliminated. Narcotic medication was weaned at a rate of approximately 25 percent per week. Gabapentin and Pregabalin were weaned after a significant drop in narcotic at the same rate.

Results

Patients received a median of seven acupuncture treatments (range 4-11). Pain was reported on a scale from 0-10 for both "allodynia" skin pain and the "shock-like" nerve pain. All patients reported a lower number for the allodynia and a higher number for the shock-like pain indicating significant relief of this pain at the conclusion of treatment. Furthermore, patients reported no pain with needle insertion and no adverse events occurred. Analysis using a Paired t-tests revealed that post-treatment ratings for both measures were significantly improved as compared to pre-treatment ratings ($p < 0.001$) (see Figure 2)

Ten of the thirteen patients presented to the clinic on pain medication (see Table 2). Of those ten, seven patients (70 percent) were completely weaned off all pain medications by the end of their treatments. Although anxiety was not measured, patients reported decrease in anxiety as their pain decreased. Two of three patients who were prescribed Amitriptyline for PHN related insomnia and anxiety were able to be weaned off of the Amitriptyline by the end of the treatments. Six patients with sufficient follow-up (both in person and by telephone) reported no pain eight to twelve months after treatment. Details may be reviewed in previous report (17)(Stone 2010).

Table 2.

Patient	Before Acupuncture	After Acupuncture
1	hydocodone 5-500mg/6hrs gabapentin 300mg/6hrs lidocaine 5 percent patch/12hrs Mentanex (high b-12, b-6, and folate)	no meds
2	fentanyl 25mg/72hrs paroxetine 40 mg	fentanyl 25mg/72hrs paroxetine 40 mg
3	hydrocodone 10-1000mg/6hrs, gabapentin 1200mg/6hrs, amitriptyline 50mg/pm, salicylic acid cream valcyclovir500mg/12hrs	hydrocodone 10-1000mg/6hrs, gabapentin 1200mg/6hrs, amitriptyline 50mg/pm, salicylic acid cream valcyclovir 500mg/12hrs
4	no meds	no meds
5	pregabilin 75mg/8hrs ametriptyline 50mg/pm prednisone 10mg Mentanex (high b-12, b-6, and folate)	no meds
6	no meds	no meds
7	gabapentin 100mg/12hrs amitriptyline 25mg/pm acyclovir 800mg/12hrs	no meds
8	no meds	no meds
9	gabapentin 100mg/12hrs amitriptyline 25mg/pm acyclovir 800mg/12hrs	no meds
10	oxymorphone 5mg/4hrs Fentanyl 50mg/72hrs carbamazepine 200mg/4hrs buytl/APAP/caff/cod 30mg	Mentanex (high b-12, b-6, and folate)
11	hydrocodone 5-500mg/6hrs	no meds
12	gabapentin 300mg/8hrs hydrocodone 7-750mg/6hrs lidocaine 5 percent patch/12hrs	no meds
13	gabapentin 300mg/8hrs carbamazepine 200mg/4hrs	gabapentin 300mg/8hrs carbamazepine 200mg/4hrs

Discussion

There is an extensive body of research on all forms and types of pharmaceutical therapies for PHN. A detailed discussion of this literature can be found in our previous report (17, 18)(Stone 2010). However, a huge gap exists on data for studies using acupuncture for postherpetic neuralgia. A MEDLINE search revealed only three case reports using different point combinations, with two of the studies using needling along the affected dermatome path. (19, 20)

Figure 2.

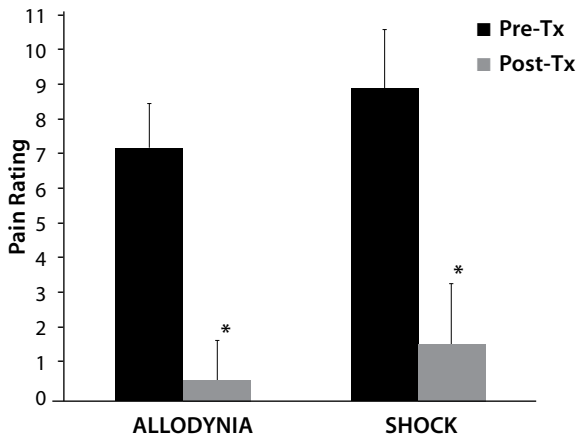


Figure 2. Mean + s.d. allodynia ratings pre- and post-treatment were 7.15 + 1.28 and 0.54 + 1.66, respectively. Mean "shock" pain ratings were 8.85 + 1.07 pre-treatment, and 1.46 + 1.85 post-treatment. Paired t-tests revealed that pre- and post-treatment ratings for both measures were highly statistically significant. ($p < 0.00000001$)

Traditional Chinese medicine (TCM) theory explains shingles/PHN as toxic Wind Heat *bi* syndrome. Many PHN patients show signs of heart *shen* disturbance (anxiety). TCM treatment strategy involves releasing wind heat, quelling the *shen* and harmonizing the body

A deviation from the TCM theory of harmonizing the body, the dermatome treatment was a collective design of both the acupuncturist and the anesthesiology pain team and was focused around the anatomical location of the affected dermatome including the nerve root and its branches (see Figure 2). TCM theory might describe the dermatome treatment as a modified "surround the dragon" technique which focuses on local needling at painful (*a-shi*) points. In this limited study, the exclusive use of the dermatome therapy shows promising results in the treatment of PHN pain and co-morbidities (insomnia/anxiety). Possible mechanisms of action for the positive effects of the acupuncture treatment include increased circulation, muscle relaxation and neuromodulation and can be reviewed in our previous papers. (17, 22)

This study has provided support that postherpetic neuralgia may be a novel clinical model for general neuropathic pain (21), which can be studied with traditional TCM treatment.

Conclusion

Studying the effect of acupuncture in PHN is directly relevant to public health. Acupuncture can potentially reduce use of highly addictive, sedative drugs used for neuropathic pain management. Assessment of multiple acupuncture treatment strategies will provide insight into the effectiveness of the different point regimens and ultimately lead to a broader range of non-narcotic treatment options for many types of pain.

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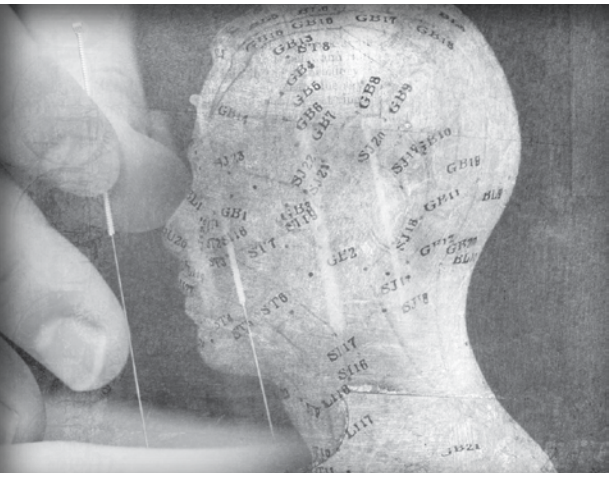

Resolution of Erectile Dysfunction in HIV-positive Male: A Case Report

By Larry Langowski, PhD and Timothy I. Suh, LAc

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Abstract

Erectile dysfunction (ED) is one of the most common complaints in HIV-positive men. This case report concerns a 54-year-old HIV-positive male seeking help with ED at a free acupuncture clinic for the HIV-positive male population. Acupuncture was performed every other week for a total of six treatments, resulting in the patient achieving erection for the first time in five years. This suggests that acupuncture should be studied as a treatment for ED.

Key Words: acupuncture, erectile dysfunction, HIV-positive male population

Introduction and Biomedical Perspective

In a review of the Massachusetts Male Aging Study survey of men ages 40-70, fifty-two percent of respondents reported some degree of erectile difficulty. Erectile dysfunction (ED) (Feldman, et al. 1994) is multifactorial in its etiology. There are organic, physiologic, endocrine and psychogenic factors; however, pure psychogenic ED is uncommon. There are many diseases that may affect erectile function by altering nervous, vascular or hormonal systems (Brosman, 2010). Examples include obesity, hypertension, hyperlipidemia, diabetes mellitus, metabolic syndrome and psychiatric disease (e.g., anxiety, depression).

Pharmaceuticals taken for other reasons can cause ED as a side effect. They range from diuretics and high blood pressure drugs, antidepressants, anti-anxiety drugs, and antiepileptic drugs to chemotherapy drugs. Some recreational drugs are also linked to ED. The National Kidney & Urologic Diseases Information Clearinghouse and WebMD list a number of drugs that are linked to ED. See Table 1.

The prevalence of ED in the HIV-positive male population is greater than in the population at large, with some studies reporting prevalence of up to 74 percent. Its etiology is unclear (Crum-Cianflone, et al., 2007). Some studies have implicated the drugs used in antiretroviral regimens used to control the disease can cause ED.

ED in the HIV-positive population can take a great psychological toll. Biological and organic pathologies secondary or comorbid to HIV can also affect the ability to have an erection (Crum-Cianflone, et al., 2007).

Introduction & AOM Background

In acupuncture and Oriental medicine (AOM), ED is translated as *yang wei* syndrome, with *yang* referring to penis and *wei* referring to flaccidity. It pertains to either the inability to attain erection or the ability to attain only partial erection. Traditionally this is thought to be caused by an overindulgence of sexual activity or by emotional disturbances. The over indulgence of sex and ejaculation indicates a loss of the Essence (Fire at Life Gate), which is stored in the kidneys and, if depleted, can cause flaccidity. The main manifestations of decline of Kidney Fire are an inability or weak erection of the penis, pallor, cold extremities, dizziness, listlessness, soreness and weakness of the loins and knees, frequent urination, pale tongue with white coating, and deep thread pulse (Cheng & Deng, 1999).

There is also the thought that a downpour of Damp Heat in to the Lower Burner can cause *yang wei* syndrome. Damp Heat in the Lower Burner is thought to be indicated by inability to achieve or sustain erection, sweating of the scrotum, heavy aching in lower limbs, thirst, bitter taste in the mouth, and dark urine. According to Wu and Fischer, traditionally this etiology is rare but pertinent to the HIV-positive population discussed here (Wu & Fischer, 1997).

In the treatment of internal disorders, "the ability of penis to erect is due to the injury of the internal organs, which is mainly caused by the exhaustion of Kidney Essence from indulgent sexual activity, or by worry damaging the mind, or by fright leading to dysfunction of the Kidney" (Cheng & Deng, 1999). In the context of a disease as frightening and stigmatized as HIV infection, the worry and fright elements of AOM theory might sufficiently explain the exhaustion of Kidney Essence, although medication side-effects cannot be ruled out.

A systematic review of the current research in Western medical and AOM databases shows insufficient evidence to suggest that acupuncture is an effective intervention for treating ED (Lee, Shin, & Ernst, 2009), with Lee et al. stating that further research is required to determine if there are specific benefits using acupuncture for men with ED. A 2009 article from the Republic of China (Yang, 2009) reported a 76 percent efficacy rate in the group using acupuncture treatment only. These variations in results only demonstrate the great need for more research on AOM's relation to ED.

Table 1. Point Rationale

Type Of Drug	Generic And Brand Names
Diuretics and high blood pressure drugs	Hydrochlorothiazide (Esidrix, HydroDIURIL, Hydropres, Inderide, Moduretic, Oretic, Lotensin), Chlorthalidone (Hygroton), Triamterene (Maxide, Dyazide), Furosemide (Lasix), Bumetanide (Bumex), Guanfacine (Tenex), Methyldopa (Aldomet), Clonidine (Catapres), Verapamil (Calan, Isoptin, Verelan), Nifedipine (Adalat, Procardia), Hydralazine (Apresoline), Captopril (Capoten), Enalapril (Vasotec), Metoprolol (Lopressor), Propranolol (Inderal), Labetalol (Normodyne), Atenolol (Tenormin), Phenoxybenzamine (Dibenzyline), Spironolactone (Aldactone)
Antidepressants, anti-anxiety drugs, and antiepileptic drugs	Fluoxetine (Prozac), Tranylcypromine (Parnate), Sertraline (Zoloft), Isocarboxazid (Marplan), Amitriptyline (Elavil), Amoxipine (Asendin), Clomipramine (Anafranil), Desipramine (Norpramin), Nortriptyline (Pamelor), Phenelzine (Nardil), Buspirone (Buspar), Chlordiazepoxide (Librium), Clorazepate (Tranxene), Diazepam (Valium), Doxepin (Sinequan), Imipramine (Tofranil), Lorazepam (Ativan), Oxazepam (Serax) Phenytoin (Dilantin)
Antihistamines	Dimehydrinate (Dramamine), Diphenhydramine (Benadryl), Hydroxyzine (Vistaril), Meclizine (Antivert), Promethazine (Phenergan)
Non-steroidal anti-inflammatory drugs	Naproxen (Anaprox, Naprelan, Naprosyn) Indomethacin (Indocin)
Parkinson's disease medications	Biperiden (Akineton) Benztropine (Cogentin), Trihexyphenidyl (Artane), Procyclidine (Kemadrin), Bromocriptine (Parlodel), Levodopa (Sinemet)
Antiarrythmics	Disopyramide (Norpace)
Histamine H2-receptor antagonists	Cimetidine (Tagamet), Nizatidine (Axid), Ranitidine (Zantac)
Muscle relaxants	Cyclobenzaprine (Flexeril), Orphenadrine (Norflex)
Prostate cancer medications	Flutamide (Eulexin), Leuprolide (Lupron)
Chemotherapy drugs	Busulfan (Myleran), Cyclophosphamide (Cytoxan)

http://www.webmd.com/erectile-dysfunction/guide/drugs-linked-erectile-dysfunction

Case History

In March 2011, a 57-year-old HIV-positive male with a diagnosis of AIDS presented himself for treatment at our free acupuncture clinic for HIV-positive patients. His main complaint was low energy. This patient is a 20-year survivor of HIV and AIDS, with an extensive medical history. In addition to being diagnosed with AIDS in 2000, he has also been diagnosed with chronic obstructive pulmonary disorder, hepatitis C, spinal stenosis and fibromyalgia. He smokes about a pack of cigarettes each day. His pharmaceutical regimen consists of atazanavir (300mg QD),

emtricitabine/tenofovir/efavirenz (fixed-dose combination, 200/300/600mg QD), ritonavir (100mg QD), montelukast (10mg BID), budesonide/formoterol (12mcg QD), pregabalin (75mg BID), and tramadol (50mg TID).

Additional relevant health information states: subjectively, the patient runs hot; he perspires in the heat and upon exertion and at night; he has pain and soreness all over; he says he has spinal stenosis from lumbar 2 to lumbar 5; due to long history of smoking he has a cough and chest congestion with yellow sputum; he denies any abdominal issues; he craves sweets and is thirsty all the time; he urinates frequently; he denies any problems with his bowels; he has occasional floaters in his vision and his hearing is good; he sleeps 5.5-6.5 hours per night with occasionally vivid dreams; he complains of poor libido without an erection for five years; he states his energy is "just ok."

The patient's tongue was red, the tongue body swollen, but it did not have a coat. The tongue's sublingual veins were purple and distended. Pulses were rapid and wiry overall on both sides but deeper on his left side.

The patient presented with history of AIDS diagnosis, but his viral load and CD4+ T-cell count, historical or most recent results, were not available.

Patient Diagnosis and Treatment

The patient was diagnosed with *yin* deficiency of the Kidney and Lungs as well as toxic heat. *Yin* deficiency is confirmed by no tongue coat, red tongue color, rapid pulse, heat, and perspiration at night—the organs most influenced by this deficiency are kidneys and lungs. The confirmation of Kidney association is low back pain with lumbar spinal stenosis. The Lung involvement is confirmed by the cough, chronic obstructive pulmonary disease, and chest congestion. The toxic heat is a result of the HIV infection and diagnosis with AIDS. All the signs and symptoms are presently under control with antiretroviral treatment.

The treatment plan called for six treatments every other week for twelve weeks. One to two inch needles (DBC brand, 32 [0.25 mm] gauge) were used. Needles were retained for twenty minutes during each treatment. The goal in treatment was to nourish the *yin* of the lungs and kidney, clear heat and resolve toxicity, upon which was overlaid a three point treatment for his reported ED.

Only acupuncture was chosen due to the limited scope of practice in the state in which the treatments were given. Point rationale is shown in in Table 2. These points were used in each of the following five treatments at the patient's request after his initial treatment. The patient was treated by four different clinicians, using these points only, at this free acupuncture clinic.

"Testing pertinent and appropriate biomarkers may also give us insight as to how acupuncture works. Androgen replacement therapy with or without acupuncture could also be assessed. This would clarify the direct relationship acupuncture might have on this population. Learning more about how acupuncture can ameliorate ED can be of great value to the HIV-positive population."

Table 2. Point Rationale

Points	Reason for Use
LU-5 (chize) CV-17 (shanzong)	treat for Lung deficiency and heat
KD-3 (taixi), SP-6 (sanyinjiao) ST-36 (zusanli)	nourish Kidney *yin* and increase energy
ST-44 (neiting) LI-11 (quchi)	clear heat and resolve toxicity
LV-3 (taichong) LV-5 (ligou) ST-27 (daju) CV-4 (guanyuan)	fortify the original *qi*, benefit essence, regulate *qi* and benefit the genitals

Results

As a result of the first treatment, the patient reported that he was sleeping better, his breathing was easier, and his libido seemed to be increasing. He said he had achieved an erection after not achieving one for the past five years and that he had the ability to achieve erections for up to one week each after the first and second treatments. After the third treatment he noted that his ability to achieve erections lasted up to two weeks. He continued to experience an increase in libido, which made him feel more positive and energetic. In a follow-up interview six months after the treatments had stopped, the patient stated that he had been able to achieve erections for 6 weeks after the final acupuncture session/treatment.

Discussion/Conclusion

This is a report of one case, consisting of six acupuncture sessions/treatments used to treat an HIV-positive male presenting with a history of erectile dysfunction along with many other comorbidities. The patient stated that he had not been able to achieve an erection in five years and, when he believed the initial point prescription had a positive effect on his capacity to achieve an erection, he requested that the same protocol be repeated for all five subsequent treatments.

Further research on larger groups of HIV-positive males is needed to investigate both the effectiveness of a standardized treatment for ED and the mechanisms by which the treatment works. One of the ways to accomplish this is to use research techniques suggested by the Patient Centered Outcomes Research Institute. http://www.pcori.org/content/research-methodology.

Testing pertinent and appropriate biomarkers may also give us insight as to how acupuncture works. Androgen replacement therapy with or without acupuncture could also be assessed. This would clarify the direct relationship acupuncture might have on this population. Learning more about how acupuncture can ameliorate ED can be of great value to the HIV-positive population.

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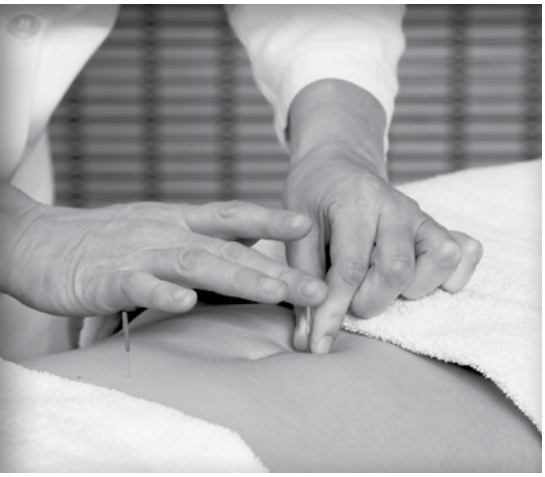

Acute Dysmenorrhea Treatment with Electro-Acupuncture: A Case Report

By Sara O'Byrne, DAOM, MAcOM, LAc, Dipl OM (NCCAOM)

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Abstract

A 27-year-old female presented with dysmenorrhea on day one of her menstrual cycle. She reported cramping and burning pain as 7/10 in severity on the Visual Analogue Pain Scale (VAS). Treatment with acupuncture and electro stimulation on DiJi SP-8 relieved her pain. This case demonstrates the effective treatment of acute dysmenorrhea. This quick and easy way to administer acupuncture treatment may help women increase productivity during their menstrual cycle. It may be a good option for patients who are sensitive to or concerned about taking non-steroidal anti-inflammatory drugs (NSAIDs) or other pharmaceutical intervention for the short term acute treatment of dysmenorrhea. NSAIDs are associated with upper and lower gastrointestinal complications, exacerbation of hypertension, myocardial infarction, heart failure and kidney toxicity. Many patients are aware of these risks and have chosen to limit their NSAID use.

Key Words: acupuncture, dysmenorrhea, electro-acupuncture

Introduction

Background

There are two types of dysmenorrhea. Primary dysmenorrhea in women is diagnosed when menstruation-related pelvic pain cannot be traced to structural abnormalities or an organic cause. Secondary dysmenorrhea is diagnosed as menstrual pelvic pain that has an organic cause. Onset of dysmenorrhea generally occurs after menarche when ovulatory cycles commence.

Dysmenorrhea is a common and possibly underreported condition that affects 45-95 percent of women in the U.S.[1] The widespread use of combined oral contraceptives with non-steroidal anti-inflammatory drugs (NSAIDs) to decrease dysmenorrhea is said to increase by four the likelihood of thrombosis in healthy women.[1]

Although many women experience a diminished incidence of menstrual cramping after adolescence, painful periods are often problematic for many women of reproductive age.[2] Dysmenorrhea is more common in women who have both an early onset of menarche and a menstrual flow of long duration. Cigarette smokers are found to have a higher incidence of this condition.[2] Absenteeism and loss of productivity due to dysmenorrhea is a significant

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problem;[3] women miss work, school, and recreational and social activities due to menstrual-related pain. Dysmenorrhea also can contribute to low self-esteem and low self-worth in young women.[4]

First-line treatment for dysmenorrhea is generally over the counter non-steroidal anti-inflammatory drugs (NSAIDs). If pain is refractory after three cycles, oral contraceptives are advised. If dysmenorrhea persists with oral contraceptive use, surgical investigation, such as laparoscopic surgery of the pelvis, is warranted to rule out and treat endometriosis or other organic pathologies.[5] If symptoms, such as post-coital bleeding, menorrhagia, dyspareunia, persist, a referral for further investigation is warranted.[3]

Acupuncture and Oriental Medicine

One acupuncture point indicated to treat dysmenorrhea and abdominal masses in women, Diji SP-8, is located three cun below SP-9. The group of acupuncture points, known as Xi cleft points, is indicated for acute pain.[6] Deadman suggests using this point for acute dysmenorrhea with the addition of electro acupuncture—the application of acupuncture through mild electrical current, which assures a quantifiable way to measure the amount of stimulation to the needle.[6] It is theorized that electro acupuncture may be more beneficial in certain conditions than non-electro acupuncture,[7] with some studies showing its effectiveness in treating primary dysmenorrhea.[8]

Recent systematic reviews and meta-analyses have shown acupuncture to be effective for short-term pain management of dysmenorrhea.[9] Other studies suggest acupressure may be as effective as NSAIDs in relieving dysmenorrhea.[5]

Case Details

On the first day of her menstrual cycle in September 2013, a 27-year-old nulliparous female with acute menstrual cramping presented to the clinic. Her pain, at 7/10 on the Visual Analogue Pain Scale (VAS), was localized in a fixed position to her lower abdomen and did not radiate. She had experienced dysmenorrhea since menarche at age 11 and had regular, 28-day cycles with 5-7 days of menstrual bleeding. The patient was not currently on prescription birth control; condoms were used for contraception and she was not attempting to become pregnant. Her menstrual blood was bright red with clots. The menstrual pain had progressively worsened over the past two years during a period of time when she was experiencing significant emotional stress. The patient had been smoking 5-7 cigarettes daily for two years and drank an average of four alcoholic beverages a week. Within the past six months she had experienced the rupture of two ovarian cysts. A 2x2cm cyst on her right ovary was diagnosed by the emergency department on July 9, 2013.

Her bowel movements alternated between constipation and loose stools. She was frequently bloated. Her energy level was low and she reported being stressed frequently. She sighed several times during the intake. She was not overweight though she reported having gained five pounds in the past few months.

Her tongue had bright red sides with bright red prickles and a thick greasy yellow coat. The coat was thicker and darker in the posterior aspect of the tongue. She also had very engorged sublingual veins. The pulse was wiry, slippery and slightly rapid in all positions.

During usage of oral contraceptives for several years, the patient experienced less dysmenorrhea, and any pain responded well to NSAID use. Because the patient was concerned about long-term contraceptive and NSAID use, she sought acupuncture as an alternative for pain management.

Diagnosis

Damp Heat with phlegm, which can be attributed to the patient's diet and smoking habit, and Blood stasis, which can occur after traumatic injury and/or prolonged stress, are common diagnoses for women suffering from dysmenorrhea—causing sharp, stabbing, burning, and cramping pain. Damp Heat with phlegm can manifest as ovarian cysts.[10] Both the red tongue body and yellow coat as well as wiry and slippery pulse also confirmed Damp Heat with phlegm, while the engorged sublingual veins confirmed the presence of Blood stasis. Liver *qi* stagnation was diagnosed by a wiry pulse, subjective reporting of stress, and her frequent sighing

during the intake. Liver *qi* overacting spleen was diagnosed by Liver *qi* stagnation signs and the alternating constipation and diarrhea.

Treatment

Two acupuncture needles were used, bilateral SP-8. The needling depth was approximately 1cun deep at a perpendicular angle until the patient experienced a subject sense of pressure and heaviness around the needling location. Electrical stimulation between the two SP-8 points was performed at 5/100 mixed frequency for a duration of 25 minutes. KPC brand .22X.30 stainless steel needles were used. No other acupuncture points or interventions were used.

Results

Initially the patient's pain drastically decreased from a 7/10 to 0.5/10 pain level. After treatment, the patient had 0.5/10 pain which lasted 2 hours after treatment. Her pain increased to 3/10 for approximately 20 minutes 2 hours after treatment, which then decreased to 0/10. She experienced no return of the pain for the remainder of this cycle.

Discussion

Although this case indicates there are many areas where diet and lifestyle changes could possibly prevent future dysmenorrhea symptoms, the acute management of dysmenorrhea is a frequent complaint in young woman. Because women with dysmenorrhea often complain they miss work and cannot participate in social activities, this quick, easy way to administer acupuncture treatment may help women stay active during their menstrual cycle. For this patient, the application of SP-8 with electro stimulation dramatically decreased her menstrual cramps. This treatment may not be applicable to all women, since treatment of dysmenorrhea with acupuncture heavily depends on point selection based on Chinese medical diagnosis; however, treatment of this point may offer rapid reduction of acute dysmenorrhea regardless of etiology.

It is unknown if a diagnosis of primary or secondary dysmenorrhea is important in this case. It is possible this patient has undiagnosed secondary dysmenorrhea or endometriosis, but without laparoscopic surgery to confirm abnormal pathology we cannot be sure this patient has primary dysmenorrhea alone. Further research is needed to assess the effectiveness of acupuncture on primary versus secondary dysmenorrhea.

The treatment in this case study was not intended to prevent future menstrual cramping episodes. Rather, the importance of this case is to address the management of acute dysmenorrhea as it occurs. For women experiencing severe menstrual cramps, immediate relief is needed. For this patient, a treatment plan was devised to prevent future episodes. This plan included acupuncture, herbs, diet, and lifestyle changes.

DiJi SP-8 may be an appropriate acupuncture point for the treatment of acute dysmenorrhea regardless of etiology, therefore her TCM diagnosis may be irrelevant to successfully treatment of her pain. This symptomatic treatment may not address the long-term prevention of menstrual cramps. The goal of treatment was to relieve acute pain quickly and was successful in this case.

Conclusion

Administering electro acupuncture on Diji SP-8 may be effective to treat acute dysmenorrhea in some women. It may be a good option for patients who are sensitive to or are concerned about taking NSAIDs or oral contraceptives. Large scale, long term studies need to be conducted to evaluate the effectiveness and efficacy of this treatment.

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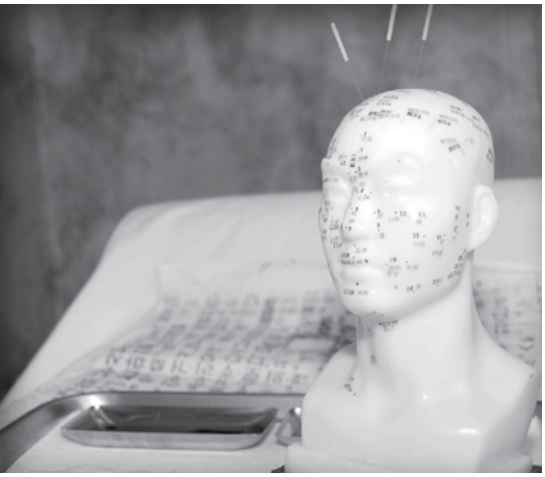

Why Do Case Reports? How These Can Benefit our Profession

By Timothy I. Suh, DAOM, LAc

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Western medical publications repeatedly state that there is not enough evidence that acupuncture works.[1] However, for generations, many aspects of acupuncture have been studied and documented as case reports (aka case studies). As practitioners, it is our responsibility to continue the case report tradition by documenting clinical outcomes thereby creating a centralized database. Presented here are two guidelines that can help our profession create this centralized database.

Key Words: acupuncture, database, research, evidence-base, case report

To Research or Not to Research?

Many practitioners in the acupuncture and Oriental medicine (AOM) field have the notion that one has to "believe in the *qi*" or that *qi* is "immeasurable." My response to those who thus feel, therefore, that "no research is necessary to validate it," is that it *is* measureable. The wisdom handed down from the ancient physicians is a culmination of observations of real-life physical as well as metabolic characteristics and changes. As they did then, the documentation of current clinical practices now can and should continue to support the evolution of the acupuncture and Oriental medicine (AOM).

Practitioners need to stop accepting its tenets and procedures as a matter of "blind faith" and actively investigate the scientific reasons why and how our medicine works. There is no western medicine or eastern medicine; there are just different, equally valid and valuable perspectives. Eastern medicine is not all-encompassing, and for us to ignore other medical perspectives but our own blinds us and ultimately limits our patient care.

The best way to strengthen our profession is to perform valid scientific research that shows our medicine works—just as the ancients have shown us. One of the best ways to do this is to create and publish peer reviewed case reports about both successful and failed clinical treatments. With a strong database of published cases, this will engender more opportunities for research and help to solidify AOM among today's approaches to medicine.

As most AOM practitioners are aware, more and more MDs, PTs and DCs are treating patients using AOM modalities.[2,3,4] By not billing it "acupuncture" per se, they are paid by insurance companies and Medicare for the same procedures and approaches that AOM

providers are trained to do and have done for thousands of years.[5] The AOM clinical practice is denigrated because what we do is "not evidence-based," but, at the same time, it is *exactly* the procedure these other medical providers use and are reimbursed for. This is possible because other professions validate their actions with their own research, thus creating a market for their brand of AOM.[6] This is all the more reason why a centralized data base of case reports needs to be created and maintained by members of the AOM profession.

How Can a Case Report Help?

Here is one interesting fact: Surgical procedures for many medical situations are promoted and developed primarily by the sharing of case reports. It is very difficult to do a randomized controlled trial on a surgical procedure.[11] A new surgery procedure is carefully thought out, hypothesized by the surgeon, and then this procedure is performed on a patient who evidences the need for this. If successful, a write-up is submitted to a peer reviewed publication, published as a case, and is made available to be considered and replicated by other surgeons.

If it proves to be continuously successful, this becomes evidence and proof that the procedure works. The treatment modality is then taught to colleagues and students, thus becoming protocol. This process sounds very similar to what we acupuncturists have been doing for thousands of years. Case reports are not just clinical stories that get lost in the shuffle of published articles. We cannot assume, as many do, that Western medicine will ignore case reports published by our profession.

Just as surgical case reports promote and further their medical specialties, I challenge all acupuncturists and Oriental medicine providers to write case reports as well as all types of scientific research papers to promote our medicine to our colleagues and to advance patient care.

Our Past…

In the *Huang Di Nei Jing Su Wen*, the manner in which one learns is through question and answer. The answers are not illogical nor are they mystical. They are a perspective of a wise person's observations of the universe. Over a millennia, there have been countless teachers from many countries who have practiced this medicine and taken the time and effort to document their observations. To honor their efforts and strengthen the medicine, this tradition should be continued. So, yes, it is part of our history to write case reports.

"During the past several years, more and more research conferences, even those concerned primarily with western medicine, have requested acupuncture research presentations. However, not enough acupuncturists are doing this research—or they are not the principal investigator or lead author of such studies. Therefore the shortage of evidence for acupuncture presented by acupuncturists continues to be the case."

Our Present…

Two directors from prominent northeast and midwest medical training institutions were recently appointed to positions in major hospitals in the midwest. They were approached by their hospital staff physicians who requested the use of acupuncture in their respective hospitals. Both directors rejected this, stating that acupuncture is not an evidence-based medicine and/or that there is not enough evidence that it works. An interesting point is that these directors each come from prestigious institutions that do promote and use acupuncture as a matter of course!

Due to this supposed lack of solid evidence that acupuncture works, insurance companies generally do not pay for the procedure, although several plans do allow for payment in some cases. It is a fact that Kaiser Permanente conducted research indicating that acupuncture to treat chronic low back pain is more effective than other standards of care, i.e., physical therapy and the dispensing of pharmaceutical medications.[9] The AOM profession needs to promote and do more of this research such that all insurance companies will join Kaiser Permanente in covering acupuncture treatments.

During the past several years, more and more research conferences, even those concerned primarily with western medicine, have requested acupuncture research presentations. However, not enough acupuncturists are doing this research—or they are not the principal investigator or lead author of such studies. Therefore the shortage of evidence for acupuncture presented by acupuncturists continues to be the case.

Several professional organizations that do promote and publicize these studies are:

- The Society of Acupuncture Research (SAR) is an important and respected organization that focuses on professional, peer reviewed scientific research in our field.
- The Society for Integrative Oncology (SIO) has a commendable interest not only in acupuncture but Chinese medicine as a whole.
- The Consortium for Academic Health Centers for Integrative Medicine in association with the International Society for Complementary Medicine Research has hosted the International Research Congress of Integrative Medicine and Health symposiums, which also includes research in AOM.

It would serve all of us well to read about what the research presented at their conferences; abstracts should be made easily available to *all* interested parties, not just organization members, as a follow up to these events.

Sources for Case Report Writing

An excellent and concise description of the types of case reports, including the stages of writing and the format or "anatomy" of these reports, has been authored by Sivarama Prasad Vinjamury, MAOM, MPH, MD (Ayurveda). It is appended to the Author Guidelines of this journal (http://www.meridiansjaom.com/files/Case_Report_Outline_Vinjamury.pdf). Dr. Vinjamury provides a checklist to help writers stay on track when writing the case report.[12] This article should be required reading for all acupuncture students and acupuncturists who are new to the art and science of case writing.

Another very helpful source is the CAse REport (CARE) guidelines described by David Riley, MD. His website, http://www.care-statement.org, provides additional information regarding the specifics of the case report content.

Dr. Riley's innovative framework includes a defined set of 13 criterion that, when consistently used, creates an easily accessible electronic database available to those who want information about any kind of medical reporting. Each section is searchable and can be indexed to easily produce meta-analyses. The growth of this database will create a valuable resource of evidence-based research. It is a very user-friendly source, and acupuncturists are strongly encouraged to utilize it.

"Surgical procedures for many medical situations are promoted and developed primarily by the sharing of case reports. It is very difficult to do a randomized controlled trial on a surgical procedure.[11]"

Conclusion

It is vitally important that acupuncturists continue the historical tradition of documenting case outcomes. As with all medicine, one learns from success as well as from clinical outcomes that may differ from initial expectation. Case reports contribute to foundational material that can be utilized for additional clinical research as well as submission to AOM journals. Writing case reports and publicizing is an important way to maintain this professional tradition and to further benefit patients.

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Bowel Movements—How Many and with What Frequency?

By Jame'e Brazie'r, DAOM, LAc, DiplOm (NCCAOM)

Jame'e Brazie'r, DAOM, LAc, DiplOM (NCCAOM) received his master's degree from Samra University of Oriental Medicine in Los Angeles, California, and his DAOM from Five Branches University, San Jose, California. Dr. Brazie'r spent a month pursuing advanced training through study of Oriental medicine and work in several hospitals in Beijing, China. With over 20 years experience in both western and natural medicine, he uses an eclectic style of treatments: Five Element acupuncture, esoteric acupuncture theory, Korean four-point, Reiki, and massage to treat a variety of physical, emotional and psychological imbalances. Dr. Brazie'r's practice, Three Lotus Dragon Acupuncture Wellness Center, is located in San Mateo, California.

Abstract

Purpose: A minimal amount of modern research has been conducted concerning what are "normal bowel habits." There is no determined standard of frequency and volume. This paper explores this issue by comparing classical Chinese to modern observations on this topic.

Methods: Modern research is compared with the ancient Chinese texts of the *Nan Jing* and *Nei Jing* to obtain a baseline of normal bowel function. Research sources includes: *The Merck Manual of Diagnosis and Therapy*, 16th ed., *Dorland's Illustrated Medical Dictionary,* 24th ed., *Taber's Cyclopedic Medical Dictionary,* 13th ed., Pubmed with search results for "bowel movement frequency," "defecation frequency" and studies and lecture notes on bowel movements by present day practitioners. In assessing this data, recent survey studies and content from ancient classical texts were compared with the author's clinical experience.

Discussion: Only a few valid modern studies were found. These included a diversity of ages and genders and were about populations of several countries. The studies were all surveys on various aspects of bowel movements. Although the data was not able to determine the normal frequency, one study did note a difference in transit time for males and females.

Conclusion: The classical texts *Nan Jing* and *Nei Jing* state that expected, normal bowel movement frequency is a minimum of two per day, and that, regarding frequency, a bowel movement for every meal, equal to the volume of food consumed, can be regarded as the healthy norm. Modern day research on frequency shows no consistency and instead focuses on the qualities of the bowel movement.

Key Words: bowel movement studies, normal bowel movement frequency, colon studies, food intake and output volume, defecation

Introduction

The subject of bowel movements may seem an unusual topic to consider, but for our patients' health and well-being, discussion on this topic should not be held back. Internal cleansing of bodily waste is not only healthy, but any aberrations in this process can affect mental and emotional well-being. In Chinese medicine, the patient is questioned and

answers are recorded regarding all aspects of our bodily functions to assess both the health of the patient and any imbalances the patient might experience. Asking patients about their bowel movement patterns to assess whether or not they are experiencing constipation or diarrhea is an important task for every practitioner.

Many patients are not well educated about the optimum number of times they should have a bowel movement each day. Some patients have this one time per week and believe they are not constipated. Many patients are surprised when an acupuncturist wants to treat them for constipation based on their bowel frequency. Modern western research and literature appears to be very scarce regarding what is deemed consistent normal evacuation frequency for the human species. Only certain ancient Asian texts present any kind of guideline for consistent minimum bowel frequency and volume.

Western Research and Literature

Medical dictionaries define medical terms and as such, provide basic scientific information about them. There is no consistent frequency indicated regatrding"bowel movement" and its synonym, "defecation."

Dorland's Illustrated Medical Dictionary states, "Defecation: 1. The removal of impurities, 2. The evacuation of fecal material from the rectum."[1] However, it does not clarify the number of times daily defecation should occur in humans or even animals. No mention is made of the amount or quality of fecal material to be expelled. The *Dictionary* only states that bowel movements are necessary to remove impurities.

Taber's Cyclopedic Medical Dictionary states," …bowel movement: evacuation of feces. The number of bowel movements varies in normal individuals, some having a movement after each meal, others one in the morning and one at night, and still others only one in several days. Thus to say that the healthy person must have at least one bowel movement a day in order to maintain health is unreasonable and not based on factual evidence. SYN: defecation"[2]

In the section discussing diarrhea and constipation, *The Merck Manual of Diagnosis and Therapy* states "no body function is more variable and subject to extraneous influences than is defecation. Normal bowel habits vary considerably from person to person, being modified by age, individual physiologic factors, and dietary, social, and cultural patterns. In an urban civilization, normal bowel frequency ranges from two to three per day to two or three per week. Changes in stool frequency, consistency, or volume, or blood, mucus, pus, or excess fatty material (e.g., oil, grease, film) in the stool may indicate disease."[3] This section sets no consistent amount or frequency, indicating only what to expect if a disease pattern has manifested. Interestingly, this citation does reference urbanization and its effect on dietary habits. "As civilization develops, the way the population eats and what it eats changes, thus affecting their bowel movements as well as overall health and well-being."[3]

Very few studies in modern scientific literature exist on the frequency of daily bowel movements. One Singapore study examines the relationship between frequency of bowel movement and bowel dysfunction: "271 surveys were analyzed, with results showing that the most common (59.0+/- 6.5 percent) bowel frequency was once a day, with 96.8 +/- 5.6 percent of individuals having bowel frequency between 3 times/week and 3 times/day. The prevalence of irritable bowel syndrome, chronic constipation, and chronic diarrhea were 3.2 +/- 2.3 percent, 7.3 +/- 3.5 percent, and 6.9 +/- 3.4 percent, respectively. Women were found to have a lower bowel frequency ($p < 0.001$) and a higher prevalence of chronic constipation (11.3 +/- 6.0 percent vs 3.6 + 3.5 percent, $p < 0.05$) than men."[3] The researchers concluded, "Normal bowel frequency may be defined as bowel movements between three times per week and three times per day,"[4] a wide range of data.

Research conducted in Avon, UK, studied the transit time interval of stool production and the effect on transit time interval on bowel movements and the quality of stool. It surveyed 1897 people, which comprised 72.2 percent of a stratified random sample of all men 40-69 years and women 25-69 years. The results indicate a gender difference exists, with males producing stool more rapidly than females, and women of childbearing age producing slower than older women. The study concluded that women had less frequency and were more prone to constipation than males.[5]

An Iranian survey study of 1045 male and female participants indicates that constipation was functional, meaning it is correctable by a modification in the behavior of the subject, with a mean frequency of 3-21 bowel movements per week. The purpose of this study was to estimate the prevalence of self-reported, ROME II-constipation and determine the average defecation frequency and stool types in the Iranian population.[6] [The "Rome process" is an international effort to create scientific data to help in the diagnosis and treatment of functional gastrointestinal disorders. Its name is derived from the Rome Foundation, a not-for-profit 501(c)(3) organization, in Raleigh, North Carolina.] Despite a higher average of bowel frequency, the previously reported normal range of defecation frequency can be applied for the Iranian population."[7] The Persian diet consists of very little processed foods and includes mostly fresh meat and vegetables, grains and fruit.

Another study conducted by the Bristol, UK, University Department of Medicine dealt with slow whole-gut transit time. It theorizes this may be associated with an increased risk of

gallstones, and possibly bowel cancer, but its true determinants are unknown. Their survey included 884 women aged 25-69 years and 677 men aged 40-69 years. Transit time was estimated using prospective examination of three stools and a questionnaire about their bowel habits, their diet and their alcohol intake, using validated food frequency questions.

In women < 50 years not taking oral contraceptives, mean transit time was relatively constant across 10-year age bands (62 to 63 hours). In older women it was also relatively constant but significantly shorter (58 to 59 hours) than younger women of reproductive ages, suggesting an effect of female sex hormones. In women taking oral contraceptives, mean transit-time was sixhours longer than in women of the same age not taking them (95 percent CI 1.4 to 10.6 hours). In men drinking > 40 g alcohol/day, mean transit time was 49 hours compared with 54 in those drinking < 20 g/day ($p < 0.0001$). For men who abstained from alcohol, an effect of dietary non-starch polysaccharide or fiber (NSP) intake was clearly apparent.

Alcohol consumption quickened transit in both sexes; oral contraceptive usage slowed it in women. Body mass index in both sexes, soluble NSP in men, and insoluble NSP in women also significantly and negatively affected transit time. The food groups related to transit time for men were potatoes and cooked fruit; for women, potatoes and bread.[8] This difference in food groups supports the theory that diet has a factoring role on constipation and consistent bowel movements.

Researchers at the Cleveland Clinic, Cleveland, Ohio, evaluated surveys completed by 425 women who reported normal bowel function with no bowel pathologies. They found that a vast diversity exists in what is considered normal female bowel habits; one daily bowel movement was not the norm. Older females and younger women who have had children reported more flatal incontinence, with one third of them experiencing some element of fecal incontinence. They found that foods most commonly caused a change in bowel patterns, followed by menstruation, stress, and childbirth. A vast majority (92 percent) did not take a fiber supplement.[9] The failure to use fiber supplements leaves the subjects' diet and menstruation as among the main factors affecting bowel frequency.

A Turkish survey study on 1018 children, 526 boys and 492 girls, ranging ranging from under one year to six years of age, showed constipation in infants under one year was due to organic disease (showing physical change to an organ from scar tissue, inflammatory conditions, tumors or bowel cancer), whereas in toddlers up to six years of age no organic constipation was found. The parents were responsible for reporting the data for each child.[10]

"The food groups related to transit time for men were potatoes and cooked fruit; for women, potatoes and bread.[8] This difference in food groups supports the theory that diet has a factoring role on constipation and consistent bowel movements."

Ancient Texts

Traditional Chinese medicine has long viewed the digestive system as a critical factor in maintaing health, which may explain why the ancient texts delved more deeply into the topic of bowel habits. For instance, the *Nei Jing* discusses the importance of the Spleen and Stomach and the result of an imbalance in the Earth element in chapter 29: "A Discourse On The TaiYin and Yang Ming Channels." The ancient text, *Ling Shu chapter 32 The Balanced Man and Starvation*, states: "The full stomach causes the intestines to empty. The full intestines cause the *qi* to move up and down, which settles and pacifies the five viscera. The blood, veins, and arteries will be harmonized and smooth. The seminal essence and spirit will be the water and grains. Consequently, the center of the intestines and stomach can, at the point, hold from these grains two dou (one dou equals 2.34 quarts) and of water, one dou five shen (one shen equals 1 pint). Thus twice a day the balanced man can eliminate two shen and one-half. For one entire day, five shen. In seven days, five times seven, or three dou and five shen, which means the amount detained from water and grains is completely drained."[12] The *Ling Shu* thus indicates both volume and a basic frequency of defecation. From these writings, normal healthy bowel frequency can therefore be viewed as having at least two bowel movements per day.

In the *Nan Jing, The 43 Difficult Issues,* Huang Ti asks: "When someone does not eat or drink, that person will die at seven days. Why is that so? It is like this: under regular circumstances one's stomach contains two pecks (one peck equals 8 dry quarts) of grains and one peck and five pints of water. Hence, a normal person will go to the latrine twice a day, each time passing two and a half pints. In the course of one day he passes five pints. In seven days—five times seven—[this adds up to] three pecks and five pints, [leading to] complete exhaustion of water and grains."[13] These measurements in Paul Unschuld's *Nan Ching* are given in modern terms and therefore show a volume according to modern standards. The measurement system used in ancient times was not uniform with modern measurement and thus is difficult to accurately replicate today. The translated measurement is an estimated value for the ancient measurement since many times a hand or foot was used to measure a distance and size.

Can "Normal" be Determined?

Why is it that modern research on defecation and bowel movements yields no guidelines on the frequency of bowel movements?

One reason why it may be difficult for modern medicine to give a frequency and rate of optimum bowel movements is due to the number of changes that have occurred in our modern day diet. According to a lecture by Dr. Robert Chu: "Originally, during the time that the *Ling Shu* and *Nan Jing* were created, the Asian diet consisted mostly of lean meat, vegetables, and fruits. The present Asian diet now resembles the western diet, consisting of a large amount of complex starchy carbohydrates, i.e., rice, pasta, and potatoes (This is not to be confused with complex fibrous carbohydrates, such as vegetables.)[13] The *Merck Manual of Diagnosis and Therapy* states that we are learning that this type of diet is not beneficial to humans as it contains a great deal of fat, refined sugars, salt, and triglicerides—all derived in large part from processed and "fast foods."

Due to both their personal and social eating habits, Westerners often consume unhealthy food items that contribute to constipation of the bowels. In addition, many etiologies, such as the side effects of certain medications as well as some emotional states such as depression, can also result in constipation.[3]

Faced with this, acupuncturists might advise patients to consider lifestyle modifications of diet and exercise and give them advice on how to combine different types of foods. Patients often rely on practitioners to not only to treat but also to educate them on the specifics of a healthier lifestyle. From the Chinese perspective, the importance of eating fresh organic vegetables, fruit, and meats with a minimal amount of grains cannot be stressed enough.

A discussion of various factors that result in constipation can become part of regular medical protocols. This is suggested by Dr. Robert Chu LAc, QME, author of *Master Tung's Acupuncture for Allergies, Autoimmune Disorders*, *and Cancer Treatment and A Quick Clinical Reference for Acupuncturist Lecture Note*s. He also recommends the inclusion of needling St-34, -36, and -37, since St-37's principle action is to move the bowels. Dr. Chu states: "Everyone feels better after a bowel movement."[13]

In clinic, this author has seen cases in which a patient had bowel movements one or two times a day but also cases of patients having them two times a week. Many patients follow different diets and may have more bowel movements because, for example, a vegan will eat more vegetables and have more bowel movements than an omnivore.

When a patient visits the clinic because of depression and constipation, the author concentrates on their constipation and treatment consists of acupuncture, massage, and herbs. Time and time again, patients treated in this manner state how much better they feel. When patients ask what the normal number of bowel movements is, they are advised that this number should match the number of times they ingest food. This is due to the variance in the patients' regularity and eating habits.

Conclusion

Modern day research on bowel movement frequency shows no consistent comparison with what the ancient texts tell us. Modern medical resources provide very little specific information on healthy bowel movements and instead choose to define an unhealthy bowel state (difficult defecation, infrequent defecation with passage of unduly hard and dry fecal material, sluggish action of bowels) and provide causative and treatment advice. The causes of unhealthy bowels include diet, psychological factors, tumors, abnormal morphology, and a sedentary lifestyle. The corrective measure primarily refers to diet.[2] The *Merck Manual of Treatment and Diagnosis* lists constipation as: "Difficult or infrequent passage of feces. Constipation can also refer to hardness of stool or a feeling of incomplete evacuation." It goes on to cite dietary and medication solutions to constipation.[3]

The ancient texts give exact measurement of what is regarded as a "normal bowel movement," with the *Nan Jing* and the *Nei Jing* suggesting that a practitioner can use the baseline of two bowel movements per day. These texts also discuss the volume of food intake, indicating a clear relationship to the volume of the bowel movement. Information on volume and frequency given in the ancient texts, compared to the modern research literature, indicates that patients should peferably have bowel movements equal to the frequency and volume of food ingestion, since on average typically three meals are ingested a day by most of us. Setting a baseline for bowel movements and redefining constipation might then decrease the number of cases of colon cancer and other bowel diseases we see today.

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continued on page 44

CLINICAL PEARLS

Dylan Jawahir, **LMT, LAc**
Clinical Pearls Editor

Greetings,

I would like to introduce you to the Clinical Pearls section of *Meridians: The Journal of Acupuncture and Oriental Medicine* (MJAOM). This section permits practitioners to share and learn from empirical findings which provide perspective and data that may not fit precisely into the confines of the classic textbook case.

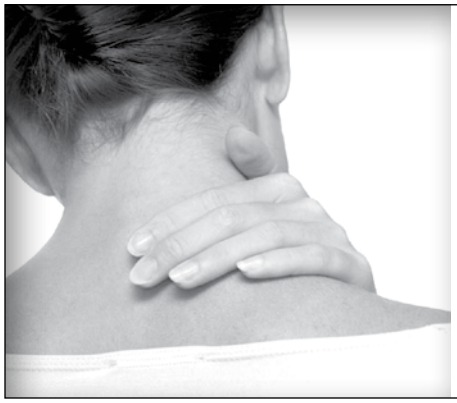
What is a Clinical Pearl? A Clinical Pearl is a concise piece of information gleaned from observation and/or technique and applied in a real world setting. Although these have deep roots in western medical education resources, their utilization in complementary and alternative medical literature is relatively new. The structure of a Clinical Pearl can vary in presentation and scope, even within the same medical field. Our format in each MJAOM issue presents a question about treating one particular condition and responses from a number of practitioners in the field who describe actual clinical procedures they have used to treat this specific medical disorder. These pearls describe uses of any and all modalities common to a doctor of TCM practicing in the United States. Like a genuine pearl, each written piece is a small yet valuable treasure for both new and veteran practitioners to appreciate, learn from, and use.

Readers are encouraged to interact with us at MJAOM. If you have a question, an idea for a Clinical Pearls topic, or a suggestion on how we can improve this section, please contact Clinical Pearls Editor Dylan Jawahir, LMT, LAc at djawahir@meridiansjaom.com. Your feedback is important to us!

We are pleased to announce the Clinical Pearl topic for our upcoming winter issue of MJAOM: ***How Do You Treat Blocked Menses (Secondary Amenorrhea) in your Clinical Practice?*** We invite you to submit to *Meridians: The Journal of Acupuncture and Oriental Medicine*. The submission deadline is **November 1**. Please first review this submission information: www.MeridiansJAOM.com.

Thank you,

Dylan Jawahir, **LMT, LAc,** Clinical Pearls Editor
Meridians JAOM



The topic selected for this issue is: "How would you treat frozen shoulder (adhesive capsulitis) in your clinic?"

Frozen shoulder, also known as adhesive capsulitis, is a common condition in which the articular shoulder capsule, a sac of ligaments surrounding the joint, becomes swollen and painful, resulting in stiffness, pain, and a restricted range of shoulder motion. This condition mainly affects people ages 40-60, with women affected more often than men. It can begin due to an injury or the inflammation of the soft tissues as with as bursitis or tendinitis. Certain diseases, such as diabetes and hyper- or hypo-thyroid conditions as well as stroke or cardiovascular disease, can increase the incidence of frozen shoulder.

How Do You Treat Frozen Shoulder (Adhesive Capsulitis) in Your Clinical Practice?

By Dylan Jawahir, LMT, LAc

Dylan Jawahir, LMT, LAc received both a degree in massage therapy and a Master's Degree in Traditional Oriental Medicine at the Pacific College of Oriental Medicine in San Diego, California. As a World Taekwondo Federation First Dan Black Belt and avid martial arts practitioner for 25 years, Dylan focuses his practice on pain management, injury rehabilitation, and post-surgical recovery. He has served on the Board of Directors of the California State Oriental Medical Association (CSOMA) and is a past editor of *All Things Healing*. He has also contributed a number of articles to various acupuncture journals. He has had a private practice since 2010 in San Diego, California.

The Mayo Clinic states that adhesive capsulitis occurs when a capsule of connective tissue surrounding the joint thickens and tightens around the shoulder joint, restricting its movement.[1] This can sometimes be seen on an x-ray.

When I am presented with a patient who has adhesive capsulitis, I ask when the onset of the condition was noticed and what are the characteristics originally associated with it. Since emotionally traumatic events are also a potential cause, I ask also about this possibility. A full shoulder range of motion (ROM) test is done and noted. Though there may be multiple causes that can initiate and sustain a frozen shoulder, I spend the first few patient visits addressing the physical side of the condition. If I can reduce pain and increase ROM even slightly, it goes a long way in gaining patient trust and improving the patient's activities of daily life.

This example treatment is indicative of a patient's first few treatments. The diagnosis for frozen shoulder is *qi* and Blood stasis. I will normally combine acupuncture with *tui na* to move *qi* and blood. The treatment points I use are:

Back points:

- SI-9: Affected Side
- Cervical Jia Ji C4-C8: Bilateral
- LI-16: Affected Side
- SI-11: Affected Side
- SI-13: Affected Side
- GB-20: Bilateral

Front points:

- Subscapularis Motor Point: Affected Side (rotator cuff muscle responsible for external rotation)
- LU-2: Affected Side (coracoid process)

The acupuncture points above are for local treatment of the shoulder and are referenced from a standard acupuncture textbook.[2] Cervical *jia ji* points are used to stimulate the nervous pathway to the musculature controlling action of the shoulder. The subscapularis motor point targets a typical muscle limiting range of shoulder motion in adhesive capsulitis. LU-2 is a point that stimulates the anterior musculature involved in stabilizing and moving the scapula. Thirty-two gauge needles are used and stimulation of the needles occurs at five minute intervals to elicit de qi sensation. The *tui na* treatment that accompanies the acupuncture points above addresses the four rotator cuff muscles as well as pectoralis minor, coracobrachialis, and scalenes. A topical *qi* and blood moving liniment is applied at the end of the treatment.

Recommended treatment is twice a week for one to two months, with modifications to point selection as necessary. A visual ROM is checked before and after treatment and stretching exercises are offered for the patient to perform on his or her own.

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How Do You Treat Frozen Shoulder (Adhesive Capsulitis) in Your Clinical Practice?

By Fritz Hudnut, MTOM, DAOM, LAc

Fritz Hudnut, LAc is a clinical supervisor at the Emperor's College of Traditional Oriental Medicine and the Yo San University student intern clinics. He has been in practice for 14 years and maintains a private practice in West Los Angeles. Fritz is the author of *Surfing the Timeless Wave*, a meditative investigation into health and life.

The problem of "frozen shoulder" is fairly common and is seen in the acupuncture clinic with some frequency. Most often the patient is in their late 40s or 50s, hence the name "Fifties Shoulder." Generally my diagnosis for the presentation is "Blood not nourishing tendon," i.e., systemic deficiency leading to the local excess of pain or dysfunction in the shoulder. I offer a multi-pronged treatment approach: local electro acupuncture (EA) on the shoulder coupled with the standard whole body points to tonify Blood and nourish tendon.

I usually don't introduce EA on the first treatment but wait until the second or third treatment, after determining the person's capacity for handling the regular stimulation from the needles alone. For patients who can handle the EA, it offers a level of effectiveness that makes it extraordinary.

The electro acupuncture portion is based Dr. Hua Gu's treatment of Chondromalacia patellae1 that involves placing six needles around the patella and then connecting two lines *diagonally* to the four needles at the corners of the patella to create a crossing "x" pattern, rather than more traditionally following the channels in an above/below pattern.

This procedure can be applied to the shoulder in several different patterns; my most common selections involve connecting Jian Qian (extra) to SJ-14, *with* LI-16 connected to Jian Zhong (extra). This means essentially connecting the front of shoulder joint to the back of shoulder joint *and* above the shoulder joint to below shoulder joint.

"Generally my diagnosis for the presentation is 'Blood not nourishing tendon,' i.e., systemic deficiency leading to the local excess of pain or dysfunction in the shoulder."

I use the Pantheon Electrostimulator unit set to a "mixed" mode. I begin with 10/2 Hz for ten minutes. I occasionally add a third distal line on the forearm below the offended shoulder using LI-11 to LI-10. In certain cases, the third line for various pain conditions has been found to be beneficial.

The rest of the protocol follows the TCM diagnosis, most often LU-7/KD-6 as distal brackets, with SP-6, LV-8, GB-34, ST-36, and sometimes also using SP-10 or SJ-8—sometimes more, sometimes less. Gentle exercise is also prescribed as it is important to maintain good muscle tone for best outcomes.

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How Do You Treat Frozen Shoulder (Adhesive Capsulitis) in Your Clinical Practice?

By Lance Naizhao Li, PhD, LAc, Dipl OM (NCCAOM)

Lance Naizhao Li, PhD, LAc, Dipl OM(NCCAOM) is a faculty member at Pacific College of Oriental Medicine (New York campus) and New York College of Traditional Chinese Medicine (Mineola). A third generation practitioner of traditional Chinese medicine, Lance has practiced for almost 14 years, specializing in pain management, facial rejuvenation, women's and men's disorders, and weight control. He currently serves on the Board of the American TCM Society.

Typically traditional Chinese medicine classifies frozen shoulder pain as Bi Syndrome and is further classified as two main patterns of diagnoses: 1) Wind Cold Damp Accumulation and 2) Qi Stagnation and Blood Stasis.

In my clinic, I like to combine the local and distal points to treat my patients.

Local Points: Tianzhong SI-11, Bingfeng SI-12, Jianliao SJ-14, and Jianyu LI-15. I also palpate to learn if other acupuncture points around that area are tender.

Distal Points: Yanglingquan GB-34: *hui*-meeting point of sinews. This treats muscle and tendon pain. Tiaokou ST-38: empirical point in the treatment of shoulder disorders; Houxi SI-3: important in the treatment of pain and contraction of the arm, elbow and shoulder; Hegu LI-4: four command point for the face and mouth. Distally this point can alleviate the pain from the upper extremities. Quchi LI-11: can both resolve obstruction in the channel and strengthen the weakness of the whole upper limb; Sanyinjiao SP-6: meeting point of the Spleen, Liver and Kidney Channels. It mainly nourishes the Blood and *yin*. Zusanli ST-36: mainly alleviates painful obstruction due to Wind Cold Damp Accumulation; Taixi K-3: tonifies Kidney *yang* and strengthens the *yuan qi*.

"Usually my patient will be treated two times a week. Some patients even get favorable results after two to three sessions..."

Sequence of Treatment:

1. LI-4 (Hegu), LI-11 (Quchi), SI3 (HouXi),GB-34 (Yanglingquan)
2. SI-11(Tianzong), SI-12 (Bingfeng), SJ-14 (Jianliao), LI-15 (Jianyu)
3. SP-6 (Sanyinjiao), ST-36 (Zusanli), K-3 (Taixi)

After withdrawing those acupuncture needles from the list above, I then insert the point Tiaokou ST-38 on the affected side. I also ask my patient to slowly rotate the affected shoulder to see if there is any improvement. In most cases, I will also perform *tuina* (Chinese massage) on the patient. If needed, I will use electrical stimulation on certain acupuncture points. Using these procedures, my patient will feel relief from this pain.

Usually my patient will be treated two times a week. Some patients even get favorable results after two to three sessions, while some other patients will take a little longer to get better—say, at least a month or two.

I normally manipulate the needles to make sure *qi* is arrived on every single point. The technique used for most points is the sedating method. However, I will use tonfiying method on SP-6 (Sanyinjiao), K-3 (Taixi), and ST-36 (Zusanli).

The whole purpose of my treatment is to dispel the pathogen, strengthen the *yuan qi*, and nourish the Blood. In doing so, the muscle and tendon around the affected region will be nourished and will regain its natural strength.

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How Do You Treat Frozen Shoulder (Adhesive Capsulitis) in Your Clinical Practice?

By Zhanxiang Wang, LAc and Hongji Zhang, LAc

Zhanxiang Wang, PhD, LAc, DiplOM (NCCAOM) focuses on pain management, cancer rehabilitation, and allergic diseases at Great Wall Acupuncture (clinic) in Carmel, Indiana. He has practiced acupuncture and Chinese medicine for more than 6 years in the U.S. and more than 10 years in China and has served as an assistant professor at the Indiana University School of Medicine. He may be reached at wangzhanxiang@gmail.com.

Hongji Zhang has over 15 years' experience practicing acupuncture and Oriental medicine. He is currently associated with Great Wall Acupuncture. For more information, please visit www.gwacupuncture.wordpress.com

The normal course of a frozen shoulder has 3 stages: the "freezing" or painful stage (1 to 9 months); the "frozen" or adhesive stage (4 to 9 months); and the "thawing" or recovery stage (5 to 26 months). By regulating qi and blood circulation in the channels, acupuncture can wipe out frozen shoulder for good. In doing so, *de-qi* (soreness, tingling, distention and heaviness sensation) is required, ideally with muscle motion, to remove the stagnation of *qi* and blood. The points should be needled alternately in each treatment, since repeatedly needling the same point will desensitize the response (difficult in *de-qi*).

Needling trigger and motor points to release the pain: A number of muscles, ligaments, and tendons link bones together around the shoulder joint. According to Travell and Callison, trigger motor points in theses tissues play an important role in pain management. Typically these local points include trigger and motor points SI-9 to SI-5, LI-14 to LI-6, TE-13 to TE-5 and GB-21. Needling four to five of these that are most tender when pressed will efficiently eliminate the *qi* and Blood stagnation that causes shoulder pain.

Needling distal acupuncture points based on traditional Chinese medical patterns: For the best long-term treatment outcomes, distal points should also be prescribed based on TCM patterns. Distal points from the meridians traversing the shoulder should also be needled. Since the Small Intestine, Large Intestine and Gall bladder meridians run directly along the shoulder, distal points from these channels, such as SI-3, LI-4, LI and GB-34 as well as extra point Zhongping, located 1 cun below ST-36, should also be needled.

> "By regulating *qi* and blood circulation in the channels, acupuncture can wipe out frozen shoulder for good."

Local moxibustion or ear needling may also be used accordingly.

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How Do You Treat Frozen Shoulder (Adhesive Capsulitis) in Your Clinical Practice?

By Karen Reynolds, LAc, RN

Karen Reynolds has been a California licensed acupuncturist and herbalist for 15 years as well as a critical care registered nurse for 27 years. Her private practice, located in Mill Valley, California, offers a mixed specialization in both 5 Element and traditional Chinese medical acupuncture well as conventional medicine lab testing, assessment, and interpretation. Please feel free to contact her at: kreynolds@balancerestored.com.

In 2013 a patient presented with a primary complaint of frozen shoulder that occurred six months prior, coinciding with her mother's death. From a five element perspective, the client was a well-nourished Wood CF (causative factor) who candidly shared that she had never cried during or after her mother's passing. She stated she had "just ignored" her shoulder pain and that "being an only child, there was too much to do" to think about it.

The pain steadily increased during the next six months. On a pain scale [rating 1 as least painful, up to 10 as worst pain possible] she had a continuous 6-7/10 shoulder pain with intermittent 10/10 "excruciating bursts." Her sleep was poor. She worked seven days a week—12 hour shifts Mon-Fri and five hours each Saturday and Sunday. She pushed through the pain to continue this rigorous professional schedule.

Pulses were tight and thin quality at the heart and liver positions and deep at the lung position. Upon palpation of Lung 2 *Gate of Clouds*, the patient immediately burst into tears, greatly surprised she was suddenly weeping.

We know from the translations of the classics that the character for clouds within *Gate of Clouds* speaks to the spirit which animates the clouds and to whom one offers sacrifices. The character for gate within *Gate of Clouds* is a saloon gate, i.e., two-way movement, and thus a gate for man interacting with heaven.

Lung 2 is known as a powerful point to treat mental or spiritual anguish and can be used as needed to tonify or sedate. Given the pathway of the lung primary meridian travels to the infraclavicular fossa, clearly this is a powerful place for things to become stuck. However, this point also allows the saloon doors to swing open such that man receives the grace of heaven above.

According to the classics, sadness is one of the seven pathological emotions. From the standpoint of the Chinese mind, no emotions are problematic unless they accrue. The Chinese characters for sadness depict an image of the heart with a screaming "No!" surrounding it, rejecting the flow and movement of life. Though not showing emotion, this patient was experiencing pathology induced by sadness.

Being a Wood constitution is indeed a causative factor for this case. If we examine the titles, charges, and functions of the Liver and Gallbladder, The *Su Wen* chapter 8 states: "The liver holds the office of general of the armed forces. Assessment of circumstances and conception of plans stem from it."[1] and "the gallbladder is responsible for what is just and exact. Determination and decision stem from it."[2]

Wood is always the grand planner. It is responsible for mastering quantity and quality of movement. As such, its movement is always up and spreading out, spreading blood to the muscles and sinews. However the movement of Wood is not healthy when it is forever rising and spreading. It is easy to forget that part of healthy decision-making is the determination of when to stop. Clearly this patient was further exhausting herself with a never ceasing plan and long stretches movement without adequate rest.

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Karen Reynolds Clinical Pearls continued from page 37

Acu-points used:

- Liver 3 *Great Esteem*: Applicable for treating the spirit and empirical for contractions or spasms of muscles. It strongly addresses the liver's function of control over the sinews.
- Lung 2 *Gate of Clouds*: Used for the above noted reasons
- Lung 9 *Supreme Abyss*: The character for abyss is that of a pure heart delving into the depths of truth beyond superficiality. As such it is a very good point for moving channel *qi* of the lung.
- Large Intestine 5 *Yang Canyon*: The character for canyon is that of water running along a bottom and bounded by earth on both sides. This point prevents risings or excitations for the spirit, is additionally ideal to re-establish the regulatory movement of *qi*, and is valuable as a distal point of upper limb local problems.
- Large Intestine 14 *Upper Arm*: Used as a local point
- Triple Heater 5 *Outside Barrier*: Used to alleviate pain and move channel qi
- Triple Heater 15 *Heaven's Forearm*: Indicated for pain in the shoulder

At the second treatment, shoulder pain had reduced to a 2/10 level and sleep was improved. The week following her second session the patient cancelled her third appointment because she said her shoulder pain, present for more than six months, had completely resolved.

This is an atypical presentation for frozen shoulder with a surprisingly rapid recovery. However, it illustrates the ability of acupuncture points to address anguish of the spirit, which can be reflected in the physical body.

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SAR & CAMM 2014 International Symposium on Acupuncture Research:

Impact of Acupuncture Research on 21st Century Global Healthcare, Beijing, China

By Cynthia Easter, MSAc

Cynthia Easter received an MSAc from the National University of Health Sciences in 2014. With Francis Yurasek, PhD (China), MSOM, LAc, she co-presented a poster at the 2014 Society for Acupuncture Research & China Association for Acupuncture Moxibustion Symposium in Beijing, China. She has participated as a reference assistant and editor for several publications.

The Society for Acupuncture Research (SAR) co-hosted its first SAR conference to be held outside the United States in conjunction with the China Association of Acupuncture and Moxibustion in Beijing, China, May 30-June 1, 2014. This international forum was designed to foster interdisciplinary dialogue and collaboration among researchers, clinicians, and policy makers. With more than 300 research abstract submissions from 19 countries, the program covered a broad array of topics featuring basic, clinical, translational, qualitative and quantitative research.

The goals for the conference included "promotion of patient-centered comparative effectiveness research, improvement of acupuncture efficacy by encouraging integrative research, and expansion of acupuncture research to a greater breadth of diseases/conditions. Ultimately, better research quality will lead to a better understanding of the role of acupuncture and moxibustion in improving human health in the 21st century."[1]

Given the responses of the more than 200 professionals in attendance, the goals were not only met but exceeded the loftiest of expectations. Opportunities to mix and mingle throughout the three days of the conference afforded new contacts to be made as well as old acquaintances to be renewed.

Group photo of conference attendees

Conference Overview

Opening Ceremony:

Professor Bao-yan Liu, MD, President, CAAM [China]

Professor Vitaly Napadow, PhD, LAc, Co-President, SAR [USA]

Professor Li-xing Lao, PhD, MB, Chair [China]

Richard Harris, PhD, Co-President, SAR [USA]

Keynote Speakers:

1. Claudia Witt, MD, MBA [Switzerland]: **"Comparative Effectiveness Research"**
2. Bao-yan Liu, MD [China]: **"Technique and Platform of Clinical Research in the Real World"**
3. Vitaly Napadow, PhD, MB [USA]: **"Neuroimaging Correlates of Acupuncture: What do we know? What lies ahead?"**
4. Hugh MacPherson, PhD, LAc [UK]: **"Acupuncture for Chronic Pain: Compelling Evidence from Innovative Meta-Analyses"**

Symposium Speakers:

Claudia Witt, MD, MBA [Switzerland]; Hugh MacPherson, PhD, LAc [UK]; Richard Hammerschlag, PhD [USA]: **"New Directions in Pragmatic Trials of Acupuncture"**

Ryan Milley, MAcOM, LAc [USA]; Robert Davis, MS, LAc [USA]; Jiang-Ti Kong, MD [USA]: **"Exploring the Diversity of Acupuncture: Lessons Learned from Research on Manual vs. Electrical Stimulation"**

Elisabet Stener-Victorin, RPT, PhD [Sweden]; Remy Coeytaux, MD, PhD, [USA]; Xiao-ke Wu, PhD, MD [China]: **"Acupuncture Research for Women's Health"**

Richard Harris, PhD [USA]; Li-xing Lao, PhD, MB [Hong Kong]; Xiao-chun Yu, MD, PhD [Hong Kong]: **"Basic Science of Acupuncture"**

A panel discussion on the conference headline "Impact of Acupuncture Research on 21st Century Global Healthcare" was facilitated by Richard Hammerschlag [USA], Claudia Witt [Switzerland], Ari More [Brazil], Christopher Zaslawski, [Australia], Bai-xiao Zhao [China]. A lively discussion generating from a global perspective concluded that, given the direction of research in the field, a significant impact can be expected to positively affect on the health and well-being of the citizens of the world.

Oral presentations were divided into eight from each of the Basic and Clinical Sciences tracks. The titles and conclusions/recommendations of each study showcased the broad field of research.

Basic Science Track

1. **"Differential cerebral response to somatosensory stimulation of an acupuncture point versus two non-acupuncture points measured with fMRI"**
   Conclusion: Results suggest that stimulation of acupoints may modulate somatosensory and saliency processing regions more readily.

2. **"Electro acupuncture shows evidence of regenerative potential in degenerated intervertebral discs in vivo"**
   Conclusion: EA increased the level of extracellular matrix in degenerated disc. It is able to keep a dynamic balance between extracellular matrix synthesis and degradation.

3. **"Effects of reinforcing and reducing methods by twirling and rotating the needle for left ventricular damage of spontaneous hypertensive rats"**
   Conclusion: Twirling reducing method has an important role in preventing myocardial damage caused by hypertension. The twirling reducing and twirling reinforcing methods (which had no significant similar effect) have different biomedical effects on hypertension.

4. **"Acupuncture effect on motor functional connectivity change in facial palsy: fMRI study"**
   Conclusion: Functional neuroplasticity changes of brain regions connectivity with the four regions of interest due to the BP and acupuncture. The resulted regions are related to sensory-motor regions, motor association regions, attention and motor learning.

Right: Dr. Frank Yurasek with Dr. Linpeng Wang

Far Right: Cynthia Easter with Dr. Frank Yurasek, both poster presenters

"Given the responses of the more than 200 professionals in attendance, the goals were not only met but exceeded the loftiest of expectations."

5. **"Specificity of manual acupuncture needling on pain control: What is the difference between BL 60, SP 6 and a non-acupoint?"**
   Conclusion: Results indicate that the stimulus to acupoints analogous to BL-60 and SP-6 at the lower limb can reduce the pain-associated behavior in mice while the non-acupoint cannot. Findings suggest that there is point specificity not only in reducing the pain behavior, but that there is specificity also in the endogenous pain control system modulated by each acupoint.

6. **"A study of the toxicity of moxa smoke following a 12-week occupational exposure in rats"**
   Conclusion: Moxa smoke has no adverse effects on rats following a three month equivalent to nine times occupational exposure, and there is no significant difference among the control and three moxa smoke groups. Data suggest that moxa smoke that is experienced in a regular moxibustion clinic is safe.

7. **"Dissociation of the acupuncture effect of somatosensory needling and needling credibility on low back pain patients using fMRI"**
   Conclusion: Physical information processing and placebo/analgesic brain area were involved in somatosensory needling effect, while cognitive processing was related to the needling credibility effect.

8. **"Evoked pressure pain functional magnetic resonance imaging (MRI) predicts clinical response to sham but not verum acupuncture in fibromyalgia"**
   Conclusion: Results suggest that evoked pressure-pain fMRI blood oxygen-level dependent (BOLD) response in pain responsive regions may be a factor in determining subsequent responsiveness to sham acupuncture but not verum acupuncture.

Clinical Research Track

1. **"Herb-partitioned moxibustion and acupuncture for the treatment of active Crohn's disease: A randomized controlled trial"**
   Conclusion: Acupuncture and moxibustion are effective and safe treatment methods for mild to moderate Crohn's disease. In addition to the placebo effect, acupuncture also has significant therapeutic effects.

2. **"The effect and safety of deep acupuncture at Tianshu ST-25 for functional constipation: a multi-center randomized controlled trial"**
   Conclusion: Deep acupuncture at Tianshu for functional constipation can increase the weekly SBMs effectively, improve the constipation-related symptoms, and be safe. These improvements can last for 12 weeks.

3. **"TCM diagnosis: Inter-rater reliability and the effects of normalization"**
   Conclusion and recommendations: Normalization improved inter-rater agreement in pathogenic diagnosis of un-well subjects. Training practitioners removed scoring bias should have some effect, and may therefore significantly improve diagnostic agreement. It is recommended that if further investigations confirm the indications of the preliminary study, a "true score" training program will be employed from the top down in our profession and improve agreement between researchers, teaching staff, practitioners, and students.

4. **"A meta-analysis of sham-controlled acupuncture studies: The importance of the dermatomes"**
   Conclusion: Segmental anatomy offers a neurophysiological explanation of acupuncture's major actions. The findings of this study mark a paradigm change in the theoretical body of acupuncture and consequently for acupuncture research. The meridian theory may no longer be the major guideline for acupuncture research and practice.

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BOOK REVIEW

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January 1996
From the series:
Chinese Medicine from the Classics
159 p

The Liver

By Claude Larre and Elisabeth Rochat de las Vallée

Book Review by Karen Reynolds, LAc, RN

The Clinical Pearls section of this journal presents cases on how to treat the condition known as "frozen shoulder." Given that the Liver official has the function of invigorating muscles, specifically the sinews, it seems a valuable task to review and deepen our understanding of the title, charge, and functions of the Liver as cited in Chinese classics. *The Liver* was first transcribed in London in 1985 following a seminar presented by the late Father Claude Larre and Elisabeth Rochat de la Vallée. Released as part of a series of books focusing on the Chinese classics, it has been re-edited and includes the Chinese characters throughout the text.

Father Claude Larre and Elisabeth Rochat de la Vallée met in Paris in 1969. Father Larre had previously lived for some 20 years in China, Vietnam, and for a short period of time in both Japan and the Philippines. His experiences and studies abroad gave him an invaluable grasp of Chinese mind, which is imperative to understanding acupuncture and Chinese classical medicine theories. In the late 1960s Father Larre gathered a small group of interested intellectuals to delve into an in-depth study of Chinese classical medical texts. Elisabeth Rochat de la Vallée was invited to be part of this group, which was initially called the Jade Circle.

Meeting once a week, this fastidious, brilliant gathering of minds labored through the *Huangdi Neijing*, aka the *Inner Classic of the Yellow Emperor,* which includes the books the *Su Wen* and *Ling Shu* as well as the *Yijing*, aka *The Book of Changes.* In 1975 Father Larre and Ms. Rochat decided to begin lecturing about their findings. A year later they founded the European School of Acupuncture. For more than 37 years, they traveled and methodically lectured on the spirit of acupuncture and its classical teachings.

"Father Larre is expert in comparing and contrasting the Western thought construct vs. the Chinese mind."

They have also established a legacy of accurate translations of the above noted texts into French, English and other western languages. In addition, they have translated the *Nanjing*, the *Shanghanlun, Jingue Yaolue* and the *Jiayijing* each into several languages. Our profession owes them a debt of gratitude as *The Liver* is simply one small piece of their vast array of written works.

It often seems that new practitioners more easily grasp the idea of Liver *qi* stagnation as blockage to the free flow of *qi* that is so necessary for the healthy liver. However, what may escape diagnosticians of all levels is the importance of the spirit of liver official divining where and when to stop spreading outward and upward. We know that the healthy movement of Wood (Liver) is always upward and outward, but like a growing tree, that movement is not constant. It is not possible or sustainable for trees to grow every minute of every day. When there is fatigue due to overexertion or a pattern of perpetually pushing the limits, this too can induce pronounced stress for the liver.

Ms. Rochat phrases it well, succinctly stating "…through the spirit of the liver there is the decision and determination of where and when to stop. The hair must be loose, the body relaxed without being too tired because above all, the great function of the liver is to make the qi circulate well." {p.19} The Liver is indeed the grand planner of the great ball; but it is as

important to the Liver that qi reach all the areas of the palace so that the service staff are not falling apart mid-party or the dancers are too fatigued to finish their waltzes.

Father Larre is expert in comparing and contrasting the Western thought construct vs. the Chinese mind. He aptly illustrates the will of life of the Liver official as anger, with a comparison to the tension necessary to "draw a bow." Tension is required to shoot an arrow with a bow. However, this anger is not, as he phrases it, "reproachful." He believes it is the tension necessary for life. There must be some amount of tension for a small flower to push up between cement lines in the sidewalk. It's doubtful the flower is angry about it. It is simply its will to grow where it is, requiring brute force to accomplish the task. I have heard teachers refer to this as the "violence necessary for life." It does not mean hostility or destructive force nor does it mean that individuals who are Wood Causative Factors are angry all the time.

The Liver is well worth reading for the first time and continues to reveal its value upon re-reading. In addition to expanding upon the liver's function of treasuring Blood, this short book includes in-depth discussions about understanding the communications between the *Shen* and *Hun*, the formation Blood, Marrow giving rise to the Liver, and disease processes of the Liver.

As a collection, the Monkey Press books appear deceptively diminutive, but wonderful things indeed come in small packages. Please see their site for more information about the series. http://www.monkeypress.net/about-monkey-press

Karen Reynolds has been a California licensed acupuncturist and herbalist for 15 years as well as a critical care registered nurse for 27 years. Her private practice, located in Mill Valley, California, offers a mixed specialization in both Five Element and traditional and Chinese medicine acupuncture well as conventional medicine lab testing, assessment, and interpretation. Please feel free to contact her at: kreynolds@balancerestored.com.

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5. **"Divergent effect of expectancy on treatment response between real and sham acupuncture"**
   Conclusion: The relationship between expectancy and treatment response is distinct between real and sham acupuncture. Findings suggest that while higher outcome expectancy predicts treatment response in sham acupuncture, such a predisposition is not associated with the response to electro-acupuncture. Once patients develop a response to real acupuncture, their expectancy rises significantly. These findings have important implications for both acupuncture research and clinical practice.

6. **"Randomized clinical trials on acupuncture published in Chinese journals: A systematic literature review"**
   Conclusion and recommendation: The number of randomized control trials (RCTs) on acupuncture was substantial and increasing in China, and acupuncture was most frequently applied to nervous, musculoskeletal, and connective tissue diseases. However, the methodological quality of the trials is still low. The authors recommend that the reports of future RCTs on acupuncture will be based on CONSORT and STRCTA.

7. **"Standardized vs individualized acupuncture for chronic low back pain: A randomized controlled trial"**
   Conclusion: In this single center trial individualized acupuncture was not superior to standardized acupuncture for patients suffering from chronic pain. As a next step a multi-center non-inferiority study should be performed to investigate whether standardized acupuncture treatment for chronic low back pain might be applicable in a broader usual care setting.

8. **"Correlates of symptom response to acupuncture: The case of Gulf War Syndrome (GWI)"**
   Conclusion: The report focuses on the correlates and predictors of response, including expectations for treatment, baseline symptom severity, confidence and satisfaction with treatment, presence of concomitant symptoms: individualized acupuncture treatments may be an effective therapy for GWI, but as with other conditions, effect sizes may be influenced by subjects' baseline characteristics and constitution.

As with the oral presentations, poster presentations were similarly divided into the Basic Sciences Track, with 134 presented, and the Clinical Research Category, with 170 presentations. In the basic sciences category, posters covered a variety of subjects ranging from studies of specific acupuncture points, auricular therapy, moxibustion, electro-acupuncture to the treatment of obesity with acupoints catgut embedding.

The clinical research group presented a wide scope of studies ranging from integration of a curriculum in medical acupuncture with residency training in family medicine at Dartmouth College to a case study involving bee venom therapy acupuncture in the treatment of agent orange-induced Parkinson's disease.

Conclusion

This symposium set many new precedents inasmuch as it was the first-ever SAR event held outside the United States. It represents a major new benchmark in the collaboration of four premiere organizations in the field: the China Association of Acupuncture and Moxibustion (CAAM) and the Society for Acupuncture Research (SAR) served as co-sponsors along with the World Federation of Acupuncture-Moxibustion Societies (WFAMS) and the Institute of Acupuncture and Moxibustion (IAM). The scope of international representation from 19 countries establishes a new reality of the global impact of the research and practice of acupuncture into the 21st century and beyond.

The Society for Acupuncture Research 2015 Conference, "Reaching across Disciplines to Broaden the Acupuncture Research Network" will be held November 12-13 at the Harvard Medical School in Boston, Massachusetts. It will be followed on November 14 by a joint conference with the Society for Integrative Oncology (SIO) and the Fascia Research Society (FRS).

Footnote:

1. "Welcome Remarks" by Professor Vitaly Napadow, Co-President, SAR and Professor Liu Bao Yan, President, CAAM

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