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It is a great pleasure to write my first editorial as the new Editor in Chief of the Australian Journal of Acupuncture and Chinese Medicine (AJACM).

Thank you to the AACMA Board and the Editorial Board members for having confidence in me to appoint me to this role. A special thanks to Deputy Editor Professor Christopher Zaslavski and AJACM Managing Editor Melinda Lyons for bringing the Journal back from its hiatus. I would like to acknowledge John Dearn’s departure from the Editorial Board and thank him for his years of service to the Journal. His contribution has been much appreciated over the years. This year marks 10 years since the AJACM first started production. This issue of the Journal brings forward a diverse range of voices from within Chinese medicine.

To my mind this is an excellent function for a professional journal, bringing the diversity within the profession into dialogue. This issue also includes fantastic reads from book reviews through to case studies.

Andrew Koh (with minor assistance from myself) offers an interpretation of the theoretical foundations of ‘the balance method’ in acupuncture.

Mining and identifying the Neijing as the origin of this method’ in acupuncture.

‘quantity’ of qi and blood in a channel.

This issue also includes fantastic reads from book reviews through to case studies.

Do you record these or do you report them? And to whom?

This paper does not highlight the fact there are practitioners who argue that they deliver ‘Western acupuncture’ separate to the ‘imported’ styles from China, Korea, Japan and Vietnam.

Do you record these or do you report them? And to whom?

It is a thoughtful piece and well worth thinking of your response when you next make a mistake or when a patient complains about the unwelcome effects of your treatment. Do you record these or do you report them? And to whom?

She raises important issues about who is an ‘acupuncturist’ and consequently who is being evaluated by reported adverse events and whether the reporting mechanisms for accidents or mistakes are adequate.

It is a thoughtful piece and well worth thinking of your response when you next make a mistake or when a patient complains about the unwelcome effects of your treatment. Do you record these or do you report them? And to whom?

Benjamin Chant, Jeannine Madson and Gudrun Diesberg bring their analytic minds to the published literature on how different ways of conceiving and practising acupuncture developed in various parts of East Asian countries have resulted in different styles of acupuncture in ‘the West’ despite a common pool of philosophical and theoretical foundations.

Such a learned study assists us to understand that the cultural environment of a medicine shapes and modifies how the medicine is performed.

This paper does not highlight the fact there are practitioners who argue that they deliver ‘Western acupuncture’ separate to the ‘imported’ styles from China, Korea, Japan and Vietnam.

To the frustration of many of our Chinese medicine students we are a diverse industry or profession.

Case studies are the evidence base of our tradition. The Editorial Board is keen to hear of your success (and failures) in your clinical practice.

We would like to provide a means for you to learn from each other. Please do not hesitate to submit your stories of clinical experience.

We are always welcoming of these case histories as well as planning to continue reporting the research reports and more academic articles you have come to expect from this Journal.

Dr Suzanne Cochrane PhD, BSW, DTCM, BAS
AJACM Editor in Chief
The search string used was (acupuncture[Title] AND (safety[Title] OR adverse event[Title])). Surveys and systematic reviews were included, but incident reports during clinical trials, safety regarding acupuncture for a specific condition or single case studies were omitted as these were likely to be included in the reviews.

Once duplicates were removed a total of 33 papers reporting or commenting on adverse events in acupuncture were extracted. The reference lists of these articles were scanned and a further 10 articles were included for review. Of these 43, 15 were letters to the editor or comments responding to articles previously published(141,291,296) (Appendix 1 - Summary of AEs from the literature search).

The general consensus within the literature is that the rate of AEs related to acupuncture, as a percentage of total number of treatments, is a safe, or relatively safe therapy when applied in clinical practice by trained professionals(2,12,14,34). However, whilst serious events are rare, minor AEs are relatively common and include pain, bleeding and bruising, fatigue and fainting(130).

Witt’s 2009 prospective study(14) is the largest prospective study to date focusing on 19,726 AEs. It reported up to 8.6% of patients reporting AEs. Most of these were minor events such as bleeding or pain at the site of needle insertion, but 2.2% of those AEs required further treatment including two pneumothoraces and one nerve lesion which lasted 180 days.

Some authors point out that many of these events may have been caused by malpractice and negligence and potentially could have been avoided. This is supported as it is unethical and negligent practice to continue practising acupuncture without appropriate training.

The purpose of this study was to develop an appropriate consent form taking into account possible risks of treatment. This was seen as being too strong, and patients being left alone too long. It could be argued that some of what was reported constitutes normal treatment effects, however, 10% of avoidable events raises concern.

Birch agrees that the over reporting of normal treatment responses does not make sense and this indicates an issue with the consent process rather than the acupuncture itself(196).

Macpherson’s 2004 paper(196) stated a total of 10.7% of patients surveyed reported a total of 1044 AEs caused directly from treatment. With the most common being ‘severe tiredness and exhaustion’, followed by prolonged or unacceptable pain at the needle site.

Only three of the reported events could be considered serious requiring admission to hospital; these were severe back pain, body rash with fever and extreme drowsiness leading to a motor vehicle accident. 109 (10%) events were considered to be avoidable including needles being left at the end of the treatment, moxibustion burns, electro stimulation that was too strong, and patients being left alone too long. It could be argued that some of what was reported constitutes normal treatment effects, however, 10% of avoidable events raises concern.

Zhang’s 2010 review(197) of the Chinese literature between 1980-2009 agreed that many acupuncture related AEs (296 traumatic injuries and 11 infections of the 479 AEs) reported in the literature can be attributed to improper technique and that increased efforts should be made to monitor and minimise risk.

Shortly following this was He’s 2012 review(198) of the Chinese literature from 1956-2010, which agreed that the majority of AEs (431 tissue or organ injury, 38 infections, 8345 forgotten/broken/bent/stack needles) were caused by negligent practice or incorrect sterilisation procedures and that they could be mainly avoided through standardisation of teaching and clinical practice.

Birch supported the robustness of this study in terms of accuracy of reporting in retrospective analyses however, he suggests that too much standardisation could impact on the diversity of acupuncture. Birch(199) concurs that education around anatomy, physiology, pathology, infection control and handling of patient are paramount in order to reduce the number of serious AEs occurring due to negligent practice.

Adams et al 2011 study(200) focused on the safety of paediatric acupuncture through a systematic review. Although the rate of AEs (279) was low at 11.8%, 25 serious events including those of infection, organ rupture, nerve impairment and haemorrhage were reported. Of these 25 events, 6 of these were at the hands of certified acupuncturists but 18 were due to acupuncture being performed by ‘unspecified practitioners’ who were listed as those not trained in traditional Chinese medicine. One of the key implications of this study was that a majority of the AEs are a result of poor clinical practice rather than as a consequence of the acupuncture itself. Poor clinical practice resulted in infection due to inadequate sterilisation.

ABSTRACT

ACupuncture is commonly presented in the literature as a safe and low risk therapy. However without a comprehensive reporting scheme for accidents and adverse events there are concerns about relying on self-reporting mechanisms.

Key issues identified within reporting are the potential for significant under reporting and the high rate of adverse events due to professional negligence.

Additionally, a proportion of reporting is not traditional acupuncture, often medical acupuncture or dry needling, and is not performed by correctly trained professionals with the World Health Organisation (WHO) recommended 500 hours of clinical training specific to acupuncture.

This article argues that acupuncture is only safe in the hands of appropriately trained professionals, and these professionals must ensure high standards of practice and continual training and review. Further points of discussion are the significant concerns with the portrayal of ‘acupuncture’ and ‘acupuncturist’ in the literature.

To emphasise this argument a snapshot on reporting over a five year timeframe within New Zealand is presented.

KEYWORDS: Acupuncture, safety, adverse events, New Zealand

Introduction

The safety of acupuncture is a debated topic in the literature with the extreme dichotomies of reporting occurring from acupuncture being a high risk dangerous therapy(1), to it being a safe and safe therapy(2).

Whilst a number of systematic reviews place adverse event (AE) rates for acupuncture treatments at <1-16% (130,131), some authors argue that this rate may be as high as 48% (170).

The definition of an AE is ‘any unfavourable and unintended sign, symptom or disease that presents during or after treatment with acupuncture regardless of a causal relationship’ (130). AEs tend to be classified according to risk which is calculated based on the frequency with which they occur and the level of seriousness. (170)

The distinction is made between unavoidable and avoidable events, and are often highlighted avoidable events likely to be caused by inadequate practice standards and negligence. Such events include things like pneumothorax, moxibustion burns, fainting of a patient while seated and leaving needles in patients following treatment.

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In New Zealand, acupuncture is a profession not regulated by legislation. Standards are maintained by the professional bodies to which membership is voluntary. These organisations require members to hold the NZ awarded four year bachelor’s degree or international equivalent, and in addition to the primary qualification, all applicants must have completed a minimum of 500 hours of supervised clinical training.

Whilst acupuncture training in New Zealand is a four year degree, there is no current restriction on practice by those not holding this level of qualification, and there exists a myriad of short courses for other allied health professionals including massage therapists, chiropractors and osteopaths.

The reporting of AEs in New Zealand is voluntary if done by practitioners, or if reported by clients, and in these voluntary reports the level of training and professional membership are often omiuted.

Reporting of safety in the literature

To provide background on the topic of AEs reported in the literature the following databases were searched: PubMed, EMBASE, Medline and AMED (from their inception to May 2016).
Accidents do happen! A discussion of Acupuncture incident and adverse event reporting in New Zealand

Kate Roberts, MHSc(TCM), BHSc(Acup)

and organ damage due to improper technique or poor anatomical knowledge.

The authors conclude that their review concurs with others that have found that ‘acupuncture is safe when performed by appropriately trained practitioners’.

Bensoussan concurred that the amount of training has a direct impact on rate of AEs. In his study, practitioner training was matched against rate of AEs reported and he noted that medical practitioners stated significantly less training in acupuncture than non medical practitioners with 72% of medical practitioners completing less than two weeks of TCM training. The rate of reported pneumothorax was double in medically trained acupuncturists compared to TCM trained acupuncturists.4 White’s 2004 review30 theorised that the cumulative worldwide incidence of serious AEs (35%) is estimated to be 0.05 per 10,000 treatments, this represents a ‘very low’ risk which is below that of many common medical treatments.

This number differs slightly from Ernst’s review of 200662 which suggests that serious events are probably rare but non-serious events occur in 7-11% of patients. Ernst goes on to state that due to under reporting this percentage may be significantly lower than the true rate of events.

This discrepancy in reported numbers of events highlights the issues surrounding reporting consistency, and additionally touches on the potential for publication bias to occur in which the number of serious or unusual adverse events may be over reported in some instances.1,43,62 Janz’ 2011 article52 highlights the risk of other therapies being reported as acupuncture in the literature on AEs. He specifically focuses on the use of ‘dry needling’ and more recently ‘Intramuscular Stimulation’ which are available as short courses of training to a myriad of health practitioners.

This re-defining of acupuncture to avoid legal ramifications of practice in states and countries where regulation is not appropriately trained practitioners'.

A five year (2008-2013) retrospective review of accident and AE reporting was conducted in New Zealand to compare results of AE reporting to what is reported in the literature. To do this the following have been investigated:

• Acupuncture New Zealand (AcupNZ) (previously New Zealand Register of Acupuncturists (NZRA)) complaints or reports,
• any Health and Disability Commissioner (HDC) complaints, or reports,
• Accident Compensation Corporation (ACC) statistics;
• reporting in a single education institute.

Professional Body

In the last five years there has been 13 reports lodged with the Register (see Table 1 AE reports to the NZRA 2008-2013). All were patient complaints except one which was a self-reported herbal medicine concern from a practitioner.

However, reporting remains voluntary therefore the risk of under reporting exists.

Snapshot on New Zealand

A five year (2008-2013) retrospective review of accident and AE reporting was conducted in New Zealand to compare results of AE reporting to what is reported in the literature. To do this the following have been investigated:

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• any Health and Disability Commissioner (HDC) complaints, or reports,
• Accident Compensation Corporation (ACC) statistics;
• reporting in a single education institute.

This highlights that there is a sufficient framework for complaints and reporting to be made and a robust system for the management of AEs. However, reporting remains voluntary therefore the risk of under reporting exists.

In the last five years there has been 13 reports lodged with the Register (see Table 1 AE reports to the NZRA 2008-2013) and one rubbish bin on fire.

These included two burns due to cupping, one extreme anxiety attack requiring hospitalisation, one pneumothorax, four reports of used needles not being disposed of correctly and one rubblish bin on fire.

In the case of each incident, detailed follow up occurs. The outcomes of all occurrences are circulated and used as learning tools for quality improvement in education, services and policies.

Insurance Body

Accident Compensation Corporation (ACC) is the key injury compensatory scheme in New Zealand. ACC manages approximately 1.6 million injury claims each year and collects information that is relevant to inform future strategies for injury prevention.

They also assist in the analysis of claim trends, identification of priority target areas and help in the development of programmes to reduce the number and cost of injuries to New Zealanders.

The ACC system is unique to New Zealand as treatment injuries or injuries caused by accidents are covered by the compensation system.

Whether or not this encourages a higher AE report rate by patients and medical professionals is unknown, but without the risk of litigation, it may be likely.

A treatment injury is caused as a result of seeking or receiving treatment from a registered health professional that is not a necessary part or ordinary consequence of that treatment. Interestingly, whilst acupuncturists are recognised as providers under the ACC Act of 2001, they are not included within the definition of registered health professionals.

Therefore, care provided by acupuncturists falls outside treatment injury under ACC legislation. This results in reporting from ACC where those treatment injuries classified as adverse events for acupuncture treatment have occurred in the hands of other registered health practitioners.66

Currently in New Zealand this group consists of general practitioners, physiotherapists, and any other health practitioners that are regulated under legislation.

Between 1 January 2008 and 31 December 2012, ACC accepted 16 treatment injury claims relating to acupuncture (Table 2 – AEs reported to ACC). Of these 16 accepted claims, 13 related to physiotherapy and the remaining 3 to general practitioners.

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The majority of the injuries would be considered as avoidable injuries such as infection which amounted to almost a third of the claims, followed by burns and bruising.

Table 1 - AE reports to the NZRA 2008-2013

<table>
<thead>
<tr>
<th>EVENT</th>
<th>NUMBER OF AE REPORTS</th>
<th>ACTION BY PROFESSIONAL BODY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsening of condition</td>
<td>1</td>
<td>No formal complaint to action taken</td>
</tr>
<tr>
<td>Acupuncture over dose</td>
<td>1</td>
<td>Practitioner reported to ACC</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>2</td>
<td>One case handled by HCC, one case practitioner reported, reviewed by NZRA</td>
</tr>
<tr>
<td>Sexual misconduct, assault, sexual assault</td>
<td>3</td>
<td>One case handled by HCC but discontinued</td>
</tr>
<tr>
<td>Due care investigated by police and HCC but discontinued</td>
<td></td>
<td>Handled externally</td>
</tr>
<tr>
<td>Due care practitioner’s guilt and is in litigation</td>
<td></td>
<td>Handled externally</td>
</tr>
<tr>
<td>Painful treatment</td>
<td>1</td>
<td>Procedures reviewed with member</td>
</tr>
<tr>
<td>Mobilation burns</td>
<td>1</td>
<td>Procedures reviewed with member</td>
</tr>
<tr>
<td>Chinese herbs containing western medicine</td>
<td>1</td>
<td>Medicinal (New Zealand Medicine Safety Authority) gave a written warning</td>
</tr>
<tr>
<td>Severe pain from skin from dental insertion</td>
<td>1</td>
<td>Practitioner reported to formal complaint, Procedures reviewed by the NZRA</td>
</tr>
<tr>
<td>Gua sha bruising</td>
<td>2</td>
<td>Procedures reviewed by the NZRA</td>
</tr>
</tbody>
</table>

Table 2 - AEs reported to ACC

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>NUMBER OF AEs</th>
<th>AE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>7</td>
<td>Burn</td>
</tr>
<tr>
<td>ACC</td>
<td>4</td>
<td>Foreign body</td>
</tr>
<tr>
<td>ACC</td>
<td>4</td>
<td>Malignant tumour</td>
</tr>
<tr>
<td>ACC</td>
<td>5</td>
<td>Infection</td>
</tr>
<tr>
<td>ACC</td>
<td>4</td>
<td>Lung injury</td>
</tr>
<tr>
<td>ACC</td>
<td>4</td>
<td>Neuro injury</td>
</tr>
<tr>
<td>ACC</td>
<td>4</td>
<td>Sinew injury</td>
</tr>
<tr>
<td>ACC</td>
<td>4</td>
<td>Scar from spine</td>
</tr>
</tbody>
</table>

Table 3 - AEs reported to HDC

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>NUMBER OF AEs</th>
<th>AE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC</td>
<td>3</td>
<td>Sexual assault</td>
</tr>
<tr>
<td>HCC</td>
<td>3</td>
<td>Overcharging</td>
</tr>
<tr>
<td>HCC</td>
<td>3</td>
<td>Whitening of condition</td>
</tr>
<tr>
<td>HCC</td>
<td>2</td>
<td>Psychological</td>
</tr>
</tbody>
</table>

Table 3 - AEs reported to ACC

This includes making sure those complaints about good health or disability service providers are taken care of fairly and efficiently.

Over the past five years, the New Zealand Health and Disability Commissioner have closed 14 complaints about acupuncturists (Table 3 - AEs reported to HDC). Again it is not clear whether these were with registered acupuncture professionals or other medical or allied professionals performing acupuncture techniques as there is currently no statutory regulation for acupuncturists in New Zealand.

Seven complaints contained allegations of inappropriate touching during examination or treatment, three complaints concerned fees charged and allegations that the treatment aggravated the presenting condition, and one complaint regarding a pneumothorax.

All of these, apart from a pneumothorax which was deemed to be an accident, were avoidable AEs.

Government Agency

The main role of the Health and Disability Commissioner is to ensure that the rights of consumers are upheld.

This includes making sure those complaints about good health or disability service providers are taken care of fairly and efficiently.

Over the past five years, the New Zealand Health and Disability Commissioner have closed 14 complaints about acupuncturists (Table 3 - AEs reported to HDC). Again it is not clear whether these were with registered acupuncture professionals or other medical or allied professionals performing acupuncture techniques as there is currently no statutory regulation for acupuncturists in New Zealand.

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All of these, apart from a pneumothorax which was deemed to be an accident, were avoidable AEs.

Educational Facility

The New Zealand School of Acupuncture (NZSA) is the largest and longest standing acupuncture education provider in New Zealand.

The NZSA has a robust accident and AE reporting system. AEs related to patient safety or safe clinical practice must be reported and handled so as to prevent repetition.

Potential risks of treatment are outlined on student clinic consent forms and a verbal consent is required from patients before application of needling or other applied therapies.

In a five year retrospective analysis of the AEs nine complaints (Table 4 - AEs reported at NZSA) or incidents have been lodged. These included two burns due to cupping, one extreme anxiety attack requiring hospitalisation, one pneumothorax, four reports of used needles not being disposed of correctly and one rubblish bin on fire.

In the case of each incident, detailed follow up occurs. The outcomes of all occurrences are circulated and used as learning tools for quality improvement in education, services and policies.
Discussion and future strategies

A reduction in AEs is vital in order to improve the quality of health care and lower the cost of care. The under reporting of AEs in most medical professions is high[28] and while it is assumed that acupuncture is also subject to under reporting, there remains unknown Good reporting systems now to be evaluated from multiple sources which will allow an analysis of contributing factors and the prevention of recurrence[14]. Being guided by professional ethics and the principle of non-maleficence, the issue of doing no harm to others, should guide the need for a voluntary reporting system.

Avenues for reporting are available and have been identified within the New Zealand setting. The reports and statistics highlighted from the New Zealand five retrospective analyses, although not definitive, seem to reflect those in published studies reporting on the topic of AE reporting. However, it remains highly likely that this data is subject to under reporting and the definitions included within the set data in terms of style of acupuncture, practitioner status and education are often unclear. The avoidable risks merit the most attention when it comes to the implementation of standardisation of the consent process paired with semi-regular checks of immune status and needle stick injury so continual review of handling procedures.

The risk of transmission of infection has fallen with the introduction of single use sterilised needles, however, this remains unknown. A valid suggestion from White addressing this is annual practitioner checklists for safe practice.(2) The under reporting of AEs in most medical professions is high[28] and with professional and governing bodies taking a leading role in to determine appropriate reporting mechanisms.

Qualiﬁed acupuncturists need to continually strive for a safety and make informed practice to ensure patient safety and best practice.

Acknowledgements

Thanks to Dr D Betts and the Research Sub Committee of the New Zealand School of Acupuncture for reviewing and supporting the writing of the article.

References

Appendix 1 - Summary of AES from the Literature

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>COUNTRY</th>
<th>ARTICLE TYPE</th>
<th>NUMBER OF AE'S</th>
<th>SERIOUS</th>
<th>MODERATE</th>
<th>MILD</th>
<th>NOT STATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams (2011)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>109 (Mild)</td>
<td>15%</td>
<td>30%</td>
<td>55%</td>
<td>10%</td>
</tr>
<tr>
<td>Baldwin of (1997)</td>
<td>Australia</td>
<td>Retrospective survey</td>
<td>10 (Mild)</td>
<td>40%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Birch (2012)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>10 (Mild)</td>
<td>10%</td>
<td>40%</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Capilli (2010)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>10 (Mild)</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Chang (2010)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>10 (Mild)</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Ernst (1994)</td>
<td>Germany</td>
<td>Prospective review</td>
<td>10 (Mild)</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Ernst (2002)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>10 (Mild)</td>
<td>10%</td>
<td>30%</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Ernst (2004)</td>
<td>Multiple</td>
<td>Systematic Review</td>
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<td>Ernst (2005)</td>
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<td>Systematic Review</td>
<td>10 (Mild)</td>
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<td>Ernst (2007)</td>
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<td>Systematic Review</td>
<td>10 (Mild)</td>
<td>10%</td>
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<tr>
<td>Ernst (2008)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>10 (Mild)</td>
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<tr>
<td>Ernst (2009)</td>
<td>Multiple</td>
<td>Systematic Review</td>
<td>10 (Mild)</td>
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</table>

**Note:** The percentages of individual studies given.
Cross-Cultural Differences in Acupuncture: A Review

ABSTRACT

Background: Over time, Chinese medicine spread throughout Asia and developed into distinguishable styles of acupuncture in China, Japan, Korea and possibly Taiwan.

Aims: This study sought to classify, clarify and describe acupuncture styles in China, Japan, Korea and Taiwan.

Methods: A systematic search was conducted using University of New England e-search resources, CINAHL (1998 to January 2015), ProQuest (1980 to January 2015), PubMed (1980 to January 2015) and Google Scholar (1980 to January 2015). Data was collated and coded into philosophical concepts, diagnostic methods and treatment principles. Patterns of relationships between styles were examined.

Results: Twenty-eight articles met the inclusion criteria. Features of Chinese acupuncture include pattern identification and syndrome differentiation as well as the four diagnoses. The solvation of ‘De-qi’ during needle stimulation is typical. Although encompassed in Chinese acupuncture as well, emphasis in Japanese acupuncture is placed on the theory of five phases, meridians and collaterals, palpation and relatively light needle stimulation. Korean acupuncture is based on a constitutional model and uses systematic treatments with substance injection into body loci and microsystem acupuncture. Taiwanese acupuncture was described as analogous to Chinese acupuncture.

Conclusion: There is a variable degree of consistency and reliability in the literature addressing acupuncture styles internationally. There appears to be a common pool of philosophical concepts, Chinese in origin, which are fundamental across all styles and have influenced the respective diagnostic methods and treatment principles in varying degrees. Japanese and Korean acupuncture styles have evolved from this, whereas details of a Taiwanese acupuncture style is limited and is assumed to be Chinese.

KEYWORDS: Acupuncture, acupuncture style, classification, China, Japan, Korea

Introduction

The Standards for Reporting Clinical Trials in Acupuncture (STRICTA) protocols recognize the diversity of acupuncture philosophy, diagnosis and treatment and necessitate the inclusion of details pertaining to style-specific techniques and approaches used in clinical trials to contextualize the practice of acupuncture within current clinical methodologies.

Despite the recognition of differences in style, there is only a limited official definition and analysis of various approaches to acupuncture. No single definitive guide has been created which classifies, clarifies and compares the philosophical concepts, diagnostic methods and treatment principles of acupuncture across East Asia.

A comprehensive analysis of the literature available on the knowledge of acupuncture styles is needed to ascertain any inconsistencies, misrepresentations and further details on the diversity of international acupuncture styles. This review examined how Chinese, Japanese, Korean and Taiwanese acupuncture styles have been classified and attempted to clearly distinguish and understand the different approaches to acupuncture in Traditional East Asian Medicine (TEAM).

This research also aimed to outline the diversity of acupuncture practice and highlight theoretical and practical adaptations.

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Methods

A literature search was conducted to identify publications regarding the similarities and distinguishing features of acupuncture styles categorised by country of origin. A key word search including a combination of the following terms was conducted: Chinese, Japanese, Korean, Taiwanese, acupuncture, acupuncture style, classification, clarification and oriental medicine.

In January 2015, an electronic database search was conducted using the following databases: University of New England library catalogue and e-search resources, CINAHL (1998 to January 2015), ProQuest (1980 to January 2015), PubMed (1980 to January 2015) and Google Scholar (1980 to January 2015). The titles and abstracts of the papers identified by the search were examined and included according to the inclusion and exclusion criteria. Additionally, the reference lists from retrieved studies were examined for supplementary sources which were then obtained and examined. To widen the search, an author search was performed using the electronic databases.

Included studies were required to attempt to clarify, classify and compare Chinese, Japanese, Korean or Taiwanese acupuncture. The studies must have included a description of the defining characteristics of the style such as philosophical concepts, diagnostic methods and treatment principles. These themes were selected because they were identified as some of the most important aspects of clinical practice.

The articles included in this review were restricted to English language publications after 1980. This review focused on literature after 1980 in order to collate data which informed modern assumptions on the similarities and differences between styles. Textbooks were not included in the review but any government or official organisation reports or publications, conference literature and journal articles were accepted. The literature is summarised in Appendix 1.

Results

Twenty-eight articles were sourced. Seven discussion papers focused on the characteristics of Chinese acupuncture, five discussion papers on Japanese acupuncture and four on Korean acupuncture. Eight publications attempted to define and compare combinations of styles. Two articles were World Health Organisation (WHO) publications, two reported randomised controlled trials, one article was a modified Delphi process and two books were included. Taiwanese acupuncture was not identified as a distinct style.

Chinese acupuncture

Six articles presented a dichotomy within Chinese acupuncture: that of pre-cultural revolution China and the standardised Traditional Chinese Medicine (TCM) of the People’s Republic of China.

All other literature described only a single system of Chinese medicine. One article validated Taiwanese acupuncture as a style but included it under the aegis of Chinese acupuncture.

Philosophical concepts

Differentiation of syndromes and pattern identification was identified by nine articles as the fundamental philosophical concept of TCM. Other literature identified Yin/Yang, five viscera and six bowels, six excesses, five phases, six meridians, febrile disease theory, trinity of meridians and collaterals and the fundamental substances as core philosophical concepts.

Freuhauf and Dalé make mention of Chinese traditional cosmology as a fundamental concept for acupuncture practice. In addition, Lao (and Deng) included body microsystem acupuncture in Chinese acupuncture. Barners, Kapchuk and Freuhauf included religious and folk traditions, such as the belief in demons, ghosts, spirits, souls and Feng Shui as part of the philosophical basis of Chinese acupuncture. Kim, Pham and Koh and Low and Ang emphasised Taoism as the central philosophy in Chinese acupuncture. Deadman et al. suggested that the diversity of philosophy is an important element in Chinese medicine and the practitioner’s ability to utilise different concepts clinically is a defining feature of Chinese acupuncture.

Diagnostic methods

Literature describing diagnosis in Chinese acupuncture included the four diagnoses (palpation, observation, olfaction/listening and inquiry), as the core diagnostic method. Observation of the tongue and palpation of the pulse were emphasised by two sources. Only one paper included meridian diagnosis as a diagnostic method in Chinese medicine.

Treatment principles

Needles, manipulation, massage, cupping, ice, gau sha, electricity, magnets, ultrasound, light, crystals, intraadermal implants, energy transfer with touch, energy transfer without touch and laser were identified as treatment tools in Chinese acupuncture.

Six articles indicated that ‘De-qi’ during treatment was strong and necessary.

The strong ‘De-qi’ needle sensation described by Deadman et al. is suggested as being more traditional and real as opposed to styles which do not emphasise a strong ‘De-qi’ sensation. Treatment around “every other day” or a possible seven treatments in 10 days for acute conditions described the frequency of treatment in Chinese acupuncture.
One article indicated that needle gauge in Chinese acupuncture was commonly 0.20 to 0.28 mm, while another specified a range from 0.32 to 0.38 mm. The findings from Ahn et al. suggested Chinese acupuncture needle insertion is relatively deeper than other styles which is confirmed in comparison to Japanese acupuncture by other authors.

**Japanese Acupuncture**

Four articles recognised several different schools of thought within Japanese acupuncture. Other literature described only a single Japanese acupuncture style.

**Philosophical concepts**

Three articles stated that the philosophical concepts of Chinese acupuncture formed the fundamentals of Japanese medicine. Katai, Ahn et al., and Yasaki underscored meridian and five phase theory. Other authors acknowledged the existence of an independent Korean acupuncture style while Flaws identified it together with Japanese acupuncture.

**Korean Acupuncture**

Several articles of thought exist within Korean (Koryo) acupuncture, most of which fall into the category of constitutional acupuncture. These frameworks rely primarily on the theory of the meridians, collaterals and five phases. Other authors stated that Korean acupuncture as an individualised approach based on psycho-somatic constitutional frameworks.

**Discussion**

The dichotomy between pre and post Chinese Cultural Revolution traditional medicine has opened debate about the suitability of modern TCM as a style. Some critics suggest TCM as a holism of acupuncture, while others seem comfortable with its application as best acupuncture practice. Heterogeneity of acupuncture styles exist in Saam and Taegeuk acupuncture in Korea and Meridian Therapy and Taikyoku Therapy schools in Japan. However, these appear to exist without contention in comparison to post Chinese Cultural Revolution and modern TCM acupuncture which are seemingly in conflict, especially when described by authors from the West. It is unknown whether this dichotomy is a product of observers from outside of China or a true representation of phenomena within the clinic itself.

There is a variable degree of consistency in the literature addressing characteristics of Chinese, Japanese and Korean acupuncture, little difference between them and that they produce similar therapeutic results.
The growing popularity of Japanese acupuncture. Only one Chinese acupuncture. Alternatively, it could be indicative of compared styles typically focused on the differences between
standardised knowledge base could have been under-exposed. The same could be said of constitutional medicine in Korea publishing power may have mistakenly become synonymous
the literature. However, it could be that authors who are
it is an emerging area of interest and has not yet been fully explored. It is possible to see distinctions in styles between Chinese, Japanese and Korean acupuncture as described through the literature. However, it could be that authors who are affiliated with a particular school of thought within a style have risen to popularity and have been able to propagate their ideas. The schools of thought with more political or publishing power may have mistakenly become synonymous with a style of acupuncture.
For example, it could be the case that proponents of the Meridian Therapy School in Japan have had greater exposure of their ideas in English and therefore an opinion may have been formed that Japanese acupuncture is Meridian Therapy. The same could be said of constitutional medicine in Korea or TCM in China where schools of thought outside of the standardised knowledge base could have been under-exposed.

Conclusion
The literature shows that there is a multiplicity of style and variation in practice of acupuncture in China, Japan and Korea. However, philosophical concepts from China are the foundation of both Japanese and Korean acupuncture practice. From the fundamental philosophical concepts of Chinese medicine, Japanese and Korean acupuncture styles have developed into distinct and separate styles. Information about Taiwanese acupuncture is extremely limited and could potentially hinder the development of acupuncture education, research and practice.

Such research could include long-term ethnographic studies so that an in-depth description of the current practice of acupuncture styles as performed by practitioners in East Asian countries can be obtained. Accurate information of philosophical concepts, diagnostic methods and treatment principles from China, Japan, Korea, Taiwan and possibly other countries and cultures will enrich TEAM knowledge and contribute to the education and practice of acupuncture internationally. A comprehensive classification and clarification of acupuncture across Asia will provide a solid theoretical platform, so that acupuncture in Australia can continue to be developed and guided by the insights of a diverse array of well-established and evolved practices.

Clinical Commentary
There is a greater depth and variety to acupuncture practice than is generally understood. Our assumptions about what acupuncture is or should be may not be based on reality and could potentially hinder the development of acupuncture education, research and practice.

References
Cross-Cultural Differences in Acupuncture: A Review

Benjamin Chau, BHSc, University of New England
Dr. Catherine DeAngelis, PhD, University of New England
Dr. Jeannie McLeod, PhD, University of New England

The Rich Resonance of Huangdi Neijing and Its Clinical Use

By Andrew Koh, MA, BA(Hons), BDCM, DipNursing RN, PhD candidate (University of New South Wales)
Dr Suzanne Cochrane, PhD, BSW, DTCM, BAS

ABSTRACT

The contributions of the various authors of the Neijing are reflected in the books’ rich philosophy, theory and application of medical concepts and acupuncture and have laid the foundation for the practice of medicine in Chinese civilisation through to the present day.

The concept of resonance 蹂蹠 encourages an exploration of the various pairings of the channels 腕俞經絡 等经. The mapping out of the pairings reveal which ones have stronger resonating relationships and are therefore given priority in the selection of channels to treat. Flexibility and versatility are thereby afforded to the clinician precisely because the acupuncture channel structure perceived by the authors of the Neijing is organic, complex and dynamic.

KEYWORDS: Huangdi Neijing, suwen, lingshu, acupuncture, resonance, shen, channel pairings

Introduction

In the past ten years, there has been a growing interest in the classics of Chinese medicine outside mainland China, leading to many claims, counterclaims of authentic practice in Chinese medicine, and hostilities between adherents of different classical medical texts (see footnote 2 in Neal, 2013).

The approach taken in this paper is a preference for talking about acupuncture in the Huangdi Neijing rather than Neijing acupuncture.

One of the strongest reasons for saying it in this way is that there is more than a single author in the Neijing, first, between the two volumes, Suwen and Lingshu, and second, within each of those books too.

To speak of ‘Neijing Acupuncture’ implies a coherent coordinated authorship or a single authorship of the Neijing. It is therefore important that we understand as much as we are able, the historical context of the Neijing and the politics leading to its compilation.

Then, we will, while bearing these in mind, look at some key concepts and how they frame acupuncture, both its clinical strategies and its application.

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We will examine the text and work through the evidence for the pairing of channels and seek to understand how this works clinically.

History

The extant text that we now have and know as the Huangdi Neijing 黃帝內經 (henceforth, Neijing), consisting of two volumes, the Suwen 種文 (Basic/Foundational Questions/ Enquiries) and the Lingshu 灵樞 (Compendium of Acupuncture/Prescription) is based on the official version of the early Han dynasty.

That in turn was based on the version compiled by Wang Bing 王冰 (762 CE).[1][2][3]

The Neijing is believed to have existed in a different form and under different names in the Han Annals during the Eastern Han dynasty prior to its compilation and later given the title we now know it by (25–220 CE).[4]

The first thing to note is that the Neijing was compiled by Wang Bing. This accounts for some of the discrepancies in style and grammar noted by sinologists.[5][6][7]

That includes knowing the compilation was edited, (re) arranged, commented on, and possibly amended by Wang Bing. The second thing to note is that there were seven chapters that were inserted into the Suwen to make up 81 chapters. The seven chapters are 66–71 and 74.

TABLE 1: INCLUDED STUDIES

<table>
<thead>
<tr>
<th>Author</th>
<th>Literature type</th>
<th>Styles Compared or Clarified</th>
<th>Summary</th>
<th>Main Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahn et al. (18)</td>
<td>Randomized clinical trial</td>
<td>CM and KM</td>
<td>Subjective experiences of the efficacy of 2 different approaches to acupuncture</td>
<td>Differences exist in the clinical trial and diagnosis between Chinese and Japanese acupuncture</td>
</tr>
<tr>
<td>Baoer (28)</td>
<td>Discussion paper</td>
<td>KM</td>
<td>Historical discourse on Chinese acupuncture</td>
<td>Korean acupuncture is constitutional medicine. Systematic treatment through scientific insight and microsystem acupuncture</td>
</tr>
<tr>
<td>Bienes (5)</td>
<td>Discussion paper</td>
<td>KM</td>
<td>Qualitative review on the adaptation of CM in USA</td>
<td>CM experiences symptoms similarly</td>
</tr>
<tr>
<td>Chao et al. (25)</td>
<td>Discussion paper</td>
<td>KM</td>
<td>Historical discourse on the schools of thought within Korean acupuncture</td>
<td>Korean acupuncture is constitutional medicine. Systematic treatment with microsystem acupuncture and substance injection into acupuncture loci</td>
</tr>
<tr>
<td>Chao et al. (16)</td>
<td>Literature review</td>
<td>KM</td>
<td>Review of MRI studies on brain response to Korean acupuncture</td>
<td>Korean acupuncture is constitutional medicine</td>
</tr>
<tr>
<td>Chowdhury and Banno (24)</td>
<td>Book</td>
<td>CM &amp; KM</td>
<td>WHO-compilation of traditional medicine in Asia, as variant of country specific paradigms</td>
<td>Differences between Chinese and Korean acupuncture exist only through differences in the public health system</td>
</tr>
<tr>
<td>Debnath et al. (7)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Comparative analysis of systems and methods in acupuncture</td>
<td>Traditional and modern methods of acupuncture have culture-specific elements traceable to China, Japan and Korea</td>
</tr>
<tr>
<td>Ding (16)</td>
<td>Chapter in WHO report</td>
<td>CM</td>
<td>Discussion between therapists on Chinese acupuncture in the West</td>
<td>Differences exist between Chinese and other styles of acupuncture</td>
</tr>
<tr>
<td>Ding and Zhang (15)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>An overview of TCM</td>
<td>Chinese medicine is based on a variety of traditional philosophical concepts including Y\n\nYin Yang, Five phases, channels and confluence etc.</td>
</tr>
<tr>
<td>Flaks (8)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Personal insights into Chinese acupuncture</td>
<td>Post Cultural Revolution Chinese acupuncture is distinguishable from Japanese, Korean and pre-Cultural Revolution Chinese acupuncture</td>
</tr>
<tr>
<td>Fuhlbrandt (9)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Discussion on the disparity between pre and post People’s Republic of China traditional medicine</td>
<td>Differences exist in an adapted Cultural Revolution Chinese acupuncture Post Cultural Revolution Chinese acupuncture is not based on classical Chinese medicine concepts</td>
</tr>
<tr>
<td>Katai (19)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Discussion between therapists on Chinese acupuncture in the West</td>
<td>Allotted differences exist between Chinese, Japanese and Korean acupuncture</td>
</tr>
<tr>
<td>Ke (10)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Personal reflection on the emphasis of palpation in Japanese acupuncture</td>
<td>Palpation is the defining feature of Japanese acupuncture diagnostics and therapeutics</td>
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<tr>
<td>Ke (20)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Personal reflection on characteristics of Japanese acupuncture</td>
<td>Japanese acupuncture is systematic, focused on palpation in diagnosis and treatment and is relatively inflexibly stimulated</td>
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<tr>
<td>Kern Jr et al. (15)</td>
<td>Discussion paper</td>
<td>CM, KM &amp; IM</td>
<td>Comparative commentary on Stress Chinese and Indian medicine</td>
<td>Korean Saung acupuncture is constitutional medicine and is more similar to Indian than Chinese medicine</td>
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<td>Kern Jr et al. (16)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Review of Korean acupuncture clinical trials</td>
<td>Korean acupuncture is constitutional medicine. Systematic treatment with microsystem acupuncture and substance injection into acupuncture loci</td>
</tr>
<tr>
<td>Kobayashi et al. (8)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Historical examination of Japanese acupuncture</td>
<td>Japanese acupuncture began to take divergences from Chinese acupuncture from around 1950 and much more observable features</td>
</tr>
<tr>
<td>Lee (10)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Basic introduction to Chinese acupuncture techniques and devices</td>
<td>Chinese acupuncture has distinct defining features research to Japanese and Korean styles</td>
</tr>
<tr>
<td>Lew and Ang (16)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Explanation and description of CM concepts in treatment</td>
<td>Tapsin is the core philosophical ideology of Chinese medicine</td>
</tr>
<tr>
<td>Mckenna et al. (6)</td>
<td>Modified Delphi process</td>
<td>Acupuncture in general</td>
<td>Explanation of STRICTA guidelines</td>
<td>Differences in acupuncture styles exist between China, Japan and Korea and are important in clinical treatment</td>
</tr>
<tr>
<td>Mitsuhashi (22)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Acupuncture on minimal stimulation acupuncture</td>
<td>Minimal stimulation acupuncture is a distinct style of CM where needles are inserted very superficially</td>
</tr>
<tr>
<td>Park H.J. et al. (11)</td>
<td>Randomized, double blind, controlled trial</td>
<td>CM</td>
<td>Clinical trial on the use of Korean Acupuncture</td>
<td>Korean acupuncture utilizes systematic treatment with microsystem acupuncture</td>
</tr>
<tr>
<td>Park H.J. et al. (12)</td>
<td>Literature review</td>
<td>CM, KM, IM &amp; TM</td>
<td>Comparison of traditional health care systems in East Asia</td>
<td>Acupuncture was developed similarly in China and Korea while somewhat differently in Japan. CM includes TM</td>
</tr>
<tr>
<td>World Health Organisation (2)</td>
<td>Book</td>
<td>CM, KM &amp; IM</td>
<td>Definitions of standard terminology in Traditional East Asian Medicine</td>
<td>Terms from Chinese, Japanese and Korean medicine are explained</td>
</tr>
<tr>
<td>Yae (23)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Personal reflection on the different schools of thought within Japanese acupuncture</td>
<td>Japanese acupuncture is systematic, focuses on palpation in diagnosis and treatment and is relatively inflexibly stimulated. Within Japanese acupuncture several different schools of thought exist</td>
</tr>
<tr>
<td>Yeh et al. (27)</td>
<td>Discussion paper</td>
<td>CM</td>
<td>Overview of Korean acupuncture</td>
<td>Korean acupuncture as constitutional medicine. Systematic treatment with microsystem acupuncture and substance injection into acupuncture loci</td>
</tr>
<tr>
<td>Yu et al. (14)</td>
<td>Discussion paper</td>
<td>CM &amp; JM</td>
<td>Comparative review of CM and JM</td>
<td>Japanese medicine as a simplified version of Chinese medicine</td>
</tr>
</tbody>
</table>

These chapters elaborate on the concept of "yuyan liuqi" (運六氣) which was developed most likely in the Tang dynasty (618-907 CE). What this suggests is that there is no single approach to Chinese medical theory and acupuncture even from the earliest time.

The Suwen itself records that people living in the four regions developed different medical methods: stone needles in the north, herbs in the west, massage in the north, acupuncture needles in the south, massage in the central region. The "sages make use of various therapeutic methods and select the most suitable one (according to the pathological conditions of the patients). The reason why different therapeutic methods can cure (the same) diseases is that (the doctors) have fully understood the causes and understood the essential principle of treatment." (The Han dynasty) The Neijing can deepen our understanding and practice of Chinese medicine, particularly in the application of acupuncture.

Politics
The first unification of imperial China occurred under Qin Shi Huang, establishing the Qin dynasty (221-207 CE). He consolidated and tightened his control over the empire through various means. Prior to his conquest, different states had their own currencies, standards of measure, written scripts, etc. It has been postulated that in the Han dynasty, the spoken language of the court and the intelligensia is more akin to modern Xiju (Hakka) or Fujian (Hokkien), not Mandarin and certainly not modern Mandarin Chinese. "Qin Shi Huang standardised everything and destroyed all that did not conform." The rewriting of history and attempts to influence/control the way the population think and therefore act, are not modern phenomena nor the monopoly of ideologies such as Nazism.

Such acts should encourage us to take a hedging position when reading the classics of Chinese medicine, especially those that date prior to the Qin-Han era and the two to three hundred years after 220 BCE. Such destruction and the assumed accompanying attempts by the intelligensia and aristocracy in hiding their previous books go quite a way to explain why texts like the Neijing are compiled from various sources into one book.

The actions of Qin Shi Huang are exemplary of him imposing a single world-view on his court and subjects and destroying everything that does not support his regime. Admittedly, some texts do survive in various conditions, but one can never answer. I write from a particular point of view, from both the Suwen and the Lingshu.

Hence, this changing plurality ought to draw our attention to our situatedness in time and space vis-à-vis the Neijing can deepen our understanding and practice of Chinese medicine, especially those that date prior to the Qin-Han era and the two to three hundred years after 220 BCE. Such destruction and the assumed accompanying attempts by the intelligensia and aristocracy in hiding their previous books go quite a way to explain why texts like the Neijing are compiled from various sources into one book.

The actions of Qin Shi Huang are exemplary of him imposing a single world-view on his court and subjects and destroying everything that does not support his regime. Admittedly, some texts do survive in various conditions, but one can never answer. I write from a particular point of view, from both the Suwen and the Lingshu.

Inevitably, this changing plurality ought to draw our attention to our situatedness in time and space vis-à-vis the Neijing. It is for this reason, combined with an attempt to grasp how the Neijing can deepen our understanding and practice of Chinese medicine, especially those that date prior to the Qin-Han era and the two to three hundred years after 220 BCE. Such destruction and the assumed accompanying attempts by the intelligensia and aristocracy in hiding their previous books go quite a way to explain why texts like the Neijing are compiled from various sources into one book.

Swee chapter eight spells out the relationship of the zangfu: the Heart is the monarch, the Liver the general, the Lung the sovereign, the Pericardium the seal, the Stomach the minister, the Intestines the ministers, the Kidney the treasury, the膀胱 (膀胱) the granary, the 胆囊 (膽囊) the storehouse, the 胆汁 (膽汁) the storehouse of bile.

If that were the case, it would imply that Chinese medicine is built on shaky foundations. On the contrary, it is suggested that the very cosmology of the Neijing, specifically of the Suwen, gives clinicians a rather strong grasp and guide to the practice of Chinese medicine, particularly in the application of acupuncture.
The rich resonance of Huangdi Neijing and its clinical use by Andrew Koh, MA, B(Hons), BTMC, DipNursing RN, PhD candidate (University of New South Wales)
and Dr Suzanne Cochrane, PhD, BSW, DTMC, BAS

The Rich Resonance of Huangdi Neijing and Its Clinical Use

The rich resonance of Huangdi Neijing and its clinical use by Andrew Koh, MA, B(Hons), BTMC, DipNursing RN, PhD candidate (University of New South Wales)
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This chapter outlines the rich resonance of Huangdi Neijing and its integration into contemporary Chinese Medicine. The richness is achieved through the strategic use of yin-yang and shen-wushen concepts, which are foundational to TCM. The resonance is felt in the patient and practitioner, and is achieved through the skillful application of acupuncture needles.

**Theory of Resonance**

The theory of resonance is central to the practice of acupuncture. It is a concept that connects the patient, the practitioner, and the cosmos. The resonance is sought through the careful selection of acupuncture points and the strategic use of needles. It is a concept that is deeply rooted in the classical texts of Chinese Medicine.

**Clinical Use of Resonance**

The clinical use of resonance is achieved through the understanding and application of the yin-yang and shen-wushen concepts. It is achieved through the skillful application of acupuncture needles and the strategic use of acupuncture points. The resonance is achieved through the careful selection of acupuncture points and the strategic use of needles. It is a concept that is deeply rooted in the classical texts of Chinese Medicine.

**Conclusion**

In conclusion, the rich resonance of Huangdi Neijing and its clinical use is a concept that connects the patient, the practitioner, and the cosmos. It is achieved through the careful selection of acupuncture points and the strategic use of needles. It is a concept that is deeply rooted in the classical texts of Chinese Medicine. The understanding and application of this concept is crucial to the practice of acupuncture.

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**References**

1. Huangdi Neijing, Chapter 66: The unity of the cosmos is bound by resonance (yin-yang), and in which transformations (hsu 休) occur due to the operations of yin-yang leading to changes (biang 便).
2. Huangdi Neijing, Chapter 66: The very subtlety of this transformational change of yin-yang is known as shen. If one has shen, then, in the words of William Blake, one is able:
   - To see the world in a grain of sand
   - To hold infinity in the palm of your hand
   - And eternity in an hour.

This shen is of vital importance. It is a primary quality, aspect, dimension of a physician.

Hence, it is said when one has this shen: ‘It does not make any difference if the theory of the Nine Needles are lost, as the physician with shen will still be able to diagnose accurately and treat effectively. The primordial importance of shen in Chinese medicine cannot be overemphasized.

**Acupuncture**

In chapter eight of the Lingshu, Huangdi states, ‘the use of needle methods must be based on the spirit’ (shen) as the basis of the acupuncture point selection.

In the source text, the word translated as ‘basis’ is better translated as root, grounded, that, namely, ‘shen’ from which the method of needling springs forth (this chapter elaborates on the wushen 五神 though with differences from the standard TCM textbooks).

The centrality of shen to the practice of acupuncture is further underscored in chapter 73 of Lingshu which details the various techniques of needling.

Towards the end of the chapter, Huangdi who is the interlocutor, asserts that in the use of needles, one must not forget the ‘cultivation and regulation of the spirit’ (shen) as the basis of the acupuncture point selection.

The line may be read more clearly as, ‘When practising acupuncture, it is required that one must not forget shen (my translation).’ With this shen, one can then tap into the resonance of the cosmos and needle according to the ‘celestial light’ (tianluang 天光), the movement of the seasons, the ‘eight directions’ (huang 六十八).

The cosmology worked out in the Suwen is repeatedly applied in the more clinically inclined Lingshu as well.

‘What the heaven has endowed man is called De (natural climate). What the earth has endowed man is called Qi (crops). The result brought about the communication between the endowment of the heaven and the endorsement of the earth, the earth is Sheng (birth).’

Once again, perhaps a clearer reading can be had with, ‘Heaven in me is De (also virtue); Earth in me is Qi. The interaction of flowing De and light Qi generates/reproduces/gives birth to (or, has generative powers)’ (my translation).

Edward Neal observed the description of shen in Suwen chapter 66, as stating ‘most manifestations found in nature can be described in terms of observable patterns of yin and yang fluctuations, but here the Neijing describes another dimension of space/time that transcends the normal observable manifestation of nature; this dimension is called shen.’

One of Neal’s clinical principles is thus rooted in this primacy of shen and the regulation of yin and yang and that is derived from the Lingshu, chapter five, where:

‘[the] essentials of acupuncture practice lie in knowing how to regulate (shen) yin and yang. When yin and yang are correctly regulated the jingqi (essence) radiates illumination (qii).’

The line may be read more clearly as, ‘That is why it is said that excellent doctors regulate Qi, ordinary doctors disturb Qi and threaten the life of the patients. So unskilled doctors have to be very careful [in treating patients].’

They must carefully examine pathological changes of the Five Zang Organs, the correspondence between the five kinds of pulse [and the Five Zang Organs], the state of Shu (Excess) and Xu (Deficiency) [as well as the state of]

softness and roughness of the skin. [Only when careful examination is made can they] select (channels and Acupuncture to perform acupuncture).’

One to one correspondence between yin-yang and shen-wushen is all. The Shangyang in one is yin-yang and shen-wushen of the other.

How then should one approach the channels and what strategies can be used clinically, based on the idea of interaction and resonance presented above?

The various pairings of channels and the rationale thereof, will be presented further more discussing how they can be applied clinically.

Pairing 1 – PI

First, there is the pairing every practitioner learns from their TCM course which is found in the Lingshu, chapter 78:

‘The Stomach Channel of Foot-Yangming and [Spleen Channel of Foot] T’aiyang are externally and internally [related to each other];’

‘The Bladder Channel of Foot-T’aiyang and [the Liver Channel of Foot] Jueyin are externally and internally [related to each other];’

‘The Kidney Channel of Foot-Shuaiyang and [the Kidney Channel of Foot] Shaoxing are externally and internally [related to each other].’

These are the relationships between Yin and Yang (Channels of the foot). [The Large Intestine Channel of Hand-Yangming and [the Lung Channel of Hand-] Taiyin are externally and internally [related to each other];]

‘The Spleen Channel of Hand-Tongli and [the Heart Channel of Hand-] Shao yin are externally and internally [related to each other].’

These are the (relationships between) Yin and Yang (Channels of the hand).
These words are the basis for the development of what is called ‘the channels extraordinary channel pairing’ (奇經别通) by modern practitioners Young Wei-chih19 and Richard Tan (see footnote 1 on page 29).

Table 1
Pairing 2 – P2
The relationships between and among the channels are not linear nor flat. Each channel has two ‘subnames,’ reflecting a different sort of yin-yang relationship, namely upper and lower, in addition to internal-external. Taiyang consists of foot Urinary Bladder (lower) and hand Small Intestine (upper). Taiyin of hand Lung (upper) and foot Liver (lower). Each tabulation can therefore be worked out for the pairs below:

Table 2
Hand Taiguyin Large Intestine Foot Taiyin Large Intestine
Hand Jueyin Large Intestine Foot Taiyin Stomach
Hand Taiyin Large Intestine Foot Taiyin Lung
Hand Jueyin Large Intestine Foot Taiyin Pericardium
Hand Taiyin Large Intestine Foot Taiyin Heart
Hand Taiyin Large Intestine Foot Taiyin Lung

Table 3
Pairing 4 – P4
In chapter 10 of the Lingshu, the interlocutor, Huangdi, was asked by his advisor Leigong, to elaborate flow of qi in the channels.

Table 4
Pairing 3 – P3
Both the Suwen and the Lingshu describe the broad functions of the six channels:

Taiyang is responsible for opening, Yangming for closing and Shaoyang for pivoting.

Table 5
Hand Taiyang Large Intestine Foot Taiyang Large Intestine
Hand Taiyang Stomach Foot Taiyang Stomach
Hand Taiyang Heart Foot Taiyang Heart
Hand Taiyang Lung Foot Taiyang Lung
Hand Taiyang Pericardium Foot Taiyang Pericardium
Hand Taiyang Urinary Bladder Foot Taiyang Urinary Bladder
Hand Taiyang Kidney Foot Taiyang Kidney

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In terms of clinical application for instance, an individual who is disposed to shallow breathing because of a restricted chest can be treated using St 43 xiaxi (the point St 43 is also chosen based on the mapping/mirroring concept which will be explored later in this paper with the application of the resonance idea examined in the earlier part). Textbooks on acupuncture indicate it is a point used for foot swelling, facial edema, abdominal distention, breathing, and foot problems.19-22 Deadman (2007) states it is used for chest fullness. The Master Tung school of acupuncture names the point menpu (66.05 by their numbering system) which means door of gold or metal door.19 It is thus named because “this point is correspondent to Lung, ‘Large Intestine’ and ‘Qi’.”23 Needling St 43 thus releases the constraint of the chest and aids in deeper breathing, increasing the capacity of the lungs themselves to take in more air.

Pairing 5 – P5
Building on the same idea of the flow of qi and thus the interconnectedness of the channels, pairing can be established with the neighbouring channel in reverse: Lung with Liver, Heart with Spleen, etc.

There will be overlaps with the other sets of pairings as can be seen in the following table, such as Large Intestine with Stomach. However, the yin-yang balance is maintained through the coupling of hand and foot channels.

This is repeated word for word in the Lingshu chapter 5:2, 3.
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Table 6

<table>
<thead>
<tr>
<th>CHANNELS</th>
<th>TIME (AM)</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foot Shaoyang/Gallbladder</td>
<td>11pm - 1am</td>
<td>7am - 9am</td>
</tr>
<tr>
<td>Foot Jueyin/Liver</td>
<td>11pm - 1am</td>
<td>7am - 9am</td>
</tr>
<tr>
<td>Hand Jueyin/Lung</td>
<td>11pm - 1am</td>
<td>7am - 9am</td>
</tr>
<tr>
<td>Hand Shaoyang/Large Intestine</td>
<td>11pm - 1am</td>
<td>7am - 9am</td>
</tr>
<tr>
<td>Hand Shaoyang/Stomach</td>
<td>11pm - 1am</td>
<td>7am - 9am</td>
</tr>
<tr>
<td>Hand Shaoying/Spleen</td>
<td>11pm - 1am</td>
<td>7am - 9am</td>
</tr>
</tbody>
</table>

Table 7

An example of this application is the use of PC6 nei guan (內關) to treat nausea arising from the stomach. (21)

Qi-blood pairing

The last channel pairing is based on the amount of qi and blood within the channels as enunciated by the Ling shu. These pairs were inferred from passages within the Ling shu and subsequently tested clinically.

The Yangming [Channels are characterised by] more blood and more qi; the Taiyang [Channels are characterised by] more blood; the Taiyin [Channels are characterised by] more blood and less qi; and the Jueyin [Channels are characterised by] more blood and less qi. The Shaoyin [Channels are characterised by] more qi and less blood. (20) Chapter 18

Table 6

The 6th set of channel pairing uses the clock map and matches according to yin and yang, hours of darkness with hours of brightness, giving us the following:

Heavenly Stems consists in 10 and Earthly Branches in 12, and the combination works out to a sexagennial cycle. Hence, the shichen terms zi to si, 11pm-1am, can be associated with the Gallbladder, the shaoying which is yang pivot, that is, turning from yin to yang.

It is the time when the Foot Shaoyang Gallbladder qi rises, moving the whole body gradually to a yang mode, towards dawn.

At the other extreme is noon, the shichen is wu to si, 11am-1pm, it is “the period of Yang within Yang” and the Ling shu chapter 2 states the “Taiyang within Yang is the heart” 阳中之阳, 心也. (20)

The Hand Shaoyin Heart qi pivots the yang qi, for while “noon is [the period of] supreme point of Yang,” when "the sun moves toward the west, Yang begins to decline." 阳中之太阴, 脾也. (20)

The so-called Chinese clock divides the 24 hour day into 12 segments of two hours each. A segment, called shichen 午时, is a double hour.

The Ling Shu Chapter 18 states that “midnight is the supreme point of Yin and the period following midnight is the decline of Yin” 夜半为阴, 故半夜为阴至, and “Yang develops to its supreme point at the noon [which is the period of Yang within Yang]” 日中而陽隴,为重陽. (20)

At midnight, as yin declines, yang in turn grows. We know from the earlier chapters such as chapter five of the Suwen, the chapter 2 states “Taiyang within Yin is the heart” 阴中之阳, 心也. (20)

Both the Gallbladder and Liver are yin in nature. The Suwen from the earlier chapters such as chapter five of the Suwen, states in the third sentence:

The Liver channel is paired with a shaoyang channel in the third sentence:肝之少阳,胆也;... 阳中之少阳,肝也

As the Liver is already paired with the Gallbladder in the external-internal relationship, one is left with the Spleen which, as seen in P4, is also paired with the Liver. The next two pairings require a little interpretation and is a process of elimination.肝之至阴,胃也... 脾之至阴,胃也

It is suggested that the Lung channel is paired with the kidney within the text itself. The first and last sentences of the section reads:肺之至阴,肾也... 脾之至阴,胃也

By itself, it remains unclear how the pairing should occur precisely. The clue is in Ling shu chapter one which positions the channels in an yin-yang manner.

The Shaoyin within Yang is the lung and its Yuan-Primary [Acupoint] is Taichong (LR 3) on both sides; the Taiyang within Yang is the heart and its Yuan-Primary [Acupoint] is Daliao (PC 7) on both sides; the Shaoyang within Yang is the liver and its Yuan-Primary [Acupoint] is Taiyuan (LU 9) on both sides; the Taiyin within Yang is the kidney and its Yuan-Primary [Acupoint] is Taixi (KI 3) on both sides. (21)

The Spleen’s phase though each works differently. Both are vital to the digestive process.
The Large and Small Intestines are thus grouped with the Spleen and Stomach for the latter reason. As the Spleen is already paired with the Small Intestine in the P3 set and the Stomach with the Large Intestine via the yangming channel, the Spleen is now coupled with the Large Intestine and the Stomach with the Small Intestine. The two last channels left are the Gallbladder and the Pericardium.

When the Qi-Blood pairings are mapped against the description of the channels given in the Lingshu chapter 78, a yin-yang symmetry is manifest for four of the pairs.

For instance, where one channel has more blood and less qi, its partner has less blood and more qi, such as the Gallbladder and Pericardium channels (see the following table 8).

The last two pairs, namely the Spleen-Large Intestine and Stomach-Small Intestine channels are weighted in favour of more blood than Qi. Spleen and Stomach Intestine channels have more blood and less Qi but Stomach and Large Intestine channels are full of both blood and Qi.

The presence of more blood seems logical when one recalls this group is where post-natal nourishment and the sustenance of life operate.

Table 8

<table>
<thead>
<tr>
<th>Pair of Yang</th>
<th>Blood &gt; Qi</th>
<th>Qi &gt; Blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung (hand)</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Kidney (foot)</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Stomach (hand)</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Liver (hand)</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Spleen (foot)</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Large Intestine (hand)</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Pair of Yin</td>
<td>Blood &lt; Qi</td>
<td>Qi &lt; Blood</td>
</tr>
<tr>
<td>Human (foot)</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Small Intestine (hand)</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Pericardium (hand)</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Urinary Bladder (hand)</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>

An example of clinical application for the Qi-blood pairing is when there is a constricted chest uses the same mirror image but approaching the foot as representing the entire body, thereby positioning St 43 right at the ‘chest’ level.

Such a framework built on the idea of resonance ying 阴 in the Sioows is clearly explicated in the Lingshu chapter 9:

If the disease is in the upper [part of the body, the Acupoints located on] the lower [part of the body can be needled [to treat it]; [if] the disease is in the lower [part of the body, the Acupoints located on] the upper [part of the body can be needled [to treat it]; [if] the disease is in the head, [the Acupoints located on] the foot [can be needled [to treat it]; [if] the disease is in the waist, [the Acupoints located on] the popliteal fossa [can be needled [to treat it]]

The example given of the set P4 using St 43 siangu 肾俞 to treat a constricted chest uses the same mirror image but approaching the foot as representing the entire body, thereby positioning St 43 right at the ‘chest’ level.

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The concentration on the lower half of the legs was based on the mirror-map and Lingshu chapter 9 quoted above. The channels used were based on the Lingshu fullness of qi and blood in the channels, focusing more on the manipulation of Blood (see Table 8).

No herbs were prescribed due to the various medications Jane was on. Immediately following the treatment, Jane said she had one episode of dizziness lasting 2-3 hours. She was very pleased.

Treatment followed an additional approach using Richard Tan’s idea of balancing.1 I needled the following points:

Tongue: pale, very little coating.

BP was 166/66. When asked, Jane said she had one episode of dizziness lasting 2-3 hours. She was very pleased.

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BP was 166/66. When asked, Jane said she had one episode of dizziness lasting 2-3 hours. She was very pleased.

Case example 1

Tom (pseudonym), a 34 year old man first visited complaining of a dull ache in his chest upper back on the medial border of the right scapula. He first experienced it over 10 years ago but it resolved by itself. On presentation, he had a sharp pain some two-three weeks before and noticed the recurrence on stretching or flexing his neck.

His relationship of seven years ended in 2012. Since then, he had not talked through the matter with anyone.

Pulse, general:
Right – thready, Left – wiry

Tongue: body – pale red, coating – dry, a little yellow.

Pulpat: Area of complaint was ropey, tight, and the ache was felt on pressure. Left upper back was slightly tight, with nil pain.

Treatment: As the channel affected is the Urinary Bladder, I used its paired channel, following P3 and P6, as a treating channel: I palpated along left Lung channel. Active point around Master Tung point 44.01 fenjun 伏兔. On needling he had an adverse reaction and felt faint. The treatment stopped. Ache a little relieved. Visits were weekly.

2nd visit: No relief post treatment. Acupuncture was treated but he was not used to treat shoulder. Instead, local treatment applied using cupping resulting in dark red patches.

3rd visit: Still no resolution. A review of the history and case took place. It was decided to return to first principle – treat shen. Followed Qi-Blood and P4 pairing and using the mirror map. It was needled on the left H3, H7 and H8. Tom said the effect was almost instantaneous. The area of ache and tightness then covering some 3cm by Rcm area was reduced to around 1cm circumference.

4th visit: Tom reported the improvement was sustained and he had more movement. He had also started talking through his relationship break up which had affected him deeply, with his usual confidant.

This was the first time he had done so since 2012. The same points on the Heart channel was used as the spine of the treatment with a few secondary points for systemic treatment.

Subsequent visits were teaching movements to sustain physical progress, encouraged meditation and talking through emotional states with his confidant.

1 Richard Tan’s course was first held in Sydney, 2012 which I had attended and form which the idea of balancing the channels came.

2 The balancing method was also based on the idea of pairing channels. However, Richard Tan used the bagua to explain the pairing.

Acknowledgement is given that the pairing numbers are in line with Tan’s.
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3rd visit: Jane reported no episode of dizziness at all. In the course of the conversation, she said she had come to “sydney to die. But now I feel good.”

Subsequent visits were based on presentations and maintenance therapy as no dizziness was experienced except when Jane overstrained herself.

Even so, the episodes would last a few hours rather than days. Jane now knows to slow down and ‘take it easy’.

Discussion

Mapping out the pairings reveals which ones have stronger resonating relationships and are therefore given priority in the selection of channels to treat. The table in the appendix, for instance, shows that the Liver Channel couples strongly with the San Jiao Channel, while the Stomach Channel resonates with the Pericardium and Large Intestine. Flexibility and versatility are thereby afforded to the clinician precisely because the acupuncture channel structure perceived by the authors of the Neijing is organic, complex and dynamic.

In case 1, the channel affected is the Urinary Bladder. Both the Lung and Heart channels show an affinity with it. However, the initial failure by the practitioner to consider the 3rd visit: Jane reported no episode of dizziness at all. In the course of the conversation, she said she had come to “sydney to die. But now I feel good.”

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Case study: Improving sperm parameters with acupuncture and Chinese herbal medicine

Nicola Macdonald DipTCM, ADVCertTCMChina, MHlthSc(TCM)

ABSTRACT

Traditional Chinese medicine for male infertility was first recorded as a treatment in 610CE in the Chao Yuan-fang’s Zhu Bing Yuan Hou Lun. Despite the long history of empirical knowledge, male fertility treatments with acupuncture and Chinese herbal medicine have been poorly researched. Western medicine has little to offer men in the treatment of most male fertility disorders, particularly where substandard sperm is the issue. This case study demonstrates a male who presented with a semen analysis in the low-normal range and improved his sperm parameters by between 34% and 50% following three months of weekly acupuncture and Chinese herbal medicine. The patient and his wife reported their first pregnancy three months after the treatment period.

KEYWORDS: male, fertility, sperm parameters, semen analysis, acupuncture, Chinese herbal medicine, spermatogenesis, teratozoospermia.

Introduction

Primary infertility is defined as a pregnancy not achieved after twelve months of unprotected sexual intercourse and is estimated to be prevalent in eight to fifteen percent of couples worldwide. In males, infertility is estimated to be present at a rate of around seven percent and may be a factor in up to fifty percent of infertile couples. Male infertility includes a variety of disorders including semen irregularities (sperm count, concentration, vitality, morphology, antibdy and DNA fragmentation disorders); varicocele, urogenital infections, cryptorchidism and obstruction within the male reproductive tract. The condition can be idiopathic in up to fifty percent of patients. Spermatogenesis, the process by which spermatozoa are formed, requires almost three months and may be hampered by a variety of factors including: exposure to environmental toxins, overheating the scrotum (>34°C), increasing age, under or over weight, infections, diabetes, smoking cigarettes or cannabis, antidepressant use, intensive exercise, and prolonged cycling.

Male fertility investigations may include physical examination, semen analysis, anti-sperm antibody test, sperm function tests and reproductive hormone serolgy (e.g. follicle stimulating hormone, luteinising hormone, prolactin and testosterone). Currently, the western medicine treatment for male infertility is extremely limited. Structural and infectious conditions may be treated with surgery (e.g. varicocele, although the benefit to fertility is controversial) or antibiotics (e.g. urogenital infections). In cases of oligospermia (low sperm count), asthenospermia (low motility) and teratozoospermia (poor morphology) there is no standard medical treatment so instead intracytoplasmic sperm injection (ICSI) is employed. In the case of azoospermia (the absence of spermatozoa in the ejaculate) immature sperm can be surgically extracted. ICSI requires that the female partner has her oocytes extracted for fertilisation. Male infertility treatment is a growing area for traditional Chinese medicine (TCM) research. Since 1997, acupuncture trials have been contributing to the small but growing body of evidence.

The following case study highlights an example of a male patient with low-normal semen analysis results who responded favourably to acupuncture and Chinese herbal medicine (CHM) treatment.

Case study: Improving sperm parameters with acupuncture and Chinese herbal medicine

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Description of the patient

A 35 year old man was referred by his wife for male fertility enhancement. They had attempted four in-vitro fertilisation cycles (IVF) without a positive pregnancy test. The fertilisation rate was 60 percent. The couple were diagnosed with unexplained infertility. The husband had already undergone two months of acupuncture and herbal medicine to support her last IVF cycle. The couple decided to take a three month break from IVF and concentrate on a regime of preconception care including acupuncture, herbal medicine, a healthy diet, no alcohol, reducing stress and increasing their exercise.

The man is average height, slim with a healthy complexion. He does not smoke, use recreational drugs or take any medications. He has no other children.

Presentation, history of presenting condition

The man’s sperm analysis showed low-normal results for count, motility and morphology (Table 3). He reported no other symptoms of reproductive disorders including erectile dysfunction, anxiety or poor libido. He calculated in accordance with their IVF specialist’s recommendations, every other day and the volume of seminal fluid was adequate. He did not experience any scrotal pain and there were no problems with urination other than waking to urinate at least once during the night.

He reported his general health as usually very good. Major findings from the consultation were:

• Sleep: Sound and only interrupted by urge to urinate
• Energy: Good energy generally, but tires early in the evening. He works very long hours and shift work
• Digestion: Good appetite, passing regular well-formed stools once daily
• Head: Suffers from dull headaches occasionally at the temples when tired (from working long hours).
• Eye: Eye irritation from wearing the computer for long hours.
• Mouth: Sometimes sticks to the roof of mouth
• Musculoskeletal: Low back ache worse when tired and cold to touch, low back ache when working long hours, knee pain from rugby injuries during teens and twenties. Tight neck and shoulders when frustrated at work
• Emotional health: Work can be stressful in managing a large team but he feels he copes well.
• Skin: Sweating easily, especially around the groin region which would also become itchy. He sweats easily, especially around the groin region which would also become itchy. He also chafes easily around the groin region.
• Exercise: Gym (cardio and weights one hour) two to three times per week. Incidental exercise walking to the bus most days. He drives stress best when he is exercising
• Tongue: Wet with teeth marks with slightly red sides and a small amount of thin yellow coating
• Pulse: The right guan pulse (Liver/Gallbladder) was wiry and the right chi pulse (Kidney Yang) was weak.

Physical examination

A physical examination showed that the patient’s lower back was colder than his abdomen. His skin was clammy and he reported that he sweated easily, especially around the groin region which would also become itchy. His general practitioner indicated that his semen was above the lower reference ranges for sperm count, morphology and motility however he wished to improve these results.

Investigations

The man attended his first appointment with his last semen analysis that was six months old. The analysis report indicated that his semen was above the lower reference ranges for sperm count, motility and morphology however he wished to improve these results.

Diagnosis

The patient was diagnosed with Liver Qi stagnation, Damp Heat in the Liver and Gallbladder and a mild Kidney Yang deficiency. The signs and symptoms to support these diagnoses are as follows:

• Liver Qi stagnation: Frustration, mood is better after exercise, neck and shoulder tension, sighing frequently and wry pulse in the right guan position.
• Damp heat in the Liver and Gallbladder: Dull headaches at temples when frustrated, sweating and itching in the groin, and red sides on tongue with thin yellow coating.
• Kidney Yang deficiency: Low-normal sperm parameters, low back ache worse when tired and cold to touch, low energy at the end of day, sweating easily, nocturnal urination, history of excessive exercise resulting in knee pain and weak right chi pulse.

The treatment principle for the first treatment focused on reducing the excess patterns: move liver qi, drain damp heat, reduce stress and increase their exercise.

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* This paper is a modified version of one prepared as an assignment in the Women’s Health in Chinese Medicine unit in the Masters of Chinese Medicine at Western Sydney University.
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The man and his wife undertook another IVF cycle the month after this test was taken. The fertilisation rate was 75 percent and although the fresh embryo transfer was unsuccessful, they reported a positive pregnancy test for a frozen embryo transfer in the next month.

Discussion

TCM considers male infertility to be related to the correct functioning of the Kidney, Liver and Spleen.18 The Kidney is known as the ‘root of life’ – it stores the Jing (essence), governs birth, development and reproduction, controls the lower uriniferous and is the gate to Jing Men (warming the lower Jiao, Jing and harmonising sexual function). The Liver regulates the movement and volume of blood, circulates the Qi to prevent obstructions and controls the sinews (including the penis). The Spleen is the root of acquired Qi and through its transforming and transporting function contributes to the development of blood Yin and Yang which are necessary for reproductive processes to occur.22,23 Sperm is probably most closely connected with the Kidney Jing. It is the Yang of the Kidney that gives sperm their motility, warms the seminal fluid to prevent it being thin and watery, and provides the spark for libido and orgasm. The Yin controls substance and is represented by quantity of semen, sperm count and morphology, and control over ejaculation. Jing essence manifests in proper sexual development or premature ageing. Liver blood deficiency can lead to a decline in Jing (fertility). Damp heat can cause obstructions within the genital region in the form of infections and this can reduce male fertility(7) and sexual function.14,15 Men over the age of 35 have a decline in their sperm parameters.24 Traditional Chinese medicine equates this to a Kidney deficiency. Kidney depletion or situations that wear out the body - that is chronic illness, excessive ejaculation and exercise, or overwork. Dysfunction is created in the Liver by the emotions of anger, frustration and repressed emotion, a greasy and spicy diet, excessive alcohol intake (creating too much heat) and a sedentary lifestyle. The Spleen is harmed through difficult to digest foods contributing to a lack of nutrients to nourish the Jing and blood, a predominance for worrying and overthinking, and exposure to damp environments.15,33 Studies suggest that acupuncture given twice per week for between five and ten weeks can significantly improve sperm count10, concentration,10 morphology,19,20 and motility20 specifically rapid motility (22). CHM research for the treatment of sperm disorders is extremely limited and poor quality. Additionally, nutritional medicine may be used as an adjunct to TCM treatment. Vitamin C, E, folic acid and zinc have been shown to reduce DNA damage by up to twenty percent in older men (44 years).3

Conclusion

The body of evidence supporting acupuncture and CHM for improving sperm parameters is small but growing. Unfortunately, many of the studies are small and the research designs are flawed as is often the case in acupuncture studies, the TCM diagnosis is lacking. One study22 made two general diagnoses: deficiency of the Kidneys and damp-heat syndrome, and found that patients with higher scrotal temperatures (due to inflammation and heat) showed less improvement in sperm count in CHM who had a course of acupuncture had normal scrotal temperatures at the conclusion of treatment.

In conjunction with the drop in temperature, almost all of those patients demonstrated an increased sperm count. This suggests that correctly diagnosing based on TCM and western medical investigations may lead to better treatment outcomes. Male fertility, in particular sperm quality, is greatly affected by lifestyle factors. Overheating, excessive exercise, weight disorders, excessive alcohol intake, obstruction of the genital region and increased age are aetiological factors in both Western and Chinese medicine. These factors must be addressed in consultations with male infertility patients, particularly during the three month pre-conception period. This case demonstrates that treatment is still beneficial if a semen analysis is low-normal. Through acupuncture treatment and CHM support, the man improved his sperm count, motility and morphology considerably, contributing to a higher ovum fertilisation rate and his wife’s first pregnancy. Western pathology provides an accurate tool for measuring the extent of sperm disorders and TCM provides treatment to significantly improve sperm parameters where there is currently no comparable Western medical option.

References

Case study: Improving sperm parameters with acupuncture and Chinese herbal medicine

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TREATMENT PRINCIPLE  POINT SELECTION  DEPTH AND TECHNIQUE

Spread Liver Qi  Regulate lower jiao  Liver 3 (LV3)  0.5 cun, towards KD1

Spread Liver Qi, Clear damp heat from Liver & Gallbladder  Gallbladder 34 (GB34)  1 cun, perpendicular

Harmonise the Liver  Tonify the Kidney, Drain damp, Benefit the genitals  Spleen 6 (SP6)  1 cun, perpendicular

Spread Liver Qi  Clear heat and benefit eyes  Gallbladder 41 (GB41)  0.5 cun, perpendicular

Spread Liver Qi  Clear damp heat from lower jiao  Liver 5 (LV5)  1 cun, perpendicular

Harmonise the Liver  Tonify the Kidney, Drain damp, Benefit the genitals  Gallbladder 3 (GB3)  0.5 cun, towards KD1

Resolve damp  Benefit the lower jiao  Spleen 9 (SP9)  1 cun, perpendicular

Calm the shen  Governing vessel 20 (DU20)  0.5 cun, transverse

Table 2. Secondary Acupuncture: Treatment principles, acupuncture point prescription and techniques (Deadman et al., 2006)

TREATMENT PRINCIPLE  POINT SELECTION  DEPTH AND TECHNIQUE

Spread Liver Qi  Regulate lower jiao  Liver 3 (LV3)  0.5 cun, towards KD1

Spread Liver Qi  Gallbladder 34 (GB34)  1 cun, perpendicular

Spread Liver Qi, Clear heat and benefit eyes  Gallbladder 41 (GB41)  0.5 cun, perpendicular

Clear heat and benefit eyes  Gallbladder 3 (GB3)  1 cun, perpendicular

Harmonise the Liver  Tonify the Kidney, Benefit the urogenital organs  Gallbladder 34 (GB34)  0.5 cun, perpendicular

Tonify the lower jiao  Kidney 11 (KD11)  0.5 cun, perpendicular

Fortify the original Qi, Benefit the essence  Conception vessel 4 (REN4) Unilateral  0.5 cun, oblique insertion to the penis

Calm the shen  Governing vessel 20 (DU20)  0.5 cun, transverse

Table 3. A comparison of the mans’ initial and post-treatment sperm analyses

<table>
<thead>
<tr>
<th>ANDROLOGY SPERM ANALYSIS 1</th>
<th>SPERM ANALYSIS 2</th>
<th>CHANGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count 27</td>
<td>63</td>
<td>+ 36 (57.1)</td>
</tr>
<tr>
<td>Motility 50</td>
<td>76</td>
<td>+ 26 (34.2)</td>
</tr>
<tr>
<td>Morphology 9</td>
<td>14</td>
<td>+ 5 (35.7)</td>
</tr>
</tbody>
</table>

Table 4. Initial Acupuncture: Treatment principles, acupuncture point prescription and techniques (Deadman et al., 2006)

Appendix 1: KPC Herbs Long dan xie gan wan

Table 5. Initial Acupuncture: Treatment principles, acupuncture point prescription and techniques (Deadman et al., 2006)

Appendix 2: China Med Men’s Formula (nan bao)

Table 6. Initial Acupuncture: Treatment principles, acupuncture point prescription and techniques (Deadman et al., 2006)

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