Volume 3, No.2 • Spring 2016

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The Journal of Acupuncture and Oriental Medicine

INSIDE

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ISSN 2377-3723 (print)
ISSN 2377-3731 (online)

CONTENTS

Volume 3, No.2 · Spring 2016

ORIGINAL RESEARCH

PERSPECTIVES

CLINICAL PEARLS

Cover Image: Spring Daisy Photo by Federica Favara

MERIDIANS

The Journal of Acupuncture and Oriental Medicine

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

Welcome to the spring 2016 issue of Meridians JAOM.

In this issue we offer a short commentary titled "Time for a Medical Renaissance: A Healthy Marriage between Western and Eastern Medicine" by Adam Gries, DAOM, LAc. This piece sets the tone for several of our articles as Gries discusses the necessity of finding ways to integrate different diagnostic and treatment strategies pulled from multiple medical approaches.

First, we present "Model for Integrating Acupuncture into Supportive Care in Oncology," prepared by Douglas McDaniel, MTOM, LAc; Katherine Taromina, MS, LAc; Raquel Similio, MS, LAc; and Elena J. Ladas, PhD, RD that addresses this specific multi-faceted approach. This piece reports on a feasible evidence-based model for the integration of acupuncture alongside conventional medical care in the oncology setting.

Our Public Health Editor Elizabeth Sommers, MPH, PhD, LAc discusses the integration of acupuncture into hospital-based services and community health centers. The piece, "Synergies: Acupuncture and Public Health," gives her view from a public health perspective regarding its role in our changing healthcare landscape.

Additionally, we present "Discussion: The Use of Acupoint Catgut Embedding to Treat Obesity" by Michelle Fedder, DAOM, LAc. Fedder explores the technique of embedding catgut at certain acupoints, which has been proven effective in treating obesity. ACE has been and still is widely practiced in China though few have heard of it in the U.S. Fedder makes the case for its integration into our scope of practice—yet another approach towards integration of medical techniques.

"Swimmer's Shoulder: An Acupuncture Sports Medicine Approach" by Cissey Xi Ye, DAOM, LAc is another example of acupuncture's potential—in the field of sports medicine. Ye specifically notes its use as a safe treatment option for shoulder pain experienced by elite competitive swimmers.

Last, but certainly not least, we offer a piece that considers the intersection of Chinese medicine, Freudian analysis, and integral thought corresponding to pre-modern, modern and post-modern ways of knowing. A practitioner and AOM scholar for over 30 years, Lonny Jarrett MS, MAc gives us "Chinese Medicine and Psychoanalysis, an Integral Perspective." His Part 1 is titled "Denial and the Diaphragm," which focuses on a deeper understanding of the impact of denial and repression on the stagnation in the body and insight into unlocking and liberating the diaphragm.

In this issue we also introduce our new Clinical Pearls Editor Mitchell Harris. He presents discussions on the topic: "How Do You Treat Erectile Dysfunction in Your Clinic?" We hope these Clinical Pearls, as well as our other past Clinical Pearls, are valuable resources for your own practice regimen.

As always, we invite your questions, submissions, feedback, and letters to the editor, info@meridiansjaom.com.

In Health,

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

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

MERIDIANS JAOM EDITORIAL BOARD

NCCAOM® Launches New Membership Organization for Nationally Board Certified Diplomate

The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM®) announces the launch of a new national membership organization, the **NCCAOM® Academy of Diplomates**.

The new Academy of Diplomates, a separate, chartered division of the NCCAOM®, "will allow the Commission to expand our services to fulfill our dual mission: *to assure the safety and well-being of the public and to advance the professional practice of acupuncture and Oriental medicine*," says NCCAOM Board of Commissioners Chair Eugene London, DAOM, Dipl Ac (NCCAOM®), LAc. "The Academy enables us to go beyond certification to help our Diplomates be successful in their careers as AOM practitioners."

"The Academy was created to serve our Diplomates and will not charge membership dues," stated newly appointed chair of the Academy of Diplomates Board of Directors, David Canzone, Dipl Ac (NCCAOM®), Dipl NBAO, DOM, "and our hope is to work cooperatively and synergistically with all AOM professional associations in support of the AOM profession."

"The new Academy of Diplomates was created based upon NCCAOM®'s 2014 strategic plan," noted Kory Ward-Cook, PhD, chief executive officer of NCCAOM®. "A major catalyst for its founding was feedback from our Diplomates through the 2015 Diplomate Satisfaction Survey."

Here are some examples of new Academy programs and activities we plan to include:

- Offer resources to help Diplomates seeking to work in hospitals and integrative practice settings
- Provide free practitioner websites (See https://www.nccaomdiplomates.com)
- Expand public awareness and professional education campaigns to promote AOM and national board-certified AOM practitioners
- Provide tools for Diplomates to manage their practices more successfully
- Obtain a Standard Occupational Code for "Acupuncturist under the Bureau of Labor Statistics (BLS) Standards of Occupational Classification (SOC) system, which will facilitate greater federal recognition for AOM practitioners (See http://www.nccaom.org/bls/)
- Secure AOM representation on the American Medical Association Current Procedural Terminology (CPT) Health Care Professionals Advisory Committee
- Help to assure third party reimbursement for acupuncturist-provided acupuncture by working with other integrative healthcare professions to insure compliance to the non-discrimination clause 2706 of the Affordable Care Act (See http://www.covermycare.org/cmc/)

One new Academy member benefit will be a free online access to all issues of *Meridians: The Journal of Acupuncture and Oriental Medicine*, the professional, quarterly, peer reviewed publication for all AOM and affiliated professionals. Discounted print copies of all future MJAOM issues will be made available to Academy members through a reduced subscription rate.

To learn more about the Academy of Diplomates or about acupuncture and national board certification please visit www.nccaom.org.

A Model for Integrating Acupuncture into Supportive Care in Oncology

By Douglas McDaniel, MTOM, LAc; Katherine Taromina, MS, LAc; Raquel Similio, MS, LAc; Elena J Ladas, PhD, RD*

(reprinted with permission from Meridians: The Journal of Acupuncture and Oriental Medicine, vol. 3, #2)

Please see bios at the end of the article.

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Abstract

Evidence for the efficacy of the use of acupuncture for supportive care in an oncology setting has prompted clinicians to establish guidelines to safely and effectively deliver acupuncture services within the context of conventional care. Developing standard operating procedures and adhering to established practice guidelines facilitates the safe provision of acupuncture services. We provide a feasible model for the provision of acupuncture alongside conventional medical care to adults and children undergoing treatment for cancer at an urban, academic medical center.

Key Words: medical oncology, pediatric oncology, neoplasms, integrative medicine, acupuncture, medicine, traditional Chinese medicine, clinical practice guidelines

Introduction

Acupuncture has emerged as having a therapeutic role for symptom management among adults and children with cancer.[1] A literature search reveals close to 800 articles published over the past decade on the role of acupuncture within cancer care. Systematic reviews have found that acupuncture is an effective supportive care modality for the management of chemotherapy-induced nausea/vomiting, pain, radiation induced xerostomia and anxiety.[2,3] Clinical studies have also reported that acupuncture may be effective in reducing hot flashes experienced by adults with breast and pancreatic cancer, decreasing lymphedema, and for the management of insomnia.[2,4,5,6]

There is still much to learn about the mechanisms by which acupuncture may impart a beneficial effect to adults and children with cancer. Several studies demonstrate that acupuncture may have a regulatory effect on the neural, endocrine and immunologic systems.[7,8] The effect of acupuncture on adrenocorticotropic hormone and serotonin, dopamine, and norepinephrine may explain its effect on pain, depression and anxiety.[5,9] Evidence also suggests acupuncture needling may encourage connective tissue health and promote analgesic effects.[10]

The expanded use of acupuncture within existing supportive care regimens and the described benefit reported by children and adults with cancer have prompted clinicians

to establish guidelines to safely and effectively deliver acupuncture services within the context of conventional care. The Society for Integrative Oncology has published guidelines on the use of acupuncture in general oncology[11] and specifically for adults with lung[12] and breast[13] cancer. These guidelines provide an overview of the evidence in order to inform clinicians, patients and researchers on the safety and efficacy of the use of acupuncture in the oncology setting.[11,12,13,14]

Acupuncture is recommended for adults experiencing poorly controlled pain and xerostomia[11] and for children experiencing chemotherapy-induced nausea/vomiting.[15] Guidelines specific to adults with lung cancer recommend acupuncture for peripheral neuropathy and for anxiety, fatigue and quality of life in patients with breast cancer.[12,13]

With the increasing evidence for safety and efficacy of acupuncture in oncology, there is a further need to establish guidelines for the provision of acupuncture services and its integration within conventional medical institutions. We describe acupuncture practice guidelines for treating adults and children with cancer in a comprehensive supportive care program within an urban academic medical setting.

Model of Care

Established in 1998, the Integrative Therapies Program (ITP) was developed to provide supportive care services to children and adolescents with cancer. The ITP was the first fully integrated complementary and alternative program in the United States for pediatric oncology. Located in the outpatient unit of the Herbert Irving Child and Adolescent Cancer Center, the ITP specializes in clinical care, research, and education for children with cancer and their families from diagnosis into survivorship.

Treatments are provided in all areas of patient care, including the outpatient and inpatient settings, radiation oncology, and the pediatric emergency room. Acupuncture services began in 2005 and in 2014 expanded into several adult oncology divisions and the adult outpatient infusion center. To ensure access to acupuncture across all socioeconomic groups, acupuncture is provided free of charge to all patients.

General Considerations

Provision of acupuncture and other integrative therapies such as massage, acupressure, aromatherapy, and mind-body therapies are provided directly alongside conventional care—a hallmark feature of ITP. Delivering acupuncture treatments without interfering with the timely delivery of conventional care requires close collaboration and communication with nursing staff, who often serve as the point person to communicate immediate needs for symptom management. Acupuncture is most frequently delivered in settings where specific complaints may be immediately addressed such as in the outpatient chemotherapy infusion center or in the hospital room during an inpatient stay. Providing acupuncture treatments concurrent with conventional care minimizes interruption in the flow of standard treatment, with the added benefit of minimizing the number of patient appointments.

To guide the delivery of care, protocols were established through collaboration between ITP clinicians and the conventional medical team [Figure 1]. Clean needle technique guidelines are followed as administered by the Council of Colleges of Acupuncture and Oriental Medicine.[16] The Center for Disease Control (CDC) practice guidelines for safely administering care to immunocompromised patients, or those who have or are suspected of infectious disease, are strictly adhered to in all settings.[17] The development of standard operating procedures facilitates the safe provision of services, fosters a productive relationship between the ITP and the conventional medical team, provides a framework for quality control and evaluation, and establishes a structure for research initiatives.

The education of the conventional medical staff was essential to breaking down the barriers of delivering acupuncture. The ITP recruited experienced licensed acupuncturists with at least five years of experience and who were able to communicate effectively about the potential risks and benefits of acupuncture to other members of the healthcare team. The ITP also initiated an education day where oncologists, nurses, and other medical professionals could experience acupuncture and learn about its application in the medical setting. Clinician experience with acupuncture has facilitated collaboration among all medical disciplines by providing them with a thorough understanding of the underlying theory, diagnostic approach, and clinical application.

Referral Pattern

Adults and children are eligible for an acupuncture consultation from the time of initial diagnosis and may be referred by an oncologist, ITP clinician, oncology fellow, nurse practitioner, social worker, or other clinical staff. Patients may also self-refer or learn about ITP from another patient. Upon referral, an ITP acupuncturist meets with the patient and their family to provide a comprehensive overview of the risks and benefits of acupuncture and assess whether the patient is likely to benefit from acupuncture for a specified symptom. Eligible candidates for acupuncture services are coordinated through the program's clinical coordinator.

Prior to the initiation of acupuncture services, treatment concerns raised by either the oncologist or the ITP acupuncturist

are reviewed, and the safest method of delivery is determined. Following physician approval, an informed consent form is completed and all risks and benefits are again reviewed with the patient and their family. Once acupuncture has been initiated, ongoing treatment continues at the discretion of the providing acupuncturist and request of the patient. If there is a significant change in the patient's medical condition, the patient's primary oncologist may be contacted again to provide approval to continue acupuncture treatment [Figure 1].

Circumstances in which a second approval may be obtained include a change in the severity of an existing condition, arrival of a new condition, disease progression, conditions that require additional supportive medical care, (e.g., mechanical ventilation, hemodialysis, oscillation), and entering a new phase of treatment, (e.g., radiation to chemotherapy or chemotherapy to stem cell transplant). Acupuncture treatments may be discontinued if other integrative therapies may be more beneficial for the condition or treatment is directed toward family based care such as in the end of life setting.

Patient Assessment and Treatment

A review of the medical record and oncologic treatment plan coupled with an intake, which includes the chief complaint(s), and a review of systems based upon traditional Chinese medicine (TCM) is performed on each patient. A TCM examination includes four diagnostic methods: inspection, auscultation and olfaction, inquiry and palpation. Observation includes assessment of the tongue (including color, form, coating), patient's body shape and facial complexion. Listening includes assessing strength and quality of the voice and breath, presence of cough or congestion, and sounds related to the quality and intensity of pain. Smelling includes assessing the presence, location, intensity and nature of pathogenic odors. Inquiry includes the onset and development of the chief complaint, including any associated symptoms. In addition, a thorough history is conducted to understand both the patient's current constitution and if possible, his/her constitution pre-cancer diagnosis and treatment.

Palpation of the radial pulse bilaterally is conducted, and depth, speed, strength, shape and rhythm are noted. Palpation of other areas of the body may be used when appropriate. This assessment process leads to the identification of the individual's TCM pattern of disharmony and the development of an initial treatment plan based upon the patient's constitution, severity of symptoms, response to treatment (both conventional and integrative) and the conventional medical plan.

This assessment, performed at each clinical encounter by the licensed acupuncturist, provides the basis for the acupoint prescription. Often, symptoms may change rapidly. In these clinical circumstances, the patient is reassessed using the described methods, and the treatment plan is modified accordingly. By integrating this approach, the ITP adheres to the traditional practice of TCM in lieu of a prescription-based approach.

ITP acupuncturists perform daily rounds in the adult and pediatric outpatient infusion centers and on the pediatric inpatient and intensive care units. Services are also provided in the pediatric radiation center and pediatric emergency department. Integrating acupuncture with conventional cancer treatment allows for immediate attention to acute treatment side effects, enhances symptom management and reduces anxiety associated with treatment or disease. For example, ITP routinely provides acupuncture treatment prior to or during the beginning of a chemotherapy infusion associated with nausea and vomiting with the objective of reducing or avoiding the side effect altogether.

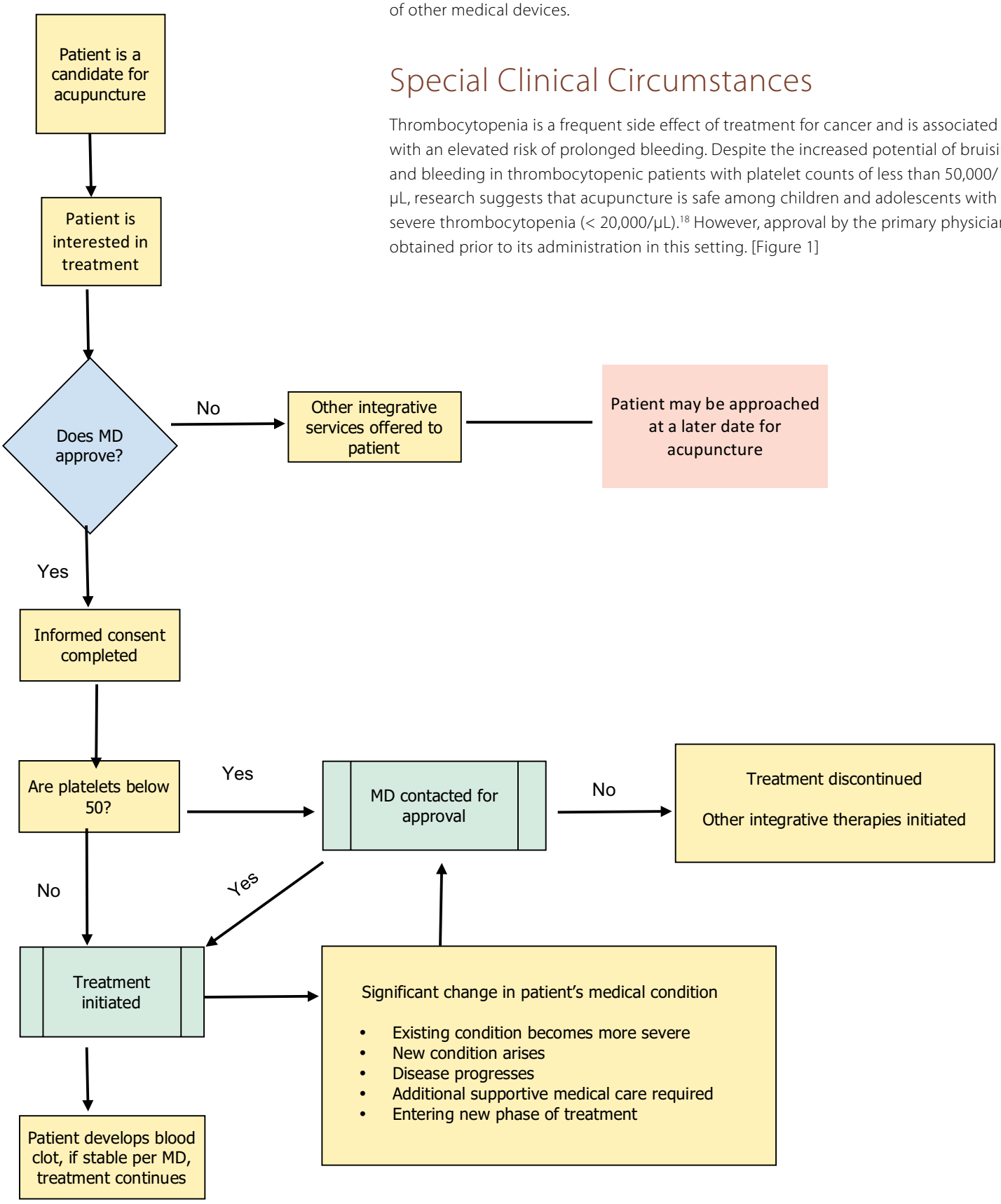
The ITP also maintains a private treatment room for patients who require more privacy or request treatment on days outside of a scheduled treatment appointment. All treatments are documented in the electronic medical record (EMR) including the chief complaint, related signs and symptoms, TCM diagnosis, treatment principle, acupuncture points needled, number of needles inserted and withdrawn and length of time of needle retention. The most recent platelet count and any adverse events, such as acute bruising or bleeding, are also recorded.

Coordination of Care

The ITP team meets weekly to discuss patients undergoing treatment as well as those patients who have completed therapy. During these multidisciplinary meetings, treatment plans are developed, coordinated, evaluated and revised as necessary. Team meetings with oncologists, nursing, and disease-specific teams also occur weekly where new and existing patients are discussed and treatment plans are established. Members of the ITP team regularly attend medical and psycho-social rounds, pediatric palliative care, and mortality and morbidity meetings. Our model ensures open and clear communication between all members of the medical team.

Delivering acupuncture around scheduled medical procedures requires flexibility by the acupuncturist. ITP clinicians work closely with the nursing staff to coordinate treatment around scheduled conventional care, as patients may be late returning from a procedure or may need to have an unanticipated procedure that could preclude or shorten the time allotted for acupuncture. As the program has matured and inter-professional relations have strengthened, it has resulted in the near seamless integration of conventional and complementary treatment. However, modification of acupuncture delivery is sometimes required to accommodate patients' positioning on the bed or chair or to

Figure 1 Acupuncuture Clinical Care Model



navigate necessary medical equipment. During these times, acupuncture point prescriptions may need modification and are only administered to areas that are free and clear of other medical devices.

Special Clinical Circumstances

Thrombocytopenia is a frequent side effect of treatment for cancer and is associated with an elevated risk of prolonged bleeding. Despite the increased potential of bruising and bleeding in thrombocytopenic patients with platelet counts of less than 50,000/μL, research suggests that acupuncture is safe among children and adolescents with severe thrombocytopenia (< 20,000/μL).[18] However, approval by the primary physician is obtained prior to its administration in this setting. [Figure 1]

Adults and children who are severely neutropenic, absolute neutrophil count (ANC) <500 cells/μL, are at greater risk for infection. Prospective studies have found that acupuncture is safe in the setting of severe neutropenia.[19] Moreover, studies performed among adults have found that acupuncture is not only safe in the setting of neutropenia but may actually have a beneficial effect on median leukocyte value.[20, 21] Most recently, a prospective trial among children with cancer found no increase in adverse events in the setting of neutropenia.[22] Our current standard of practice does not exclude the provision of acupuncture for children and adolescents with severe neutropenia.

Lymphedema and deep vein thrombosis (DVT) are two clinical circumstances where ITP acupuncturists are guided by the oncologist's assessment of the patient's evolving condition to ensure safe delivery of care. Acupuncture has been found to be safe and effective for patients with lymphedema; [23] however, the patient's oncologist is contacted prior to initiating acupuncture. Acupuncture needle insertion along the affected limb is initiated only with physician approval and otherwise avoided.

Special attention is warranted when blood clots are present due to the potential effect of acupuncture on the movement of blood.[24] Acupuncture is administered only after the oncologist provides approval and determines the clot is stable. Acupuncture is always contraindicated near or around areas where the integrity of the skin is compromised, directly or adjacent to a tumor site, or near an intravenous line or port.

Needling Considerations

Adults and children with cancer may or may not be any more sensitive to acupuncture needling sensations compared to a non-cancer population. As per routine TCM practice, patients with cancer should be assessed for constitutional strengths and weakness, level of fatigue, hunger and thirst and previous experience with acupuncture. Caution should be taken with those who are in a weakened state, overly fatigued, have not eaten, or are dehydrated. Choice of needle length, gauge, and method of manipulation is based upon the patient's presenting constitution, the area to be needled, and the desired treatment response.

Unique Considerations for the Pediatric and Adolescent Population

Children with cancer have a high acceptance rate of integrative therapies.[25] When introducing acupuncture to children and parents, a step-wise approach is implemented to ensure the comfort with and understanding of acupuncture. First, a detailed description of acupuncture and its function from a TCM and conventional medical approach is explained. The acupuncturist shows the patient an acupuncture needle and explains where the needle(s) will be placed, the desired treatment outcome (e.g., reduce nausea, stop pain). The practitioner describes the sensation that will most likely be experienced and the length of time of needle retention.

Any questions that the child or their parents have are answered. Needles are generally retained longer with older children and adolescents than with toddlers and infants, where needles are inserted, stimulated and may be immediately withdrawn. Sometimes children will ask that their parent receive acupuncture first. This gives the parent a chance to relay their experience to their child and reaasure them that it is safe and comfortable.

Prior to needle insertion, all patients (children and adults) are informed that if they become uncomfortable at any time during the treatment they may request that one or all of the needles be immediately withdrawn. After the needles are inserted, the acupuncturist remains with all patients during the treatment to ensure close monitoring during the acupuncture session.

Conclusion

Acupuncture is an accepted supportive care modality for both adults and children with cancer.[2] As cancer centers begin to fully integrate acupuncture into supportive care regimens, it is important to consider its safe and timely delivery. Experienced acupuncturists, who have an understanding of conventional cancer treatment and are able to work alongside the medical, radiological and surgical oncology teams, can have a significant impact on the care of patients undergoing cancer treatment.

Open communication between the medical team, the patient and their family, other support services and the acupuncturist leads to collaborative comprehensive cancer care. Essential to the safe and effective delivery of acupuncture in the oncology setting is the development of a comprehensive integrative acupuncture treatment plan that is reviewed and modified as necessary as the patient's medical care evolves. We provide a model for its integration to adults and children undergoing treatment for cancer.

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Douglas McDaniel is the senior acupuncturist for the Center for Comprehensive Wellness. In addition to his teaching experience, Douglas has helped develop hospital training programs for several AOM schools. He is engaged in research relating to the use of CAM to treat cancer patients.

Katherine Taromina is the program manager for the Center for Comprehensive Wellness. In addition to her research interests, Katherine provides continuing education for acupuncturists regarding the use of traditional Chinese medicine when treating adult and child cancer patients.

Raquel Similio is an acupuncturist and massage therapist for the Center for Comprehensive Wellness. She uses a wide range of integrative therapies to provide supportive care for adults and children with cancer.

Elena Ladas is an assistant professor of nutrition in pediatrics at the Institute of Human Nutrition and co-director of the Center for Comprehensive Wellness. She is a clinical investigator with expertise in the use of CAM in cancer patients both nationally and internationally.

Swimmer's Shoulder: An Acupuncture Sports Medicine Approach

By Cissey Xi Ye, DAOM, LAc

Cissey Xi Ye, DAOM, LAc received both her master's and doctorate degrees from the Oregon College of Oriental Medicine in Portland, Oregon. She also holds a Bachelor's in Exercise Science from the George Washington University Milken Institute School of Public Health. As an undergraduate, she received an NCAA Division I athletic scholarship to compete on GWU's varsity swim team. Dr. Ye currently maintains a private practice in Beaverton, Oregon. She may be contacted at cissey.ye@gmail.com

Abstract

Shoulder pain has been reported to be a leading injury among competitive swimmers. Despite its prevalence, the current body of biomedical literature offers few preventive or treatment solutions. This lack of consensus regarding the management of swimmer's shoulder has prompted an evaluation of acupuncture, which can be an effective modality to apply as part of a sports medicine regimen. This paper examines and reviews research that indicates that acupuncture can be effective as a safe and low-risk treatment of painful shoulder among competitive swimmers when compared to conventional modalities.

Key Words: swimmer's shoulder, shoulder pain, shoulder injury, sports medicine, acupuncture, traditional Chinese medicine

Introduction

Within the past two decades, there has been a steady rise in the popularity of competitive swimming. This is demonstrated by an increase in the number of year-round athletes registered with USA Swimming, the governing body for competitive swimming, with 232,253 athletes in 2001; 249,182 in 2005; 286,147 in 2009; and 340,568 in 2013.[1] Competitive swimming starts around eight years of age and continues through college, with organized master's level participation beyond the age of 25. In 2010, the number of total high school team athletes was 284,795, while collegiate participation totaled 20,794 athletes (the 7th most popular collegiate sport).[2]

While only a handful of competitive swimmers achieve Olympic glory, the training for these athletes of all ages can be rigorous due to factors such as frequency and duration of practices as well as the intensity and volume of distance that was swum. It is not uncommon for

an age-group swimmer to be training six days a week and fitting in nine practices that average two hours each.

The average distance covered is 6500 to 10,000 meters per day, which equates to 60,000 to 80,000 meters per week.[3] A distance-swimmer may even double this workout amount. If the average stroke count is eight to ten per 25 meters, swimmers might perform up to 30,000 rotations of each shoulder per week.[4]

With competitive swimming being a year-round sport, these numbers can then be extrapolated to stroke counts exceeding one million rotations per arm per year. Another way to quantify this is to equate the distance swam per year to 2,300 miles, which is the distance from Seattle to Washington, D.C. There is no argument that competitive swimming places a tremendous amount of stress on the body, most specifically to the structures of the shoulder girdle and glenohumeral joint.[3]

These staggering statistics, coupled with the fact that nearly 90% of the forward propulsive power in swimming comes from the upper extremities, show it is hardly surprising that shoulder pain is the most common injury among the competitive swimming population. The prevalence of shoulder injuries in competitive swimmers has been reported to be as high as 91%.[4–6]

Richardson et al.[7] indicates that the incidence of shoulder pain was 52% of elite swimmers and 27% of non-elite swimmers. In McMaster and Troup,[8] 66% of senior development swimmers and 73% of elite simmers reported a history of pain in the shoulders. The frequency of pain in both studies was highest for the elite swimmers, which may be due to increased training volume and number of years participating in swimming.[3]

There is a bounty of research and literature aimed at understanding the causes and limitations of athletes with shoulder pain; however, there is a lack of consensus regarding the management of swimmer's shoulder within the sports medicine community.[9] Acupuncture has been documented as an effective intervention in the treatment of shoulder pain in a myriad of both acute and chronic situations.[10,11] The purpose of this paper is to propose acupuncture as a possible method of treatment for the maintenance and prevention of painful swimmer's shoulder in a fast-growing competitive swimming population.

What is Swimmer's Shoulder?

The term "swimmer's shoulder" was first coined in 1978 to describe common generalized pain within the anterior shoulder region experienced by competitive swimmers. This pain pattern typically occurs both during and post-workout, and it is the most common reason for missed training and competition.[12] Swimmer's shoulder has now evolved into a generic term referring to a syndrome (a group of symptoms) rather than just one specific diagnosis.

Swimmer's shoulder can result from injuries involving the muscles and soft tissue structures of the rotator cuff, biceps brachii, upper trapezius, rhomboids, deltoid, and serratus anterior. All these structures are involved in the stroke cycle of freestyle or the front crawl, the main stroke used for training. The subacromial bursa, labrum, ligaments and other anterior capsule structures can also be affected.[12,13]

Biomedical Background

Etiology + Pathogenesis

The main mechanisms that contribute to swimmers' painful shoulders are due to repetitive overuse injuries that induce inflammatory conditions such as tendonitis, bursitis, capsulitis or arthritis. These conditions may lead to subacromial impingement syndrome, with supraspinatus tendinopathy being the most common cause.[14]

The subacromial region and its structures are the most frequently affected in the shoulder. This space is comprised and bordered by the acromion, acromioclavicular joint, and coracoacromial ligament superiorly and the humeral head inferiorly. It contains the subacromial bursa, biceps tendon, and supraspinatus tendon, which are the main attachments that move within the region during glenohumeral and shoulder girdle movements.[15]

A recent study by Sein et al. used magnetic resonance imaging (MRI) that showed changes within the rotator cuff and surrounding tissues. From these images, it was proposed that shoulder pain in elite swimmers was primarily due to swim-volume-induced supraspinatus tendinopathy. Results also showed that 69% of the 52 swimmers scanned by MRI showed evidence of supraspinatus tendinopathy with more elite swimmers having a higher incidence of supraspinatus tendinopathy.[13]

Other MRI findings consisted of unstable biceps attachment, bicep sheath effusion, supraspinatus tendon tear, subscapularis tendinopathy, labral tears (20%), thickening of the subacromial (63%) and subscapularis bursa. Minimal and moderate increased subacromial and subdeltoid fluid were observed. Acromioclavicular joint arthritis also affected 33% of the imaged athletes.[13]

Butler et al.[16] conducted a retrospective cohort study of 14 swimmers that presented to an orthopedic shoulder surgeon over a six year span. These athletes all experienced a period of over six months of failed non-operative management prior to surgical consult. Diagnoses varied from subacromial impingement (4), internal impingement (3), labral tears (2 SLAP, 3 Bankart), humeral avulsion of the glenohumeral ligament (1) and multidirectional joint laxity (1).

In this study, the swimmers with impingement did not require arthroscopy and, with non-operative management returned to swimming in a mean time of 1.6 months. Athletes with labral studies required arthroscopic labral repair and these swimmers and these swimmers had a post-surgery mean time of 2.9 months return to swimming.[16]

Other studies have also suggested that high amounts of training during growth of an athlete induces changes in flexibility and stiffness around the shoulder and trunk, which leads to muscular imbalance of the core, scapulothoracic articulation, and glenohumeral mobility. All of these changes may predispose the young and developing athlete to shoulder pain.[5]

Diagnosis

Swimmers presenting with shoulder pain usually undergo a thorough clinical evaluation. The history is often described as a gradual onset of pain that is located anteriorly or at the lateral aspect of the shoulder. Anterior shoulder pain may be located over the long head of the biceps tendon in the bicipital grove and may represent increased humeral head translation from scapular dysfunction.[5]

The swimmer may report a clicking sensation that may result from a chronically inflamed subacromial bursa or from the glenoid labrum. Clicking over the shoulder may indicate an acromioclavicular joint disorder. Clicking from the back of the shoulder may represent a posterior labral tear. A "dead arm" sensation when using the arm in an overhead position is often a symptom of a labral lesion.[5]

Table 1 Clinical Evaluations of Swimmer's Shoulder

Subjective pain	Is it deep in the shoulder (labrum, underside cuff, minor instability), on the lateral aspect (bursa, supraspinatus tendon), anterior (biceps tendon), on the back of the shoulder (posterior-superior labrum), or over the shoulder (acromioclavicular joint)?
Pain provocation	Hawkins impingement sign, O'Brien's active compression sign, and dynamic labral shear test with reproducible pain (i..e., to the area reported above)
Assessment of scapula kinesis	Assessment with scapula assistant test and scapular retraction test. Pectoralis minor tightness. Thoracic kyphosis and core stability (one-leg squat).
Evaluation of glenohumeral rotation	External/internal rotation at 90 degrees of abduction in the supine position with the scapula fixed. Glenohumeral internal rotation deficit (GIRD) and excessive external rotation.
Instability evaluation	Sulcus and anterior-posterior drawer test. A total of 6+ or more is severe hyperlaxity. Apprehension test provoking true anterior apprehension, not pain.

Bak, K. (2010). The practical management of swimmer's painful shoulder: etiology, diagnosis, and treatment *Clinical Journal of Sport Medicine: Official Journal of the Canadian Academy of Sport Medicine,* 20(5), 386–390.

Diagnostic imaging such as x-ray, ultrasound, and magnetic resonance arthrography are usually taken to rule out any unusual anatomic variant or pathologies, but the radiographs are commonly normal.[4] Plain X-rays of the glenohumeral joint may show calcification in the supraspinatus tendon or in the subacromial bursa. Recently, ultrasound has been used as a noninvasive and economical tool to identify cuff tears.[5]

Magnetic resonance arthrography is the most precise diagnostic tool as well as the most invasive and costly. However, findings can be confusing because many asymptomatic shoulders have similar presentations such as irregularity of the labrum and its attachment to the anterior glenoid. Additionally, asymptomatic swimmers may have an abundant capsular volume without having pathological instability.[4,5]

Treatment

The first line of treatment and prevention for swimmer's shoulder is aimed at avoiding collision of the rotator cuff and the subacromial bursa with the undersurface of the anterior acromion as well as the internal impingement of the labrum and reduction of the capsule. This can be achieved during a training session in which the coach analyzes and corrects the stroke technique. Specific exercises can also target the specific dysfunction such as poor body posture, instability and muscle weakness, and imbalance.[5,17]

Swimmers experiencing the first signs of shoulder pain during training should report this to a qualified sports medicine professional. The earlier the injury is noted, the less inflammation and the less time it takes to move past this initial phase. Apart from rest and time off from training, conservative treatments include non-steroidal anti-inflammatory drugs (NSAIDs) at high doses (example: naproxen sodium 1375 mg per day or ibuprofen 800 mg 4 times a day) for seven to ten days.[18,19]

Athletes experiencing chronic or daily pain unrelated to swimming activity may resort to injection of corticosteroid in the subacromial/intrabursal space but only after NSAIDs and rest have failed. While the athlete is recovering from the inflammatory process due to the injection, modalities such as heat, ultrasound, electrostimulation, or trigger point and soft tissue therapy may be applied to hasten the process.[4,20]

Surgical treatment is only recommended as a last resort and should be carried out between three and six months after onset of pain if there is no improvement with conservative or medical measures.[17] Swimmers often expect to return to their pre-injury level after arthroscopic treatment, but this is not always the case. Subacromial decompression gives good pain relief but poor return rates to swimming.[17]

A systematic review conducted by Gaunt and Maffuli even proposed that the poor rate of surgical outcomes may be attributed

to the actual pathology in swimmers with painful shoulders and might be due to aggravating iatrogenic effects of arthroscopic surgical techhniques.[17] The excessive flexibility requirements of fast swimming are in complete contrast to the aims of the surgical procedures.[20] In 18 swimmers who underwent arthroscopic surgery for long-standing pain, operative procedures included debridement in ten swimmers, partial release of the coracoacromial ligament in four, and bursectomy in four.[5,17] Only 56% were able to compete at pre-injury level after a median four months following surgery.[5]

In summary, rehabilitation of swimmer's shoulder ailments should involve stroke cycle assessment, clinical evaluation, and correction of swimming technique as well as the promotion of equilibrium between muscles involved during repetitive stroke cycles. If conservative measures fail, medical and surgical interventions are available despite mixed outcomes. Prevention is often agreed upon as a better solution, which can be achieved by education, early detection, and report of pain by athlete, coach, and team medical personnel to avoid new and reoccurring injuries.[17]

AOM Background

Etiology + Pathogenesis

Bi Syndrome

In Chinese medicine, swimmer's shoulder falls under the general disease category of obstruction syndrome (*bi zheng*) leading to painful shoulder (*jian tong*). It is usually characterized by joint pain along with restriction of movement that is aggravated by exercise.[21]

"Theoretically, all acupuncture points are useful in relieving pain, since they all have the action to activate the free flow of qi and blood, thus unblocking obstructions, which is the root cause of pain.[22] However, depending on the affected area or type of pain, specific point combinations are selected for better results."

The main etiology of *bi* syndrome is caused by the simultaneous invasion of exogenous wind, cold, and damp. This can be induced by living in damp conditions and places, wearing clothes soaked by sweat or rain, frequent exposure to water, and periods of prolonged cold rainy weather. Chronic wind-cold-damp *bi* may also produce heat that can cause obstruction of the channels and collaterals.[22]

Endogenous factors also determine the development of *bi* such as the pre-existing constitution and depletion of the body. If the body is strong and healthy and not crippled with prolonged illness, the patient will be better able to fight off an exogenous attack. However, patients without any deficiency may develop *bi* syndrome if the external causes are strong enough.[22,23]

The competition swimming pool is the perfect environment to breed and contract wind-cold-damp. Not only is water the epitome of dampness, the pool temperature is kept at range of 77° to 82° F (25°-28°C) in accordance to the stipulations of the International Swimming Federation (FINA).[24] This is below body temperature of 98.6° (37°C) so heat is constantly being absorbed away from the body. Many pools are outdoors, leaving the swimmer exposed to the wind. Chlorine and other chemicals are also present in the water, which can accumulate in the body and produce toxins. With the frequency of training and amount of exposure to these elements, swimmers are highly susceptible to developing *bi* syndrome.

Patterns + Differentiation

Acute *bi* syndrome patterns are categorized into four classes based on specific external pathogenic factors and clinical manifestations. Wind (wandering) *bi* is characterized by wind evil with pain roving through various locations. Symptoms include soreness and pain that migrate from joint to joint, aversion to wind and limited range of motion. Cold (painful) *bi* is characterized by the accumulation of cold with severe pain. Symptoms include excruciating pain in the affected joints and limbs. Pain is localized and aggravated by cold. Joints are usually stiff with difficulty in movement.

Damp (fixed) *bi* is characterized by accumulation of dampness with muscular and joint numbness, aching, heaviness, swelling and pain of fixed location. Heat *bi* is characterized by fever and red swollen painful joints. Other symptoms include burning joint pain that is aggravated with pressure with a preference for cold. Heat *bi* typically stems from untreated and chronic wind-cold-damp that has transformed into heat. [22,25]

Chronic cases of *bi* syndrome will lead to more complicated patterns, such as *qi* and blood stasis, along with phlegm accumulation patterns, which is characterized by swollen joints, intermittent pain, possibly deformity, stiffness, difficulty in movement, and subcutaneous nodules. *Qi* and Blood deficiency along with Liver and Kidney deficiency pattern is characterized by intermittent joint pain with difficulty in movement, numbness of limbs, soreness and weakness of the lower back and knees, cold intolerance, fatigue and preference for warmth.[25]

Acupuncture Treatment

The treatment principle for *bi* syndrome is to expel wind, dispel cold, transform dampness, clear heat, and unblock channels. Theoretically, all acupuncture points are useful in relieving pain, since they all have the action to activate the free flow of *qi* and blood, thus unblocking obstructions, which is the root cause of pain.[22] However, depending on the affected area or type of pain, specific point combinations are selected for better results. Since we are focusing on shoulder pain, we can apply meridian theory and choose specific points along the channels that pass through the shoulder region.

All arm channels cross the shoulder (Lung, Large Intestine, Heart, Small Intestine, Pericardium, Triple Warmer). However, most of the functional structures are in the lateral and posterior aspects and are governed by the arm yang meridians: Large Intestine, Triple Warmer, Small Intestine. The Lung meridian plays the dominant role in the anterior shoulder since the Heart and Pericardium meridians pass through the axilla where few soft tissue structures are present. The leg *yang* meridians of Gallbladder and Bladder also cross the shoulder. In addition, the *yang wei* and *yang qiao* extraordinary channels have connections at the shoulder. When treating swimmer's shoulder, selecting acupuncture points that treat both the underlying causative factors of *bi* syndrome and applying channel pathology theory may produce better therapeutic effects.[22,26] See Tables 2 and 3.

Table 2 General Acupuncture Point Prescription Based on Predominant Pattern Pathology

Type of *Bi*	Manipulating Method	Point Selection	Actions and Indications
Wind *bi*	Reducing Method	BL-12 Fengmen	Expels wind. Opens the channels.
		BL-17 Geshu	Influential point of blood. Expels wind.
		SP-10 Xuehai	Removes blood stasis, regulates blood. Expels wind.
Cold *bi*	Moxibustion Reducing Method Deep Insertion, Prolonged Retention	BL-23 Shenshu	Tonifies yang. Dispels cold.
		CV-4 Guanyuan	Tonifies Warms and regulates blood. Dispels cold.
Damp *bi*	Moxibustion Reducing Method Deep Insertion, Prolonged Retention	ST-36 Zusanli	Courses wind, transforms damp.
		BL-20 Pishu	Tonifies SP, transforms damp.
		SP-5 Shangqiu	Forties SP, removes dampness.
Heat *bi*	Reducing Method	DU-14 Dazhui	Clears heat.
		LI-11 Quchi	Cools pathogenic heat.

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Table 3 Shoulder-Specific Acupuncture Point Selection Based on Meridian Theory

Point Selection	Actions and Indications
SI-13 Naohui	Clears channel, benefits joint. Indicated for pain in the shoulder and arm. Affects the triceps muscle.
SJ-14 Jianliao	Dispels Wind, Cold. Relax Tendons. Affects supraspinatus and infraspinatus tendons.
SJ-15 Tianlao	Crossing point of Yang Wei channel. Dispels wind and damp of the channel and shoulder joint. Invigorates Qi, Blood and relieves pain for shoulder trauma, arthritis, bi syndrome of the rotator cuff. Affects trapezius muscles.
LI-15 Jianyu	Meeting point of LI with Yan Qiao meridian. Clear heat, remove wind, relax tendon, smooth gleno-humeral joint function, sedate pain. Affects supraspinatus tendon.
LI -16 Jugu	Crossing point of Yang Qiao meridian. Indicated for pain and motor impairment of shoulder. Affects the acromio-clavicular joint and supraspinatus.
SI-9 Jianzhen	Keeps the shoulder joint intact by dispelling wind, activate circulation of Qi and Blood in the SI channel. Removes statsis, sedate pain, benefits the shoulder. Local point to treat scapular, shoulder pain and stiffness. Affects the teres minor muscle.
SI-10 NaoShu	Crossing point of Yang Wei and Yang Qiao meridians. Indicated for swelling of shoulder, aching and weakness of the shoulder. Activates channel and alleviates pain. Affects infraspinatus muscle.
SI -11 Tianzong	Pain in the scapular region and removes obstruction from the SI channel. Affects infraspinatus.
SI -12 Bingfeng	Benefits sinew and reduces pain. Indicated for pain in the scapular region, numbness and aching of the upper extremeties, motor impairment of shoulder. Affects supraspinatus.
SI-14 Jianweishu	Indicated for aching of the shoulder. Benefits the sinew and reduces pain. Affects the levator scapulae muscle.
SI-15 Jianzhongshu	Indicated for pain in the shoulder. Benefits the sinew and reduces pain. Affects splenius cervices.
ST-38 Tiankou	Dispels Wind and Cold, relaxes tendons. Use on contralateral leg while patient moves shoulder. Help with weakness and motor impairment of shoulder.
Jianqian	Local anterior point for gleno-humeral joint pain.
Jianhou	Local posterior point for gleno-humeral joint pain.
GB-34 Yanglingquan	He-sea and Earth point of GB channel. Influential point of sinews and tendons. Strengthen and relax tendons. Removes heat and dampness and wind. Sedates pain, benefit the joints.
LU-2 Yunmen	Smooths function of joints, especially when the arm cannot be adducted. Affects pectoralis major and minor.
LU-5 Chize	He-sea and Water point of LU channel. Relaxes tendons of arm along LU channel that crosses the anterior shoulder.
LU-9 Taiyuan	Shu-Stream, Yuan Source, Earth point of LU channel. Influential point of blood vessels. Treats pain along LU channel in same nature that LU-5 does.
GB-21 Jianjing	Meeting point of GB channel with SJ and Yang Wei channels. Relaxes the tendons and relieve stiffness. Connecting point with the shoulder region.
BL-41 Fufen	Indicated for stiffness and pain of the shoulder. Dispels wind and cold, strengthens the tendon, invigorates the connecting vessels. Affects the serratus posterior superior muscle.
BL- 43 Gohuangshu	Indicated for chronic shoulder pain and qi deficiency. Affects the serratus posterior superior muscle.

Referenced from:

Close to the Bone: The Treatment of Musculo-skeletal Disorder with Acupuncture and other Traditional Chinese Medicine. (1990) (Ringbound edition). Woy Woy, N.S.W.: Sydney College Press.

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AOM Research on Shoulder Pain

The current body of AOM literature does not consist of any studies specifically about swimmer's shoulder. However, there is a substantial collection of randomized controlled trials, literature reviews, and case reports pertaining to the effectiveness of acupuncture and general shoulder pain.

One study conducted by Molsberger et al.[10,9] examined the effectiveness of acupuncture in treating chronic shoulder pain with a participant pool of 424 subjects. Subjects were randomized into three groups consisting of traditional acupuncture, sham acupuncture, and standard orthopedic care. Traditional acupuncture was administered by experienced acupuncture practitioners at LI-4, LI-11, LI -14, LI 15, SJ-5, SJ-13, SJ-14, SI 3, SI-9, ST-38, GB-34, and BL 58. AsiaMed 0.3 mm needles were inserted unilaterally in the affected side to a depth of 1-2 cm.

Needle manipulation was mild to strong to achieve *deqi* around the acupuncture point. Sham acupuncture was carried out by the same physicians as traditional acupuncture and was standardized to eight needles at defined non-acupuncture points. These were four needles above the medial part of the tibia bilaterally, with depth of needle insertion less than 5 mm. Each treatment consisted of needle retention of 20 minutes.

Patients were blinded to the type of acupuncture and received 15 treatments over six weeks. Visual analog scale (VAS) measurements were taken periodically starting at baseline, six weeks during treatment and three weeks post-treatment.

Following treatment, analysis revealed that the traditional acupuncture group improved by 68%, the sham acupuncture by 24%, and the standard treatment at 28%. At the three-month follow-up, VAS scores showed 65% improvement with traditional acupuncture, 24% with sham acupuncture, and 37% with standard treatment (physical therapy, heat or cold therapy, ultrasound treatment and transcutaneous electrical nerve stimulation (TENS)).

Objective findings also presented with greater range of motion in the traditional acupuncture group compared to sham. Additionally, shoulder mobility was seen immediately following treatment and at the three-month follow-up in the group that received traditional acupuncture. This article suggests that acupuncture is beneficial and feasible alternative to standard conservative treatment. In addition, no serious adverse events or side effects were observed in any of the intervention groups.[10]

A similar randomized controlled trial conducted by Vas et al. evaluated the effectiveness of acupuncture in conjunction with physical therapy to treat shoulder pain.[27] A total of 425 participants suffering from unilateral subacromial syndrome were recruited. All patients underwent three weeks of physical therapy.

"Shoulder mobility was seen immediately following treatment and at the three-month follow-up in the group that received traditional acupuncture. This article suggests that acupuncture is beneficial and feasible alternative to standard conservative treatment. In addition, no serious adverse events or side effects were observed in any of the intervention groups.[10]"

Additionally, each patient was randomly assigned to receive either acupuncture or sham TENS for adjunct therapy.

Acupuncture was administered by an experienced practitioner at ST-38 ipsilaterally to the site of pain using the *tiao-shan* technique towards BL-57. The *tiao-shan* technique consists of the perpendicular insertion of a single-use sterile filiform needle, 7.5 cm long, 30-gauge at a depth of 4.5-5.0 cm. Stimulation with rotation was done until *deqi* was achieved in the lower limb. The needle was kept in place for 20 minutes and manipulated for one minute every five minutes. During periods of manipulation, the patient performed active mobilization of the shoulder, in abduction and internal and external rotation.

At the end of the trial, 53% of patients received acupuncture had decreased pain intensity and consumption levels of analgesics and NSAIDs compared to the 30% decrease among TENS patients. In conclusion, this trial revealed that acupuncture in combination with physiotherapy is capable of alleviating pain and improving function in patients with painful shoulder better than physical therapy alone. Additionally, patient perception of improvement—an outcome of "much better"—was reported by 75% of the patients in the acupuncture group one year after completing the treatment. There were no significant adverse events reported in either of the treatment groups.[27]

Another clinical trial conducted in Sweden by Johansson et al. assessed the effectiveness of acupuncture associated with home exercises in treating patients with subacromial impingement syndrome within a primary care setting.[28] A total of 91 participants were recruited and randomized into groups to receive either subacromial corticosteroid injection or ten acupuncture treatments (twice weekly for five weeks) combined with home exercises.

Acupuncture was administered by a pre-trained physical therapist using standardized point location and needle insertion. Needles were sterile, single use, 30 mm long and 0.30 mm in diameter. Points selected were LI-4, LI-14, LI-15, LU-1, SJ-14, and *deqi* was achieved upon insertion through rotation and stimulation of the

needle. The needles were retained for 30 minutes and re-stimulated every 15 minutes.

When patients were asked to report adverse effects, there only minor complications reported associated with the needle penetration. If pain or a bruise occurred, it resolved in a couple of days. Otherwise, both treatment groups reported a significant improvement over time regarding pain, shoulder function, and health-related quality of life (HRQL) as evaluated at a 12-month follow-up. It can be thus concluded that both treatments can be recommended for patients with subacromial impingement syndrome, and that the choice will influenced by the accessibility of the treatment and individual patient's preference.[28]

A 2013 study also conducted in Sweden examined the effect of acupuncture on postoperative pain in day surgery patients undergoing arthroscopic shoulder surgery. It included twenty-one participants scheduled to undergo arthroscopic shoulder surgery. Surgeries were either acromioplasty or the Bankart procedure conducted under general anesthesia. All patients received the same amount of local anesthesia at the end of the operation. Patients scheduled for surgery on odd weeks were included in the acupuncture group and even weeks in the control group.[11]

A nurse skilled in acupuncture administered acupuncture at GB-21, LU-1, LI-11, LI-4, SJ-3 and SJ-5. Stainless steel acupuncture needles were inserted in a sterile fashion. The treatment included lifting and thrusting, twirling and rotating the needle two times during the treatment. Each acupuncture treatment lasted for 30 minutes.

Patients in the acupuncture group received treatment immediately upon arrival in the post-anesthesia care unit. The control group did not receive acupuncture intervention, only standard care. In patients receiving acupuncture, pain decreased steadily throughout the first day post-operation. In the control group, there was an opposite trend as increased pain throughout the first day. Results upon data analysis found statistical significance between acupuncture and control groups. Sleep quality, a secondary outcome, also revealed significant improvement in the acupuncture group compared to the control group.

This study concluded that the application of acupuncture seemed to have a reducing effect on postoperative pain in day surgery patients. The authors also encouraged the education and use of acupuncture as a non-pharmacological approach in postoperative pain management to improve patient care.[11]

Discussion + Conclusion

Although the above studies were not conducted on swimming athletes suffering from painful shoulder, they still speak to the specific diagnoses (subacromial impingement, tendonitis, labral lesion) and their standard biomedical interventions that many swimmers would encounter in the event of injury. What these recent studies do suggest is that acupuncture is effective in treating shoulder pain, especially when compared to standard conventional treatment modalities.

The research also demonstrates that acupuncture could be used in versatile ways during different stages and settings of shoulder pain disease and treatment progression. Not only did acupuncture perform well compared to conservative treatments (NSAIDs, physical therapy), it also suggests acupuncture to be effective when juxtaposed to more invasive measures (corticosteroid injections) and even in a post-surgical setting. None of the studies reported any serious adverse events or side effects. Therefore, acupuncture appears to be a safe and low-risk intervention in treating shoulder pain.

What also stood out in the literature review were the different styles of acupuncture used in the studies. The Molsberger et al. and Ward et al. studies selected numerous local, adjacent, distal and empirical acupuncture points while Vas et al. chose to examine the effects of single-point acupuncture. This difference could be further studied. Additional topics for discussion could include the use of moxibustion, herbs, different styles of acupuncture (*ashi, tung,* trigger point) and other Chinese medical modalities and its effects on shoulder pain.

Additional research and study protocols are needed to efficiently assess the effects of acupuncture in the prevention and treatment of swimmer's shoulder. Because most of the current studies are retrospective cohort studies, it would be of value to conduct a prospective study to monitor progress in treatment and rehabilitation of injured swimmers.

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Discussion: The Use of Acupoint Catgut Embedding to Treat Obesity

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Abstract

Clinically, there is a very high level of interest on the part of patients in the topic of weight loss from a traditional Chinese medicine (TCM) perspective. While acupuncture has been shown to be more effective in reducing overall weight and body mass index than western anti-obesity drugs, patients have been found to have abandoned the therapy due to its requirement of long-term adherence and the high expense associated with frequency of treatment. One result of this has been the development of the acupoint catgut embedding as a treatment for obesity. Although shown to be effective in China, this technique has been very slow to gain credence or incorporation into the acupuncture scope of practice in the U.S.

Key Words: acupuncture, obesity, weight loss, acupoint catgut embedding (ACE), catgut

According to the World Health Organization, "coexisting with undernutrition, there is an escalating global epidemic of overweight and obesity, which poses a major risk for serious diet-related non-communicable diseases, such as diabetes mellitus, cardiovascular disease, hypertension and stroke, and certain forms of cancer. Its health consequences range from increased risk of premature death to serious chronic conditions that reduce the overall quality of life."[1]

Clinically, there is a very high level of interest on the part of patients in the topic of weight loss from a traditional Chinese medicine (TCM) perspective. Studies have shown that, while acupuncture has been shown to be more effective in reducing overall weight and body mass index (BMI) than western anti-obesity drugs,[2] a significant number of patients have abandoned the therapy due to the need for long-term adherence and the high expense

"Implanting catgut sutures at specific acupuncture points can provide long term stimulation of the point, which may lead to an increase in local blood circulation and fat metabolism. Due to the ease of operation, durable and strong stimulation, and the long intervals between each treatment, ACE has been broadly adopted as a viable approach to weight loss in China.[2]"

associated with frequency of treatment. In response to these disadvantages, the acupoint catgut embedding (ACE) method, which had previously been employed in the treatment of various other medical conditions, was considered as a viable alternative in the treatment of obesity.[3]

Based on TCM acupuncture theory, absorbable catgut sutures are implanted at specific acupuncture points. Catgut sutures are a type of surgical suture that are naturally degraded by the body's own proteolytic enzymes over the course of approximately one week. Implanting catgut sutures at specific acupuncture points can provide long term stimulation of the point, which may lead to an increase in local blood circulation and fat metabolism. Due to the ease of operation, durable and strong stimulation, and the long intervals between each treatment, ACE has been broadly adopted as a viable approach to weight loss in China.[2]

While catgut sutures are an approved FDA device, ACE does not yet fall within the scope of practice of licensed acupuncturists in the United States. At present, there are only seven states in the U.S. where their scope of practice permits point injection therapy.[4] Catgut-embedding may not technically fall within the currently accepted definition of injection therapy as it is not a "liquid medicine"[5] and may involve re-insertion of the embedding device. However, with further research and procedural guidelines that adhere to strict sterility standards, an argument may be made for inclusion of the practice under the category of injection therapy. Ultimately, injection therapy could viably become part of each state's scope of acupuncture practice.

Extensive research has been undertaken in China on the effectiveness of acupoint catgut embedding to treat obesity.[1] Studies have shown that BMI, waist circumference, hip circumference, waist-to-hip ratio, and insulin resistance were all decreased significantly with acupoint catgut embedding therapy. This paper discusses two recent articles on this topic: (#1) "Systematic Review and Meta-Analysis on Acupoint Catgut Embedding for Obesity" by Taipin Guo, Yulan Ren, Jun Kou, Jing Shi, Sun Tianxiao, and Fanrong Liang[2] and (#2) "Observation on Therapeutic Effect of Catgut Implantation at Acupoint on Simple Obesity of Different Syndrome Types" by HQ Wang, BH Ge and GR Dong.[6]

Though their review was confined to randomized controlled trials (RCTs) comparing ACE with a control group, the systematic review and meta-analysis (#1) repeatedly pointed out that in the vast majority of studies reviewed, there was poor methodology, high risk of bias, and/or small sample size. Although randomization was claimed, no illustration of the generation of random sequence was included. The authors also acknowledged the difficulty of applying blinding to participants and applicants. This being said, the discussions showed that the pooled outcomes using ACE presented a tendency of consistently superior effects with less adverse effects compared against other interventions.

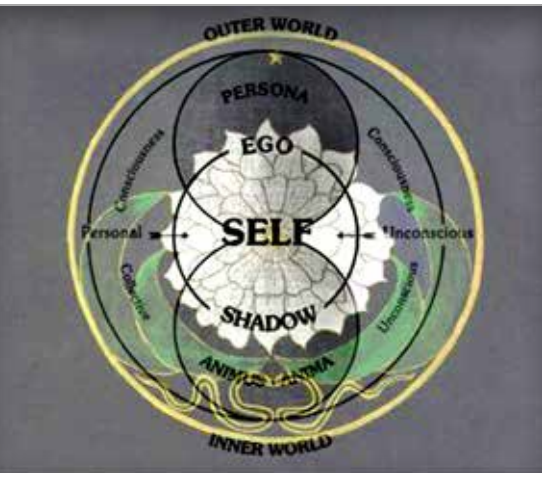
These authors sequenced the usage frequency of specific acupoints, indicating Tian shu ST-25, Zhong wan Ren-12, Feng long ST-40, Guan yuan Ren-4, Qì hai Ren-6, Da heng SP-15, Ren ying Ren-9, San yin jiao SP-6 and Zu san li ST-36 as those most frequently used. They concluded that further high quality, rigorously designed studies with an FDA approved drug used as control were recommended.[2]

In contrast, the individual study (#2) claimed the double-blind method and included a sample size of 137 cases. Significantly, the samples were divided into groups based on TCM diagnosis, a method not mentioned in any of the studies in #1. Point selection for #2 included Liang men ST-21, Zhong wan Ren-12, Tian shu ST-25, Qì hai Ren-6, Feng long ST-40, and adjuvant points selected according to the different syndromes. Through this method they concluded that ACE was best for treating obesity due to stomach heat and dampness, which was due to Spleen *qi* deficiency, but less so for treating endogenous heat due to *yin* deficiency.[6]

Healthcare providers have a moral obligation to explore all feasible procedures as we strive to provide our obese or overweight patients with the most successful outcome. As increased weight loss associated with the implementation of ACE is evidenced, we TCM practitioners have at our disposal an effective technique to address what can today be termed an obesity epidemic.

As noted, ACE has been shown to be more effective in reducing overall weight and BMI compared to western anti-obesity drugs. It does not require long-term adherence or high expense. It can be performed with relatively low risk as serious complications have been rarely reported to have occurred.[7] While we may face opposition from other healthcare providers hoping to maintain their portion of the nearly $60 billion U.S. weight loss industry, we need to join forces and lobby politically for the right to make use of this effective, low-risk, low-cost method to treat obesity.

CONTINUED ON PAGE 32



Chinese Medicine and Psychoanalysis: An Integral Perspective Part I: Denial and the Diaphragm

By Lonny S. Jarrett, MS, MAc

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Editor's note: East Asian medicine, a blend of modern and traditional treatment strategies and techniques rooted in ancient Chinese classics, provides a unique opportunity for scholars to research and explore these classics from a philosophical or anthropological point of view. The editorial team at MJAOM is pleased to present the perspective of one of this field's master scholars, Lonny Jarrett.

Abstract

This article considers the intersection of Chinese medicine, Freudian analysis, and integral thought respectively corresponding to pre-modern, modern, and post-modern ways of knowing. Both Chinese medicine and psychoanalysis are inductive synthetic methods of discerning the quality of interior human functioning. It is therefore not surprising that they would share some similar perspectives on the human condition. The integral perspective aspires to a synthesis of all perspectives into a comprehensive and developmental framework leaving no part of the self behind.

Part I examines the psychoanalytic ideas of suppression, repression, sublimation, shadow, and the unconscious in terms of their relevance to the practice of Chinese medicine. These are considered specifically in relationship to the diaphragm as the physiological embodiment of "wall." The physiological consequences of denial are considered in the terms of CM and acupuncture and herbal treatments for "liberating" the diaphragm are presented.

Key Words: acupuncture, analytical psychology, Chinese medicine, denial, diaphragm, Freud, integral, integral medicine, Jung, shadow, unconscious, *Ban Xia Xie Xin Tang*

Introduction

Carl Jung's famous foreword to Richard Wilhelm's translation of the Yijing served as my first introduction to Chinese philosophy. The historic meeting of Jung and Wilhelm laid an important foundation for East/West integration. Wilhelm's translation of the 17th century Chinese alchemical text, "The Secret of the Golden Flower" (*Taiyi jinhua zongji*), furnished significant evidence for his theories of the unconscious, its symbolism, and potential for human transformation.[1] The importance of this connection has been noted and beautifully elaborated by Shirley S.Y. Ma.[2]

In light of the last century of development in the field of medicine and culture it is easy to view Freudian analysis as passé, a relic of the Victorian era. However, it is important to acknowledge that he was one of the most significant thinkers in the 20th century. His elaboration of parts of the self, such as the *id*, ego, and unconscious, and psychodynamics, such as repression, suppression, negation, sublimation, and transference expanded our knowledge of the human condition beyond that of the pre-modern traditions (all of the "-isms"). His work was seminal, and much development of thought in diverse fields that followed was either an elaboration of, or a reaction to, it. As part of my ongoing synthesis, I've been reading the analysts as well as their critics and will share some insights here.

Part I reviews some of the important concepts contributed by psychoanalysis to our understanding of human nature. Part II will discuss Freud's work on the anal character type as it shares some interesting overlap with Chinese medicine (CM) regarding the metal constitutional type. Like the Chinese, Freud was thinking synthetically, using functional concepts to describe the inner dimension of humanity. Therefore, it's not surprising that his insights would complement and correlate to a degree with those of our medicine's founders.

Background

"One who contains *de* in fullness is to be compared to an infant. . . . Such is the perfection of its life-force *(jing*)." *Daode jing*[3]

In Freud's view, the infant is flooded with Eros (life force)—the entire surface of its body constituting, in essence, an erogenous zone. In the newborn, there is no distinction made between "self" and "other" or between the infant's mouth and the mother's nipple. In short, there is no self-awareness. The infant is held to be bisexual, having not differentiated into genetically based and culturally reinforced categories of identification. Freud uses the term "polymorphic perversity" to refer to this state of unbridled expression of Eros free of repression. I understand Eros as the life force, creative impulse, and evolutionary impulse. In CM terms I consider that it overlaps the notions of de (德:"Original nature, Virtue"), *jing* (精: "Essence"), *zhenqi* (氣: "authentic *qi*."), *zhengqi* (正氣: "upright *qi*"), and *yuanqi* (元氣: "original, primordial *qi*").[4]

The sole motivation of the infant at this stage of development is to pursue what is called the "pleasure principle." A substantial basis of Freudian thought rests in understanding the mechanisms where by the self internalizes culture as a denial of this pursuit. We may understand "the pursuit of the pleasure principle" as the lowest (first and second chakra: CV-1 and CV-2) expression of the life force in its trajectory toward the true, the good, and the beautiful. At later, higher stages of development, transmission of the positivity inherent in the life force is expressed as the cultivation virtue based on a selfless motive (fourth chakra and higher CV-14 to CV-20). [5]

Freud elaborates three stages of early development: the oral (breast feeding, thumb sucking), the anal (control of feces), and the genital (adult sexuality). In response to genetically-based and culturally reinforced conditioning, Eros is gradually withdrawn from the body's surface eventually to be concentrated in the genitalia. Subsequently, sexuality as a substitute gratification for unity is constrained to orgasmic release, contextualized by all of culture's taboos internalized as fear and desire. Hence is born Freud's universe of psychological complexity.

The psychoanalytic theory of infantile sexuality and its sublimation, which I critique later on, suggests that there is a hidden connection, both functional and physical, between the lower organs of the body and higher spiritual endeavor. In other words, the pursuit of the pleasure principle is *sublimated* into the pursuit of virtue.

"Sublimation," a term borrowed from alchemy, implies that the erotic impulse is redirected to achieve higher aims that are at once more socially acceptable while at the same time helping us cope with what was for Freud the relentless pressure arising from the sexual impulse. In the context of CM we can understand "sublimation" to be the process whereby *shen* and *jing*, fire and water, heart and kidney interact to manifest the myriad traits and capacities of human beings the pinnacle of which is the emergence of virtue (*de*:德).

Difficulty arises when unrepressed Eros manifests as the ecstatic embrace of life, and the entire self, in pursuit of the pleasure principle, is discovered to be at fundamental odds with the "reality principle"—that of having to adapt and work to survive in the context of cultural values. Brown notes that the human infant is shielded from this reality principle by parental care and therefore has a significantly longer time to pursue pleasure than any other animal.[6] Problems arise as the growing infant comes into increasing contact with the reality of social mores that forbid acting upon what are perceived to be "lower impulses."[7] Such

lower motivations are repressed and suppressed causing neurosis or worse and at best are sublimated into higher aspirations and achievements.

The ego, intuiting and suppressing knowledge of its eventual death, seeks substitute gratifications as it strives in vain for its own immortality.[8] An in depth discussion of ego is beyond the scope of this text but, in short, we may think of ego in two ways. Ego can be considered a healthy stage of normal development, a necessary foundation for transcendence to higher stages. Ego may also be thought of as an individual line of development present at all stages. As such, it can be understood as "the habit of focusing attention on the personal domain of experience in denial of the universal aspects of the self," "the illusion of separation," and as "the force of habit that maintains the status quo," i.e., the stubborn and irrational refusal to evolve in the face of the challenges engendered by the limitations inherent in one's current stage of development.

The infant seeks the mother's nipple as a substitute for having left wholeness while the adult seeks fame, fortune, and sexual union. Eros—the creative force, the life impulse, the evolutionary impulse—is diverted laterally as the individual becomes increasingly embedded at his current stage of development (ego, for most of us), the soul ceases its vertical ascent, and consciousness fails to evolve.

Suppression is never selective. The truth that we refuse to face and shove out of sight creates divisions within the self that undermine subsequent development as well as the integrity of functioning in diverse realms of the self that we in CM recognize as "officials" (organs) in the inner kingdom. The roof of a house is only as reliable as its foundation.

From a CM perspective, syndrome patterns denoting both *qi* and blood stagnation and the separation of *yin* and *yang* are physiological metaphors for such divisions within the self. Chinese medicine is the science of catalyzing the emergence of greater integrity. Hence we diagnose the separation, and catalyze the reunion, of *yin* and *yang* and promote the flow of *ai* and blood. In so doing, we inevitably make the unconscious conscious as constructed walls melt within as the self evolves toward unity.

The Unconscious and Shadow

These are two important dimensions of the self not accounted for in the classic texts of CM where inner forces were often conceived of as spirits (*shen, ling, hun, po*), ghosts (*gui*), and evils (*xie, gu*), ultimately as "other." Freud's insight that the unseen interior dimension of the human being is, in fact, "self" represents a significant advancement of perspective.

The unconscious (ucs) and shadow may be used as synonyms, with "shadow" referring to the entirety of the ucs. Shadow may also refer specifically to aspects of the personality that one denies within one's self, yet projects onto others as discussed below. Freud humbly attributed the discovery of the ucs to poets, though he was the first to have significantly mapped its terrain. Jung is responsible for the elaboration of the ucs as "shadow."[9]

In his seminal work, *The Atman Project*, Ken Wilber elaborates five realms within the ucs that are briefly reviewed here.[10]

Ground Unconscious

The foundation is the "ground-unconscious," referring to all future potentials that are enfolded within us that have not yet arisen to enter awareness. Wilber notes that the fetus possesses a ground-unconscious consisting of "all the deep structures existing as potentials ready to emerge, via remembrance, at some future point."10 Such potentials are unconscious but not repressed, as they have not yet emerged. The ground unconscious includes the following four dimensions:

Archaic Unconscious

The "archaic-unconscious" is the most primitive dimension of the ucs. It is phylogenetic in origin and also not repressed because it has yet to enter awareness. It is not the result of personal experience but rather consists of fundamental urges such as alimentary drives, emotional-sexual influences, and mental-phantasmic images. These are related to unique predispositions inherited from one's ancestry and phylogenetic past.

The archaic unconsciousness is largely pre-verbal and is associated with the functioning of the lower brain stem. The archaic-unconsciousness may be thought of as including deep structures within the self, perhaps rooted within the condition of the soul, that relate to the experience of all of humanity, as well as one's people, through evolution. The term "one's people" encompasses all women, all men, and one's specific ethnic, regional, and national heritage.

This has profound implications in terms of framing our "personal" healing as a responsibility owed to others for the rectification of our own souls for their sake. For example, when I take on "my" conditioning, I take on the conditioning of all Jewish men, of all white Americans, etc. The commitment is that "the karmic line stops here." This principle points to the practice of medicine from a non-dual perspective. When we treat the patient, we treat culture. In holistic medicine, personal integrity is the foundation of clinical efficacy, and all theory and technique are in service to that. Hence, integral medicine is based on the recognition of "one self."

Submerged Unconscious

The "submerged unconsciousness" consists of material that had been previously conscious and that we have made unconscious through simple forgetting, negation, disassociation, or repression. Wilber refers to the personal dimension of the submerged

unconscious as the "shadow," spanning the spectrum from the most primitive dimensions of the archaic unconscious up through verbal scripts and injunctions. Simply, the submerged-unconscious consists of all that we have chosen consciously or unconsciously not to face because it threatens to disrupt the *status quo* and our ego's self-image.

Embedded Unconscious

The "embedded-unconscious" represents the state and stage of development of an individual's actual condition right now. It is the perspective, the set of eyes that one is looking through but can never be seen. Freud called this the "super ego," referring to that aspect of the ego as self that is aware of thoughts, feelings, emotions, sensations, and the body but never sees its own self. It is the inner voice, the judge, the protector, and the seeker that represses but is blind to its own existence.

A significant point of holistic medicine is to identify this dimension of the self and to help make this subject, the "I" sense, an object in the patient's awareness so that he may begin to act upon it. What we can and will see, we can change. The embedded-unconscious is the part of the self that is not repressed yet is hidden from us. And it is this part of the self that is capable of repressing content and sending it into latency.

Emergent Unconscious

The "emergent-unconscious" manifests as the call of our future self. Whereas the ground- and archaic-unconscious have been likened to the history of all oak trees inherent as the template within the acorn, the emergent-unconscious represents the specific unique potentials of the unfolding of the individual as a specific tree.[11] Just as the past is pushing to assert itself within consciousness, so too is the future. Intuitions of the future can be repressed in just the same way as past experience and for the same reason, they threaten to dislodge us from the status quo. In the face of this calling the ego intuits its own death.

Shadow

"Shadow" manifests in two ways that concern us in the practice of medicine—projection and irony. Projection involves rejecting in others those parts of our own self that we repress and will not own. For example, not liking someone because we deem him to be arrogant and failing to see his own arrogance. I take everything a patient tells me about an "other" as most significantly a reflection of his relationship to his own self. Hence, if a patient says "I can't stand my brother, I'm nothing like him," when I have asked "Really? What is he like?" I take the patient's answer to be a statement about himself. Conversely, if a patient says "I really admire my sister," when I ask "What do you most admire about her?" I listen with ears attuned to the presence of self-doubt and pride within the patient. In this case, she has possibly projected a positive attribute onto another, failing to value those very virtues within herself.

"Unconsciously identified with his resistance, the patient is unaware he is giving voice to the motive force of stasis inherent in the illness itself. A patient's affect can also contradict the content being communicated. I assess this in terms of the patient's quality of expression gleaned from observation."

Irony manifests when a patient literally contradicts himself as if two different people with entirely different motives were speaking. In this regard it's quite possible that the patient's authentic self (a selfless motive) will begin a sentence and the patient's ego (a selfish motive) will finish it by directly contradicting the words initially spoken.[12] For example, after receiving therapeutic advice a patient might say, "I know everything you say is true but here are the reasons I can't comply." More subtly, when asked to take his herbs three times daily a patient might say, "I'll try." Implicit within these two simple words is a world of impure motive, victimization, and resistance to the effort expended in, and stated goals of, seeking treatment.

Unconsciously identified with his resistance, the patient is unaware he is giving voice to the motive force of stasis inherent in the illness itself. A patient's affect can also contradict the content being communicated. I assess this in terms of the patient's quality of expression gleaned from observation. For example, when discussing his marriage, a patient might say, "I love my wife," while communicating repressed anger and a diminishment of openness in the heart and pericardium. This can be gleaned from the sound of shouting changing to lack of shouting in the voice and a transition to an ashen (lack of red) facial color.[13]

A final example is that of a patient who emphatically impressed upon me how apathetic she felt toward her relationship, her work, and life in general. I pointed out the irony of the high level of care she was demonstrating to be certain I understood her message and that, in actuality, this embodied both her care as well as a simultaneous denial of it. In anticipation of our next meeting, I asked her to direct her attention to how frequently she denies her sincere care about things in her life. She returned a week later reporting that all her symptoms had subsided, her depression had lifted, and that she felt enlivened and positive. Often a simple reframing by directing attention to a dynamic is all that is needed to shift it.

Revealing Shadow: Making the Implicit Explicit

Even at the stage of the fertilized egg, the template of the body embodies structures that condition consciousness as the body develops. Archaic patterns of culture and of mind are encoded at the moment of incarnation—a moment that has a trajectory and is not neutral. Unconscious motivations lead to actions that tend to build the past, continuing through the present and into the future. Hence, the outcome of an unconsciously lived life is determined by forces we are unaware of or don't understand. Actions based on ignorance tend to engender unnecessary suffering for self and other. Suppression creates division within the self in a way that thwarts the life impulse in its trajectory toward the true, the good, and the beautiful.

Plato considered that the true, the good, and the beautiful were universal essences embodied to various degrees in the world of form. From an evolutionary perspective, the trajectory of human development is toward the conscious embodiment of these virtues. French Jesuit priest and paleontologist Teilhard de Chardin conceived of an "omega point," identifying it as a future moment in which the entire universe gains awareness of "self as god," comprising the trajectory and motivating force of all development.[14]

The syndrome patterns named in CM can all be understood as metaphors for such division. Cold, wind, damp, heat, blood and *qi* stagnation, exit/entry blocks, possession, etc. can all be taken as functional constructs describing inner separation. Dysfunctional behaviors are predicated on, and reinforce, such division. The fundamental motive of authentic medicine is to remove what is false and strengthen the presence of what is real.

The clinician must discern the degree to which such separation is perpetuated by various degrees of input from unconscious motivations. Any condition has multiple sources of input. A significant goal in authentic holistic medicine is to remove the patient, to whatever degree possible, as the source of his own illness and suffering. Hence, the healer endeavors to help make what is implicit explicit, so that the subject (the patient's self-sense or ego) becomes an object in awareness that can be acted upon by the more aware emergent self.

We endeavor to make the unconscious conscious so that the outcome of an individual's life is shaped relatively more by freely-made choices inspired by the better future he intuits is possible and relatively less by unconscious reactions to a hidden past. In this way, behavior is relatively more motivated by a positive striving to manifest higher potentials and is relatively less dictated by genetically based and culturally reinforced habit.

In coining the term "integral," the Indian sage Sri Aurobindo referred to a practice of yoga (Sanskrit, literally "union") in which no part of the self is left behind. He conceived the purpose of such practice as the explication and evolution of spirit through the manifestation of all involuted implicit potentials.[15] Chinese medicine can be understood as the art and science of integrity; that is to say, it diagnoses the separation of *yin* and *yang*, and all intervention is aimed at the elimination of separation and toward reunification of these two principles.

All traditions of authentic holistic medicine proceed in this way as evolution toward wholeness implies eliminating separation and catalyzing the emergence of a higher unity. All separation inevitably has psychological and emotional manifestations; hence, helping to make the unconscious conscious is an integral part, and the inevitable consequence, of healing.

The Diaphragm: Suppression, Repression, and the Internalization of "Wall"

Only an unrepressed humanity, strong enough to live-and-die, could let Eros seek union and death keep separateness.
Norman O. Brown[16]

Man has forgotten how to die because he does not know how to live. Rousseau[17]

Here, stagnation in the diaphragm is examined as one embodiment related to the physiological consequences of failing to face our own condition. Suppression results when we expend resources to deny dimensions of our experiences that challenge us. Repression is similar to suppression but constitutes an outright denial that the repressed material even exists.

The diaphragm represents the internalization of "wall." Above that wall shines the sun (heart), the moon (lungs), and the stars (the sensory orifices and GV-20, 23), representing the light of conscious awareness.[18] In Daoist alchemy, enlightenment is mediated by the opening of the Mysterious Pass (*yuanguan*: 元 關), a portal between non-being and being, the unconscious and the conscious.[19] While the Mysterious Pass is a functional metaphor having no specific location in the body, it's interesting to consider its function in relationship to the diaphragm.

Denied material is forced beneath the diaphragm with a concomitant tightening of that muscle as resources are expended to hide truth from awareness. All twelve channels run through the diaphragm; hence, denial (suppression/repression) is never selective and has global consequences. Denied material in the unconscious agitates in lower dimensions of the self to motivate

us in unseen ways. Such is the nature of anxiety when we are pursued by content that we will not face.

The life force continually pushes to ascend, and it requires physiological resources to keep material from entering awareness. The life force incarnates into water (*yin*) as form and is drawn upward by the wood element as it strives toward the heart as sun. Evolving perspective is the imperative of the wood element whose charge it is to face directly into the truth without denial.

Despite our best attempts at denial, the life force, Eros, continues to push and assert itself into our awareness, bringing with it that which we would prefer to hide from, hence, to repress and suppress is to deny life. In CM we may understand the embodiment of this denial as *qi* and blood stagnation, with their associated symptoms of depression, frustration, and memory impairment.[20]

"Opening the diaphragm" is an important first step in treatment that may yield results across a broad spectrum of imbalances and symptomatology. Such treatment can also allow for emergence of repressed content into awareness, creating some distance between that content and the self so that it may be framed relatively more objectively. With such material integrated and reframed, the patient may cease to expend so much effort repressing the past and be able to more effectively turn attention toward the better future she aspires to create.

Opening the Diaphragm

Consciousness as an infinite field recognizes no separation and from that perspective, all "wall" is constructed and thus illusory. The diaphragm itself is "merely" a muscle, and its condition and function represent the confluence of a great many influences.

Reviewed here is a group of points and two herb formulas useful for liberating the diaphragm. (Note that these are covered at length in my texts.[21])

Acupuncture: Lv-3, 13, 14; Gb-40, 24; Hp-6; CV-12, 15; Lu-1; Bl-17, Bl-46 (41 Worsley system)

Herbs: *Banxia houpo tang, Banxia xiexin tang*

Analysis:

The journey of qi from Lv-14 to Lu-1 is by far the longest exit/entry couple by a factor of 4-6 times.[22] It's also the most circuitous route of *qi* through an internal pathway connecting any pair of exit/entry points. Metaphorically it's the embodiment of the creative circumvention of "wall," the place that aspiration (wood)—our motive force of striving—meets inspiration (metal), i.e., the shiny object in heaven that we desire. This represents the union of the *hun* (evolutionary impulse, light rising through the vehicle of the mind/body within) with the *po* (the descending light cleansing and bringing clarity to the form of the body/mind).

Liver-13 addresses the past (*Zhangmen*, 章門, "Gate of law" unresolved injustices, "Chapter Gate" supporting finishing with the old and starting the new). Liver-14 (*Qimen*, 期門) as "Gate of hope" is relatively more future-facing. In Lv-14 the character *qi* (期) denotes the passage of a period of time as well as "hope" in the sense of looking forward.

In a personal communication, Heiner Fruehauf pointed out the association of *zhang* in Lv-13 with the Metonic 19 year cycle that includes all possible celestial combinations of sun, moon and stars. As the last point in the circulation of *qi* (氣), Lv-14 represents death, finality, and letting go back into the abyss of the lung. Such *qi* carries with it the report of accrued merit to the place in the imperial compound, in heaven/consciousness, where records are kept denoted by its progression to Lu-1 the "Central Storehouse." Note that in the phrase *qiwang*期望) meaning "hope," *wang* denotes the full moon after which it will fade (death). As the cycle begins again with entry into Lu-1, *qi* (氣: a homophone of 期) is renewed with each breath, and *po* (魄), the spirit of the lungs, presides over the waxing phase of the moon as light is brought to bear on that which was hidden in darkness.

The use of *po* referring to the waxing of the moon is a symbol of the rebirth of the soul. The moon is *yin*, yet can reflect the light (*shen*, spirit) of the sun. Within the human, *po* brings light to and extracts value from what is dark and thus hidden. The function of *po* may be likened to that of the bacteria in the intestines that digest waste and convert it to light in the form of ATP. In the context of this article, "waste" is all that we've buried down in the basement. The light within it is the lesson to be learned, a lesson that we expend resources to avoid for the sake of preserving the ego's fragile status quo. Zhuangzi refers to the words in ancient texts as "dregs and sediments" (糟魄), referencing their failure to convey reality as compared to actual practice. In this context, "po" denotes "dregs."[23]

I use *banxia houpo tang* to address *qi* stagnation in the diaphragm, chest, and throat, and to "disappear" grief that I think of as "insubstantial phlegm."[24] This is useful when there are suppressed yet tender feelings in the heart coming into conflict with a rising rage from the liver in regards to painful separation.[25] Associated symptoms can include, depression, anxiety, pressure in the chest, and "plumpit *qi*." I choose *banxia xiexin tang* when there is loss of appetite and difficulty digesting food, thought, and experience. This dynamic is typified by confusion, ambivalence, and difficulty sorting while both speaking and listening, which implicates dysfunction in the small intestine as well as "heart sickness."[26]

This formula is given when there is "binding of hot and cold" that prevents the spleen from "raising the clear *yang*" and the stomach from "descending the turbid *yin*." This binding (*pi*: 痞) typically is experienced over the diaphragm in the region of acupuncture points CV-14 and CV-15, the heart and heart protector mu points respectively.[27]

"Failure to raise the clear *yang*" can be taken as a metaphor for denial of that truth concealed below the diaphragm (in the unconscious), endeavoring to impress itself on awareness. "Failure to descend the clear *yin*" can be taken as a metaphor for failing to let go of unwholesome attachments that accumulate to become burdens (damp).

I interpret the description of the formula's actions as a physiological metaphor for the presence of ambivalence that inhibits the healthful processing of available options. This ambivalence is a result of stagnation, i.e., the failure to choose and act in a positive and proactive manner or, in the words of the *Yijing*, in a way that "furthers." Such a dynamic often presents when one is ending a significant relationship and is caught in the clash between the experience of love (heat) and love lost (cold) ("should I stay or should I go?"). In my studies with Ted Kaptchuck, he has metaphorically translated the name of this formula as "Heartbreak Soup."

Opening the diaphragm allows for the free ascent and descent necessary for a healthful relationship between innate and acquired resource, early and later heaven. Acquired *qi* (food/water/air/life experience/thought) descends via the stomach channel, while kidney *jing* ascends as marrow is engendered and a disordered relationship to fear is transcended congruent with the emergence of wisdom.

Between heaven (fire, heart, *shen*) and earth (water, kidney, *jing*) the earth and wood can be at war contributing to suppression through constriction of the diaphragm. Wood represents spontaneous recognition (no time) and earth represents process (transition of the seasons through time).[28] Conflict between spontaneity (wood) and process (earth) can tighten the center, resulting in disharmony of the human dimension involving *qi* and blood. Note that the virtues associated with the middle, wood, and earth, are *ren* (仁) and *xin* (信), both possessing on the left the radical (亻) for humanity. Conflict in the center, with its associated constraint, can prevent proper communication between *shen* (consciousness) and *jing* (potential).

Cutting off from, i.e., repressing, what we consider to be "soiled" and "not self" in our depths is never selective and thus impedes our connection to our authentic potential (*jing*). To the ego, facing the truth that the fears and desires on which it is based are merely constructed is analogous to death. To paraphrase Brown, "he who is not strong enough to die is not courageous enough to live." A goal of integral medicine is to help the patient truly live, becoming what *Laozi*, Freud, and Jung might call an "authentic individual" (*zhenren*: 真人).[29]

Summary and Conclusions

Part I has briefly considered the import of some basic psychoanalytic concepts and their relevance to the clinical practice of CM. The concepts of sublimation, repression, suppression, the unconscious, and shadow all can be understood within the constructs of Chinese physiology and herbal and acupuncture point functions. The examples of tension and stagnation in the diaphragm have been presented to illustrate these relationships, but any and all human phenomena can be looked upon from the perspective of this synthesis.

The capacity for synthesis is a great strength of the quality of mind found at the heart of CM. As CM has migrated to the West for the last 350 years it has evolved to become a world medicine. For CM to attain its full potential as the leading integral medicine of the 21st century, we can find much to embrace in the past 100 plus years of philosophical insight into the human condition that has emerged in the West.

Part II will consider Freud's writings on the anal character type as they pertain to some basic correspondences in CM. I will also discuss the strengths and limitations of Freud's psychoanalytic theory regarding its relevance to both the outlook and the therapeutic goals of our medicine while striving toward a deeper synthesis in our understanding of the human condition.

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CONTINUED ON PAGE 37

CLINICAL PEARLS

The topic discussed in this issue is:

How Do You Treat *Erectile Dysfunction* in Your Clinic?

Erectile dysfunction (ED) is the inability to achieve or sustain an erection necessary for satisfactory sexual activity. ED, also referred to as impotence, should not be confused with lack of sexual arousal (decreased libido) or problems with ejaculation and orgasm (ejaculatory dysfunction). Decreased blood flow, typically due to the narrowing of vessels that supply blood to the penis, is often the cause of ED in older men. Emotional issues can commonly be the reason for ED in younger men.

Sometimes it is a combination of physical and psychological causes that produce erectile dysfunction. For this reason, it may be important to include the patient's partner in the dialogue of treatment options. One of the most difficult aspects of treatment is to discuss with patients the fact that sexual arousal, both physical and mental, involves more than just achieving an erection.

Any condition that includes increased blood pressure, high insulin levels, or neurological functioning may cause some degree of ED. Additionally, side effects from medication—especially anti-depressants, tobacco and alcohol use—can also contribute to this condition. An important risk factor to consider when someone presents with ED is their cardiovascular function; therefore, treating these patients for ED must take into account possible cardiovascular risks.

Traditional East Asian medicine views ED within the disease category of *yang wei* or withered *yang*. The genitalia and their function are strongly related to Kidney *yin* and *yang*. The penis is also the meeting of the "hundred sinews" and the sinews are associated with Liver function. In addition, the Liver channel encircles the genitals. Therefore, almost any problem related to the Liver could result in impotence including cold stagnation, dampness and heat or Liver *qi* stasis. Spleen and Heart patterns can become involved due to their relationship to blood production.

Treatment may consist of a combination of acupuncture, moxibustion, mind-body activities (such as *qi gong* and meditative breath work), herbal formulas, lifestyle modification (including emotional attitude towards sexuality) and food therapy. Other complementary treatments can assist these modalities in helping their root cause.

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Practitioners, we welcome your Clinical Pearls about each of our topics. Please see our website for the topic and submission information for our summer v.3 #3 issue: www.meridiansjaom.com Also check us out on Facebook.

How Do You Treat Erectile Dysfunction in Your Clinic?

By Mitchell Harris, LAc, Dipl OM (NCCAOM)

Mitchell Harris, LAc, Dipl OM (NCCAOM) practices East Asian medicine at his clinics in Rogers Park and Lakeview. Mitchell is dual chair of clinical procedure and faculty governance at Pacific College of Oriental Medicine-Chicago where he teaches eastern nutrition, Japanese acupuncture, clinical methodology and practice management. He is the creator of Herbs From East, LLC and is co-founder of the integrative medical video website www.IMNEducation.com.

Erectile dysfunction (ED) is a condition that is often brought about either directly as an initial chief complaint or after the practitioner has gained the patient's trust while treating other conditions. ED can wrongfully be considered by some patients as a deficit of masculinity, thus the organic and psychological aspects should be dealt with in a mindful way so as not to alienate the patient's view of their identity while encouraging a new perspective.

"ED can wrongfully be considered by some patients as a deficit of masculinity, thus the organic and psychological aspects should be dealt with in a mindful way so as not to alienate the patient's view of their identity while encouraging a new perspective."

As practitioners, we want to engage the patient's spirit and keep them involved in their treatment plan, which could take weeks, or even months, to possibly achieve a more full recovery. That said, increments of change can be quickly noted in quality and length of erection by needling and moxibustion, which enacts *qi* and blood movement and tonfication through the local area.

For a local area treatment for erectile dysfunction, needle UB-33 manually at a depth of roughly 60 mm for 5-15 min. After that, one may needle the pudendal nerve point region, located in the gluteal region (at the point 50-60% of the distance along a straight line from the posterior superior iliac spine to the lower inner edge of the ischeal tuberosity). Use a needle up to 90 mm in length until a stimulation of *da qi* arises in the pudendal area. If no sensation arises this may clue one in to possible vacuity in the area. Stimulate for 5-15 min or use e-stim for low frequency (2-10Hz) for 15 min with strength sufficient to be felt in the pudendal area. Do this at least once a week for 5 weeks. I learned this from a study done in Japan for ED among diabetic patients that showed positive results.

Underlying root treatment patterns are important for proper acupuncture, herbal and nutritional care. Before starting the above treatment one should consider employing a nourishing technique. I prefer a Japanese meridian therapy root treatment of gentle acupuncture using the 5 Element Mother/Son support cycle according to the *Nan Jing*.

The following diagnoses are common possibilities for pattern based treatments:

Kidney *yang* vacuity, Kidney *yin* vacuity, Kidney *yin* and *yang* dual vacuity, damp heat, pouring down in the Kidney channel, damp heat in the Liver channel, Liver cold, Liver *xue* and *yin* vacuity, Heart and Gallbladder *qi* vacuity, Spleen and Stomach vacuity, Spleen vacuity with phlegm dampness, Heart and Spleen vacuity, and external attack of damp heat.

Common points: Ren 3, Ren 4, Kidney 3 and Ren 1 with moxa pole, if appropriate, or direct half rice grain moxibustion on top of sacrum in odd (*yang*) numbers.

Auricular acupuncture to consider: kidney, subcortex, external genitalia

Meridians JAOM is pleased to announce that Mitchell Harris is our new Clinical Pearls editor. He welcomes your suggestions for new Clinical Pearls topics as well as your submissions on each current topic. Please contact him at cpeditor@meridiansjaom.com.

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CATGUT CONTINUED FROM PAGE 21

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How Do You Treat Erectile Dysfunction with East Asian Medicine in Your Practice?

By Stephen Bonzak, LAc, Dipl OM (NCCAOM), FICEAM

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The western medical diagnosis of erectile dysfunction can be modeled in East Asian medical terms using *yin-yang*, Five Phase, and Six *qi*. According to the *Huangdi Neijing*, the Cold Water of the North, located in the lower abdomen, can only rise up through Wood and stimulate the penis to become erect when the Fire of the South located in the chest descends down through Earth and Metal to warm it up. Put in different terms, the "ancestral sinew" becomes erect when there is enough *yang*-infused blood moving through the Jueyin Liver channel below.

"As an herbalist, I treat ED using formulas primarily from the *Shanghan Lun* and the *Jingui Yaolue*."

Therefore, erectile dysfunction can occur due to one of several pathologies: 1) Shaoyin Heart Fire is too weak to descend and warm the Kidney Water below preventing it from generating good quality blood that can circulate through Jueyin Liver Wood, 2) there is a block in Taiyin Spleen Earth and/or Yangming Stomach Metal preventing the Heart Fire from descending from the South to the North, or 3) too much Jueyin Wood Wind is surging upward causing Shaoyin Heart Fire to flare up and away out of storage, or 4) the blood of Jueyin Liver Wood is weak and cannot hold the *yang* inside it.

As an herbalist, I treat ED using formulas primarily from the *Shanghan Lun* and the *Jingui Yaolue*. For each of the patho-dynamics described above, here are some formula ideas that can help treat this condition:

1) For Fire that is too weak to descend down into the Water and warm it up, a good representative formula is the prescription Tian Xiong San taken from chapter 6 of the Jingui Yaolue on Taxation Deficiency. It has the following ingredients: Tian Xiong (substituted with Fu Zi) 60 g, Baizhu 24 g, Longgu 60 g, Guizhi 18 g.

   For opening up Yangming Metal and Taiyin Earth when there is damp-heat obstructing the descent of Fire into Water, use the formula Gan Cao Xie Xin Tang from line 158 of the *Shanghan Lun*: Zhi Gancao 12 g, Banxia 12 g, Huangqin 9 g, Huanglian 3 g, Ganjiang 9 g, Renshen 9 g, Dazao 9 g.

2) For surging of Wood Wind up and away from Water, Chai Hu Jia Long Gu Mu Li Tang from line 107 of the *Shanghan Lun*: Chaihu 24 g, Huangqin 9 g, Banxia 12 g, Shengjiang 9 g, Guizhi 9 g, Fuling 9 g, Longgu 30 g, Muli 30 g, Daizheshi 9 g, Dahuang 12 g, Dazao 6 g.

   For weak Jueyin Blood unable to hold on to the yang it needs to move properly, I use a formula such as Shen Qi Wan from chapter six of the *Jingui Yaolue on Taxation Deficiency*: Sheng Dihuang 24 g, Shanyao 12 g, Shanzhuyu 12 g, Fuling 9 g, Zexie 9 g, Mudanpi 9 g, Guizhi 3 g, Fuzi 3 g.

These formulas can be given in custom compounded granular formulas using the dosages mentioned above. Patients should take a daily dose of 8 g twice a day for the best results.

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How Do You Treat Erectile Dysfunction in Your Clinic?

By Barbara Ferrero, LAc

Barbara Ferrero, LAc received her master's of science in traditional Chinese medicine from Pacific College of Oriental Medicine-San Diego in 2011. She has a family practice in Truckee, California, specializing in orthopedics and internal medicine. She partners with the High Fives Foundation, a nonprofit organization that supports athletes suffering spinal cord injury through their rehabilitation. She can be reached at barbferrero@gmail.com

I practice in a small mountain town where many athletes reside. I treat a lot of orthopedic disorders and have several patients with spinal cord injury (SCI). Most SCI patients are men, and many of them deal with a degree of erectile dysfunction (ED). In patients with spinal cord injury, the incidence of sexual dysfunction is elevated. ED affected 89.5% of the patients in a study published by the International Journal of Impotence Research.

In the absence of nerve injury, ED is usually related to Kidney *yin* and/or *yang* deficiency. In my limited clinical experience, I have a 100% success rate using Chinese medicine—an indication that this option, even when used as an addition to the pharmaceutical route, can be very valuable.

"As with other symptoms of paralysis, I observed that sometimes the physiology works, even if the patient is unable to voluntarily elicit a certain movement or function."

However, when the ED is caused by trauma, there is always a pattern of dysfunction from the site injury, mostly Du and UB channel *qi* and Blood stagnation. I did not find that only treating the pattern has yielded any results in the short term (within eight treatments).

As with other symptoms of paralysis, I observed that sometimes the physiology works, even if the patient is unable to voluntarily elicit a certain movement or function. Speculating that this may be the case in ED, I tested a point combination to fuel and course the Liver *qi,* using Li Gou, Liver 5, since it goes to the external genitals.

The first time I tried this protocol on a patient who was having trouble getting and maintaining erections, he got an erection, which lasted almost the full needle retention. The following week, this was tried again and the same thing happened. At the time of this writing, this patient has continued to receive treatment on a weekly basis (we are now at week 6) and has been able to achieve voluntary erections.

I decided to try this protocol on two other spinal cord injury patients of similar age, 25-35. They achieved similar effects when I used this point protocol: All needles bilateral when applicable. Even stimulation every 5 minutes. Smokeless moxa over Li Gou, Liver 5 and Zu San Li, Stomach 36. Total retention: 30 min.

Li Gou, Liver 5 spreads liver *qi*, regulates liver *qi* and benefits the genitals. Bai Hui, Du 20 raises *yang*, counters prolapse, and nourishes the sea of marrow.

Zu San Li, Stomach 36, in the Setting the Mountain on Fire pattern, supports the correct *qi* and fosters the original *qi*, tonifies *qi* and nourishes blood and *yin*. It is indicated for the treatment of the five taxations and seven injuries.

Moxa warms meridians, induces smooth flow of *qi* and blood, and strengthens *yang* from collapse.

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Time for a Medical Renaissance: A Healthy Marriage between Western and Eastern Medicine

By Adam Gries, DAOM, LAc

Adam Gries, DAOM, LAc received his master's in 2002 and his doctorate in 2015 from the Pacific College of Oriental Medicine-San Diego. In his Raleigh, North Carolina practice, he utilizes Japanese acupuncture to address the foundational relationships established in classic texts, while relying on orthopedic acupuncture to address issues at the musculoskeletal level. Dr. Gries combines this *yin/yang* approach with an emphasis on emotional/cognitive healing. He values the opportunity to navigate through the physical, emotional, and psychological components of health to help patients reclaim a sense of peace. Please contact him at: www.AwakeningsHealth.com

As modern medicine evolves, with bodies of evidence supporting a variety of medical disciplines, it becomes progressively more important to find proper systematic strategies for combining and coordinating multiple medical approaches into a streamlined diagnostic and treatment plan to improve patient care.

My wife and I married with the intent to shape our lives together using a team format. However, the team approach often results in one or both individuals relinquishing their unique identities, resulting in a compromised union in which the whole equals far less than the sum of its parts. My wife and I therefore continuously strive to co-create by maximizing the synergy of our two unique expressions. What can be termed "a medical renaissance" must apply the same approach and tenacity if it is to ever be realized.

I have spent my professional career coordinating and integrating patient care that utilizes both eastern and western medical approaches. Viewed objectively, they each have impressive virtues as well as a proper place concerning the future of an advanced, comprehensive healthcare system, yet I continue to witness a number of eastern medicine doctors outright rejecting the merits of western medicine. I also witness western medicine's attempts to integrate eastern care but only within western medicine's paradigm.

I suggest there are three approaches that today's medical establishments take when considering other related disciplines. I have defined these as: *oppositional*, *integrated*, and *pluralistic*.[1] *Opposition* derives from a fear-based model in which the driving thought is to protect the integrity and superiority of the chosen discipline and promote it as the highest level of care. While it is imperative to ensure the safety and efficacy of every medical intervention, I believe *opposition* is a recipe for strained relationships and a low ceiling for the advancement of health care.

At first glance, the concept of *integration* embraces the right idea. The term "integrated medicine" is currently fashionable and used to showcase a progressive medical system. But integration can only maximize the combined medical potential when the components have an overlapping foundation. Even then, it becomes hard to maintain a connection to the nuanced differences that make up the individuality of each component.

The same goes for married couples, too. We often integrate to the point of becoming one identity rather than two unique individuals; rather, we need to learn to co-create while remaining rooted to the essence of us each as an individual. Western and eastern medicines are two distinct scientific systems founded upon completely different paradigms. Trying to absorb one medicine into the other only serves to compromise the integrity, efficacy, and scope of the medicine being absorbed.

Rather than complete segregation or a striving to comingle these two different approaches to medicine into one "super paradigm," I suggest a *pluralistic* approach, which allows for and honors the presence of each system without unethically altering either one's foundational integrity. A *pluralistic* approach provides a clean slate from which to build a foundation for a true interdisciplinary medical network for 21st century health care.

Once a medicine proves to be safe and effective within its scope of practice, it is then time to learn how to "play with the other kids on the block." As with a healthy marriage, a *pluralistic* approach to medicine provides great potential for multiple paradigms to find their place in a respectful, healthy relationship in which each discipline can bring their full knowledge and wisdom to the horizon of an advancing medical frontier.

Please Note: The next commentary will discuss how appropriate methods of research can validate medical approaches such that we can continue to offer our population the promise of safe, effective, and ethical medical intervention.

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17. Cited in Loy D: 2000.
18. Note that the left half of the character *shen* (神) depicts heaven and earth as the two (二) between which emanates the light of the moon, the stars, and the sun, "the mutations of which reveal to men the transcendent things." Wieger L:1965. Lesson 3D;29.
19. See Jarrett: 1999;20-21. Also, Ma S: 2005:242.
20. For a review of the inner dimension of qi and blood stagnation see Jarrett LS: 1999:299-314. Denial can be correlated with any of the stagnations identified in CM.
21. The acupuncture points are covered individually in my clinical practice text (Jarrett LS: 2004). For a discussion of exit/entry blocks and the diaphragm see pp. 83-84, 681-682, 691-692. For Bl-17 see pp.288-289 and 388-389. For Bl-40 (45) 41 (46) see pp.404-405.
22. For a review of the exit and entry points and their relationship to the heart and sensory orifices see Jarrett LS: 2004:75-93.
23. Zhuangzi CH.9. Watson, B: 1964.
24. For a discussion of *Banxia houpo tang* and the dynamics of the diaphragm see Jarrett, 2004, pp. 83-83 and 129-131.
25. For a discussion of the diaphragm pulse See Hammer, L: 2001, pp.450-451.
26. For an excellent review of this formula and its modifications see: Xu H & Zhong W: Modern applications of *ban xia xie xin tang*, and their development. *Australian Journal of Acupuncture and Chinese Medicine*. 2008;3(1):25-30.
27. In the Five-Element tradition of JR Worsley, CV-15 is used as a *mu* point for the pericardium.
28. For a discussion of the relationship between wood and earth see Jarrett LS: 2004:554-6, 646-648.
29. For a discussion of *zhen* see Jarrett LS: 2015.

Letter from Public Health Editor

Intersections and Synergies: Acupuncture and Public Health

Elizabeth Sommers, PhD, MPH, LAc

Elizabeth Sommers, PhD, MPH, LAc has degrees from Boston University School of Public Health and New England School of Acupuncture. She has worked and published in the areas of acupuncture detoxification, health economics, and treatment of HIV/AIDS. Her book *Acupuncture as an Adjuvant in the Treatment of HIV/AIDS* was published by Lambert Academic Publishing in 2014. She currently chairs the American Public Health Association's Section on Integrative, Complementary and Traditional Health Practices. A public health advocate, Dr. Sommers is committed to ensuring that health care, including wellness, is a right not a privilege.

Acupuncture continues to become part of the fabric of health care in the U.S. through its integration into hospital-based services and community health centers. It is therefore worth examining its connections with public health as it is instructive to understanding and envisioning its role in the future healthcare landscape. A working definition of public health that encompasses its role in health promotion and disease prevention has been developed by the American Public Health Association:[1]

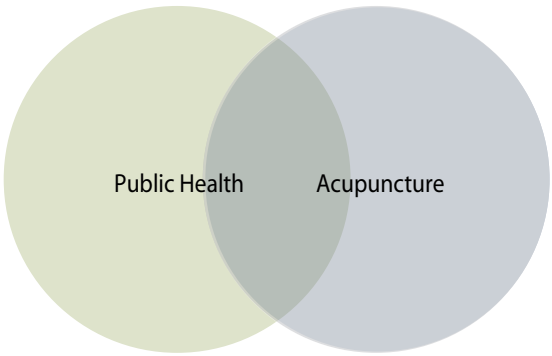
> *Public health promotes and protects the health of people and the communities where they live, learn, work and play. While a doctor treats people who are sick, those of us working in public health try to prevent people from getting sick or injured in the first place. We also promote wellness by encouraging healthy behaviors.*
>
> *Public health works to track disease outbreaks, prevent injuries and shed light on why some of us are more likely to suffer from poor health than others. The many facets of public health include speaking out for laws that promote smoke-free indoor air and seatbelts, spreading the word about ways to stay healthy and giving science-based solutions to problems.*
>
> *Public health saves money, improves our quality of life, helps children thrive, and reduces human suffering.*

Recognizing that health and wellness need to be based within communities and populations, the hallmarks of public health include the characteristics of access, affordability, and appropriateness of care. Just as clean air or water are considered "public goods," that is, for the benefit of everyone in the population, the health of the public is rooted in these characteristics.

The term "access" refers to the ability of all citizens to be able to utilize approaches to health that they choose. Clinics and services need to be based in proximity to the individuals that they serve; services must be delivered in respectful ways and in languages that are understandable. "Affordability" is associated with the capacity to pay for care, whether that is accomplished by an individual or any type of third party insurer. Care is deemed "appropriate" when it is effective, acceptable to the individual receiving it and results in the individual's satisfaction with the delivery process.

Because public health emphasizes health promotion through lifestyle practices and health education, also taking into account that medical care delivery is sometimes necessary, public health shares common roots with acupuncture and traditional Asian medical practices. Although each arena (*viz*. public health and acupuncture as part of traditional Asian medicine) is unique, both share the common vision of embracing practices that result in increased health, wellness, and wellbeing. There are therefore important overlaps in these two paradigms that are worthy of appreciation and further investigation.

To graphically illustrate both the individualities and overlaps, consider the following Venn diagram:



Each sphere has its own practices and characteristics, but there are significant overlaps that include aspects such as health information and education based on theories of traditional Asian medicine (*e.g.* Five Elements, Roots and Branches): dietary recommendations, pain management based on non-pharmacological approaches, treatment to promote sobriety and mitigate substance use, relieving treatment-related symptoms associated with chemotherapy for individuals dealing with cancer, and other serious and/or chronic conditions such as HIV/AIDS.

Examining these intersections can lead us to better understand the contributions of each approach to health. Each approach has its distinctive features but, taken together, the cumulative effects are bigger than the sum of the parts. As acupuncture continues to be integrated into a comprehensive and multi-disciplinary healthcare system, recognizing these synergies can help us to better position acupuncture as an integral part of the healthcare landscape.

Two nationally recognized leaders in the move to integrate public health and acupuncture in the fabric of care in the U.S. are Carla Wilson PhD, DAOM, LAc and Sivarama Vinjamury MD (Ayurveda), MAOM, MPH.

"As acupuncture continues to be integrated into a comprehensive and multi-disciplinary healthcare system, recognizing these synergies can help us to better position acupuncture as an integral part of the healthcare landscape."

Wilson, the director of both the DAOM program and research at ACTCM, California Institute of Integral Studies, shares the following thoughts:

"Integrative medicine fully embraces acupuncture as a fundamental component of collaborative care in the U.S. Unfortunately, there remains limited inclusion of the whole system of the medicine and specifically herbal medicine.

The profession, as a whole, must take seriously just how important it is to educate health care administrators, western medical colleagues and researchers, and the public, to the value and depth of increased health and healing potential that the whole system of Chinese medicine can provide.

We exist during a dynamic and evolutionary time. There is increased focus on the need for new knowledge and new ideas, best practices, and innovative research geared towards transforming the current landscape of pain management, addressing chronic illness, and specifically contributing to oncology treatment. Too often we hear of challenges faced by patients and their caregivers as they interface with the health care system.

What if we chose to contribute to the redesign of health care FOR patients with perspectives FROM patients as well as others across the continuum of care? Are we up for the challenge? I think we are. Are we ready to engage and be in full collaboration in the provision of medical care in the US? I believe we are prepared for this transformation and we are well on our way toward this future."

Vinjamury, a professor and researcher at the Southern California University of Health Sciences (SCUHS), directs capstone research at SCUHS. He offers the following perspective on integrative practices:

"It is imperative for all integrative health practices to be part of multidisciplinary teams and settings to effectively treat chronic ailments because they often need more than one tool. It is a win-win for all stakeholders. Patients also prefer and appreciate such collaboration because they do not have to deal with (worry about) informing their MD about other treatment approaches they are trying simultaneously or intend to try for their condition(s).

INTERSECTIONS AND SYNERGIES: ACUPUNCTURE AND PUBLIC HEALTH

> *The integrative health practitioners and MDs will have a great opportunity to learn from each other about each other's philosophy, methods, strengths and limitations as well as rationale for choosing a particular therapy, all in first person. Finally, the clinical outcomes may improve and reduce costs because all therapies will complement each other."*

Recognizing these intersections and synergies empowers us as providers to create models of clinical service that reflect the value of traditional Asian medicine and acupuncture. Singer and Adams[2] surveyed health service managers and administrators in a number of hospitals and out-patient clinical settings in Australia to determine characteristics of effective integrative care. Their paper identifies the following factors that are key requirements for successful integrative practice:

- Enthusiastic and well-informed health service managers
- Validation of the clinical importance of complementary and alternative medicine (CAM)
- Climate of inter-disciplinary respect and collegiality
- Supportive organizational structures
- Clear respectful boundaries
- Knowledge-sharing
- Well-informed referral practices
- Promoting CAM research
- Having CAM champions (i.e., medical staff supporters)
- Co-location

Although the survey doesn't specifically focus on acupuncture integration, acupuncture services were available in many of the environments queried.

The commonalities shared by public health and traditional Asian medicine will continue to become evident as our work in hospitals and community health settings evolves. Given that we are in the midst of a "crisis" of sorts in U.S. health care, building on the synergies of public health and acupuncture can provide an important opportunity for healing.

1) http://apha.org/what-is-public-health

2) Singer J and Adams J. An exploratory study of the health service managers' role in providing effective integrative health care. *European Journal of Integrative Medicine*. February 2013;5(1):27-35.

MERIDIANS

The Journal of Acupuncture and Oriental Medicine

The Journal of Acupuncture and Oriental Medicine

Volume 3, No. 2 • Spring 2016

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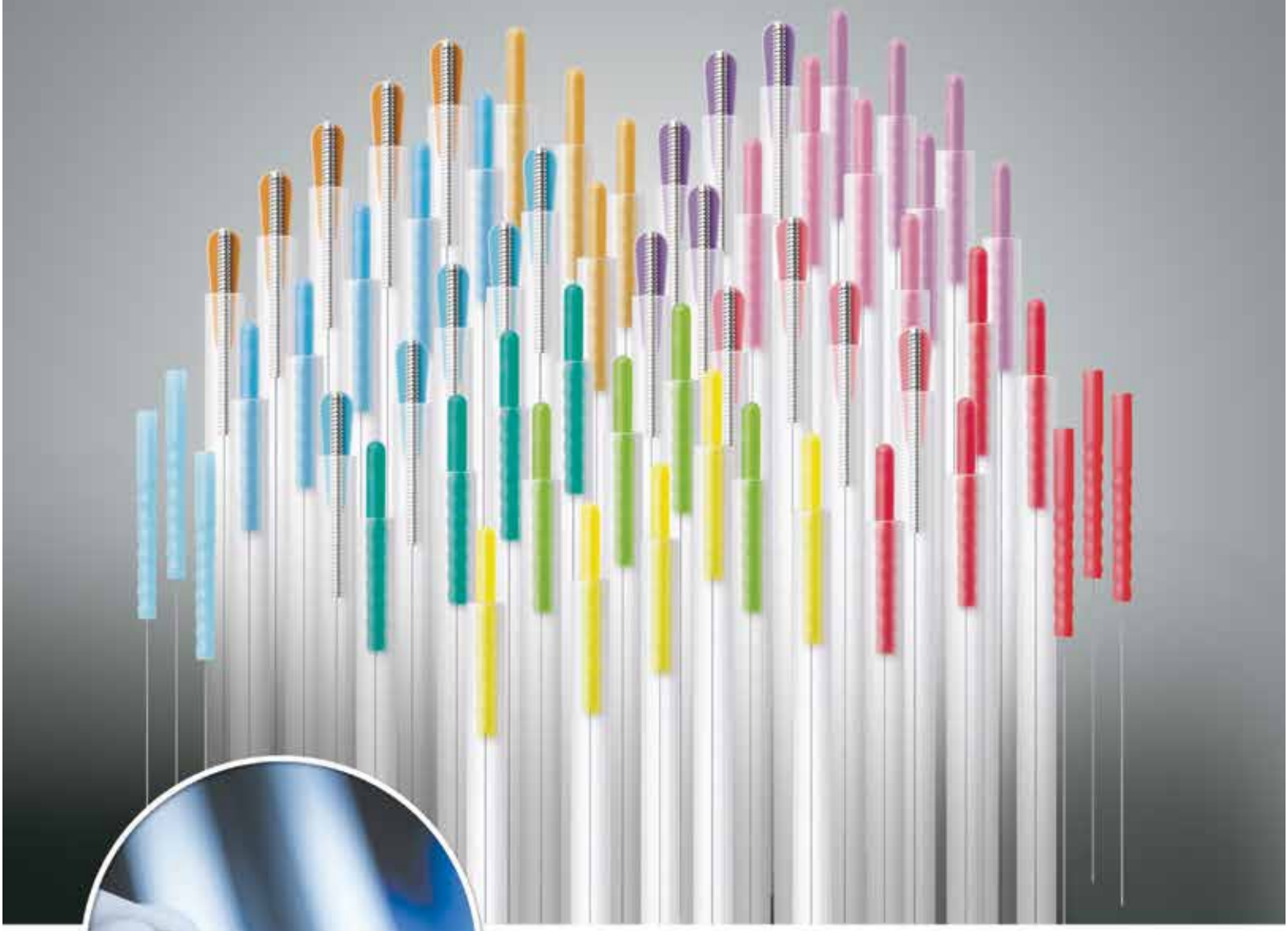

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