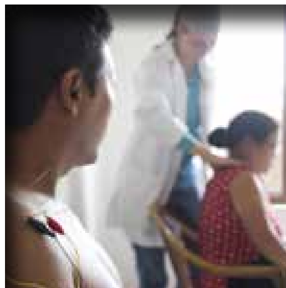

Compendium of Clinical Case Studies

Volume One

AcupunctureReliefProject

Forward

Acupuncture Relief Project volunteers participating in the **Third World Medicine Immersion Program** work six days a week not only providing care to patients but also participating in over 40 hours of continuing education focusing on improving their skills in case evaluation, treatment planning and patient progression. Upon completion of their course, each practitioner presents a case study for peer review. These case studies help us analyze the efficacy of our clinic efforts and contribute to a body of evidence that supports our overall project model. We share them here to provide our community some insight into our work in advancing our medicine both at home and abroad. Patient photos contained herein are used by express permission of the patient.

If you have any questions or comments about these case studies, please contact Andrew@AcupunctureReliefProject.org

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CASE STUDY: Typhoid Fever Induced Paralysis

Andrew Schlabach MAcOM EAMP

OVERVIEW

32-year-old female presents with left sided paralysis of upper and lower limbs. The patient suffered a fever due to Typhoid at age 12 that caused convulsions and coma. After a 20-year history of paralysis this patient recovered most of her upper limb function and some lower limb function with acupuncture treatment.

SUBJECTIVE

Patient presents with left sided paralysis of the upper and lower limb. She has no pain in the effected limbs but reports numbness and tingling in the fingers and toes of the effected side. This condition started at age 12 after suffering a high fever, due to Typhoid, which caused convulsions and a 5 day coma. She was treated at the local hospital for Typhoid but has received no treatment for the paralysis. Patient also reports right-sided knee pain, likely due to poor structural alignment and asymmetrical walking posture. Patient reports persistent low energy, sadness and is easily moved to tears. Patient has three children and works as a farmer. Menstruation is regular at about 30 days, scanty flow of pale color for 2-3 days. No menstrual pain or PMS symptoms.

OBJECTIVE

Patient appears to be in good health for age and environment but has a slow affect and seems to be somewhat mentally diminished. Her demeanor is of a person in their early teens.

The left arm is held closely to the chest and the fingers of the left hand are tightly contracted. The fingers can be passively extended with little force but they return to a contracted condition immediately on release. The patient can move the shoulder normally but cannot actively flex or extend the elbow. The hand has no active response. All joints can be passively moved through all ROM without pain or difficulties. Sharp/Dull test on the fingertips shows no objective numbness. DTR on bicep and tricep tendons is normal. DTR in brachioradialis is unresponsive.

The left leg is normal in size and coloration. The left foot is inverted at rest and requires some force to passively evert. Hip flexion and extension have normal ROM and are well coordinated. Muscles strength is similar to the well side. Leg flexion and extension has normal active ROM but are poorly coordinated taking about 15 seconds of concentrated effort to complete the motion. Muscle strength is about 20% of the well side. Patient does not have any active control of the left foot. DTR of patellar tendon and hamstring is sluggish and weak. DTR of the calcaneal tendon is unresponsive. Sharp/dull test of the toes shows no objective numbness.

Pulses are deep and weak and tongue is pale and deeply scalloped.

ASSESSMENT

DX: Motor paralysis of several major muscle groups in the upper and lowers limb likely due to febrile damage to the central nervous system.

TCM DX: Wei syndrome due to Qi and Blood deficiency. Obstruction of the channels and meridians.

PROGNOSIS: Due to the fact that this condition has been left untreated for 20 years, it is unlikely to expect significant response.

INITIAL PLAN

Treat with acupuncture 3 times per week for 10 treatments then reassess. Focus on the Yang Ming to stimulate Qi and Blood. Make heavy use of electro-acupuncture crossing multiple joints especially concentrating on anterior and lateral compartments of the leg and flexor/extensor complexes of the forearm. Internally use Dang Gui San 4g TID to tonify and move blood.

Typical treatment: Left: ST36 electro to LR3, GB34 electo to GB41, LI10 electro to LI4, HT3 (distal) electro to HT8, Ba Xie (with heavy stimulation), Ba Feng (with heavy stimulation). Right ST36, SP6, KI7, HT7, DU 20, 24

Alternative treatment: Pi Ci needling of hand and foot Yang Ming channels, Scalp motor sensory (Leg, Foot and Arm zones x3) on well side with electro stimulation

OUTCOME

After 10 treatments the patient reported no change in condition. The patient was then counseled that because of the long-term nature of the condition and the lack of response to treatment, it was unlikely that acupuncture treatment would be beneficial. The patient opted to continue treatment but after 18 treatments she still reported “no change”. At this time the patient was encouraged to discontinue treatment. The patient immediately broke into tears saying that she wanted to continue treatment because when she started she was unable to carry the water bucket but now she could. Also before she started treatment she could not walk to the clinic but now she could. This was a major revelation of change in condition, which bought to our attention that culturally “no change” often means, “I’m not cured”. After a more thorough objective examination, it was observed that the patient now had weak uncoordinated active movement of the fingers. She could also actively evert the foot. After this discovery the patient was treated every other day for 4 weeks in which time she made rapid improvement. Eventually she was given exercises to teach both the well and ill hands how to isolate individual finger movements. She was instructed to use her eyes to observe

her well hand though a series of individual digital movements and then try to replicate the movements with her ill hand. Progress was slow but continual. The patient had to be constantly encouraged to exercise and every treatment session the patient was reminded how far she had progressed. After 48 treatments over 3 months the patient had full active dexterity of the left hand although the left arm remained 10-20% weaker than the right. The left foot did not respond as well and remained 50% weaker than the right. Dexterity of the toes was not recovered however the patient could dorsiflex and plantar flex the foot.

CONCLUSION

This patient was nearly released from care due to poor communication, objective observation and subjective reporting. When dealing with paralysis recovery, careful objective observation and measures are imperative as the patient is not always aware of the slow changes that are taking place. Visual exercises in addition to the acupuncture treatment significantly accelerated the recovery process. Paralysis patents also need constant encouragement as the course of treatment is slow and often the condition seems to plateau before new changes take place.

CASE STUDY: Cervical and Lumbar Spondylosis

Danielle Lombardi MAcOM LAc

OVERVIEW

70-year old male presents with severe cervical and lumbar pain, neuropathy of the arms, hands, legs and feet; incontinence of bowels, and anal rash. His doctor has advised surgery. After 8 treatments he is able to sustain 40 -50% relief of pain for four days.

SUBJECTIVE

Patient presents with severe lumbar and cervical pain, and reports bilateral heaviness, weakness and tingling sensations in his arms and legs. He reports that the neuropathy is worse in his left arm, but is present in all 10 of his fingers, and brought on by cold water and cold temperatures. The tingling in his right leg is worse than in his left leg. Patient also has incontinence of bowels, which occurs 4 to 5 times a day. Bowel movements are urgent, formed and easy to pass, but there is pain due to a rash around his anus. He reports feeling hot inside his body, especially at night. His doctor has advised surgery, but he is hopeful that acupuncture might help his pain enough to avoid this.

The onset of neck pain was 4 to 5 years ago, and the onset of his back pain was 8 to 9 years ago. Patient relates his pain to a history of heavy labor, working as a field digger and brick carrier. For years he carried more than 60 kg on his back, but now he is unable to lift 200 g of weight. The pain came on gradually, but has become severe in the last year.

The neuropathy in limbs began 14 months ago after being hit from behind by a bus. He landed on his right medial knee, upper thigh, chin, nose, forehead, and right anterior shoulder. There were no broken bones, but an MRI which was ordered on 4/13/11 revealed damage to his nerves. After the accident he was unable to grasp food properly, count money, or hold a glass.

The neuropathy radiates from the neck, down the right arm and into both hands. Patient reports heaviness, weakness, and tingling in all fingers, but denies pain in the limbs. He can feel warm and cold, but he reports subjective numbness in both hands.

Patient reports no change in pain or neuropathy with time of day, but cold weather makes it worse and heat makes it better.

The neck and back pain are severe, and the symptoms are constant.

In the right leg, patient reports a cold tingling sensation from soles to the knee, which is most intense between the lateral ankle at GB 40 and the lateral leg at GB 34.

OBJECTIVE

Patient appears to be in relatively good health, but severely challenged by the pain in his neck and low back. During the first visit he was unable to perform AROM and orthopedic tests due to the severity of his pain. At the onset of treatment he was unable to walk without support from his wife, and showed exquisite pain when standing up or beginning to walk. He also showed trouble balancing when standing up before and after treatment; almost falling over on occasion.

Sharp/Dull test on the fingertips, arms and toes show no objective numbness. DTRs on bicep, triceps, brachioradialis, patella, hamstring and Achilles are normal. Grip strength is 50% weaker in left hand than right. Nail bed blanching shows normal circulation in both hands and feet.

Cervical AROM shows full range of motion with flexion and lateral flexion, extension and rotation, but with report of severe pain with motion. Cervical compression test increases neck pain and heaviness in arms. Cervical distraction test brings relief to neck pain and heaviness in arms. Upon palpation there is severe pain and tenderness at left C2, C3, C4, and right and left C6 and C7.

Lumbar flexion AROM is 80 degrees (normal 90 degrees) with pain on motion. Extension is 15 degrees with pain on motion (normal 30), lateral flexion is 20 degrees with pain (normal 30), and rotation shows 25 degrees with pain on motion (normal 30).

There is no radiation of pain with exams.

The muscles along the neck and back present with severe rigidity upon palpation. It is difficult to insert a needle without bending due to tenseness of erector spinae musculature.

Tongue: purple-red body, thin bright pink tip, slightly deviated to the right, transverse cracks, and purple sublingual veins.

Patient records include:

CERVICAL MRI, April 13 2011. Five months prior to treatment

- Cervical spondylosis of C4 – C7
- Bulge of disk posterocentral at C3 – C4.
- C4 – C5 (posterocentral protrusion of disk) at C5 – C6; narrowing of bilateral neural foramina with possible impingement of bilateral existing nerve roots

- Disk osteophyte complex with left posterocentral protrusion of disk C5 – C6 causing compression of the cord – bilateral impingement of nerve roots
- Diffuse bulge of disk with left posterocentral protrusion at C6 – C7 with indentation of thecal sac and cord – possible impingement of existing nerve roots
- Slight increased signal intensity in the cord at C5 –C6 level with myelopathy

LUMBAR MRI:

- Lumbar spondylosis
- Right sided spondylosis at L4 – minimal anterolisthesis of L4 over L5
- Mild bilateral posterolateral bulge of the disk at L1 – 2, L2 -3, L3 -4 with mild narrowing of bilateral lateral canals
- L4 – L5 disk bulge/posterocentral protrusion – stenosis of bilateral lateral canal and neural foramina
- Bulge of disk with annular tear and posterocentral protrusion at L5 – S1 with mild compromise to central and lateral canal – no nerve root impingement
- T2 sagittal image of dorsal spine shows minimal posterocentral bulge of the disk at T8 – 9, denting the thecal sac

ASSESSMENT

DIAGNOSIS: Cervical Spondylosis of c4 - 7, with nerve impingement at c5, c6, c7 and disk bulges at c4, c5, c6, c7. Lumbar spondylosis, with right-sided spondylosis at L4, disk bulges at L1 – L5.

TCM DIAGNOSIS: Bone Bi syndrome. Qi and Blood stagnation of Bladder Channel and Governing Vessel at cervical and lumbar regions due to and compounded by history of overwork and trauma. Underlying Kidney Yin xu creating a malnourishment and deformity of Bone, leading to Qi and Blood stagnation, turning into Qi and Blood xu. Qi Deficiency and Stagnation in the Channels leading to neuropathy in the hands and feet.

PROGNOSIS: Due to the physical deformity of the cervical and lumbar spine, it is unlikely to fully resolve the condition. With continued acupuncture treatment in conjunction with stretches, traction, massage, electro-stimulation and cupping, a decrease in pain and neuropathy is likely. The aim is to avoid or delay surgery for as long as possible with consistent acupuncture and conjunctive therapies.

INITIAL PLAN

Patient to be treated at the clinic 3 to 4 times a week for one month, and to assess treatment progress at that time. There will be a focus on Hua Tou points in the cervical and lumbar regions to stimulate qi and blood circulation in local areas of degradation, disk bulging and pain. Teaching patient stretching and exercises to reduce pain will also be an integral part of treatment. Nourish Kidney Yin, tonify Qi and Blood, move Qi and Blood.

TYPICAL TREATMENT

Acupuncture: Hua Tou Jia Ji points needled deep at C4, C5, C6, and C7. Hua Tou Jia Ji at L1, L2 L3, L4, and L5 needled wide and deep angled medially, with bilateral electro-stimulation at 5 continuous frequency for 30 minutes. Electro-stimulation from S2 to DU2 bilaterally at 5 continuous frequency for 30 minutes. BL40, KI7, LR3.

Cupping: bilaterally along Bladder channel from cervical to lumbar region x 10

Massage: tiger balm or bai jie balm applied with massage and pressure point therapy to neck, shoulders and low back.

Traction: neck and arms with a focus on neck for 10 - 15 minutes and arms for 2 minutes.

OUTCOME

At the first visit the patient reported relief from the tingling in his hands during the first five minutes of treatment. When electro-stimulation was applied to points on his back and neck, he reported a return of heaviness and tingling to his hands and was upset with the reversal of relief. After the initial treatment he declined the use of the electro current because he felt that it had exacerbated his symptoms. For the next 3 treatments the patient reported no significant change and expressed frustration at the lack of progress. At the 5th treatment, cupping was used, after which he reported some mild improvement. At the 7th treatment traction of the neck and arms was applied, as well as a deeper and wider approach to the needling of the HTJJ points in the lumbar back with a reintroduction of electro-stimulation. On the 8th treatment the patient reported 2 full days of relief from treatment #7, with a 40% reduction in the pain. On the 9th treatment he reported 40 – 50 % improvement that lasted for 4 days after treatment. He also reported less pain around the bowel movements due to the disappearance of the anal rash, as well as a 50% increase in his bowel control. He reported being able to walk for an hour and a half without trouble, and appeared to be able to sit, stand and walk without the distress that he exhibited in his first several visits to the clinic. Upon palpation his musculature was also much less rigid than before.

CONCLUSION

This patient presented with a difficult case due to severe pain, the pressure of impending surgery, and no significant change until the 7th treatment. This case teaches the importance of having the patience to follow change in the course of a treatment plan. The strategy is now revised to a more long-term plan of 3 visits a week for six months, with a reassessment of the need for surgery at that time.

With continued treatment over the next six months, the intention is to manage pain, regain balance and agility, reduce the neuropathy and regain bowel continence. Future treatment should be focused on acupuncture with conjunctive therapies: Electro-stimulation, cupping, traction, stretching, and massage.

CASE STUDY: Chronic Abdominal Pain

Felicity Woebkenberg MAcOM LAc

OVERVIEW

31 year old male presents with chronic abdominal pain. The patient has suffered from abdominal pain for the past 11 years, but has had worsening of symptoms in the past year. Case analysis after 11 visits over two months.

SUBJECTIVE

Patient presents with abdominal pain to the epigastric, umbilical, and hypogastric, lumbar, and iliac regions. The patient describes the pain as burning and sharp in nature, worse after eating, and migratory in nature. Symptoms have occurred gradually over time (starting 11 years ago), but have increased in severity over the past year. The patient had an endoscopy 5 months ago which was negative. The patient states that he has trouble maintaining his weight (most likely due to malabsorption), and in the past has had diarrhea stools as often as 6-7 times a day. Currently, this patient is having 1-2 stools a day which at times are small in amount and often feel as if they are incomplete (and also described as "goat- like stools"). He denies blood or a tarry appearance to the stool, but states that at times there is some visible mucous. He has cramping to the abdomen and sensations of nausea without vomiting prior to bowel movements relieved after defecation. The patient also states that he gets frontal and temporal headaches prior to bowel movements with relief after defecation. The patient describes a bitter taste in the mouth after meals. In the morning, the patient awakes to belching, foul breath, liquid in the mouth, as well as a bitter taste. The patient describes the liquid as watery, slippery, and light green to black in color. The patient has also described intermittent low-pitched ear ringing, as well as intermittent itching to the skin with a mild redness and rash. The patient states that all of his symptoms are worse with spicy and greasy foods. The patient feels warm overall. His primary emotion that he states that he presents with is frustration and anger. He has difficulty resolving conflicts with others, and avoids challenging situations rather than confronting them. The patient denies that there were any significantly stressful life events during the time that his symptoms progressed over the past year. He has high pitched tinnitus to both ears. The patient has a family history of an Aunt who also had a similar condition with similar symptoms and died at the age of 40.

Typical Diet: Dhal and rice, potato's, minimal spicy foods, no alcohol

OBJECTIVE

The patient appears thin and somewhat malnourished and deficient. His cognition appears to be intact, and his speech is age appropriate. He is visibly disturbed by his illness and there is a sense of desperation in his search for a solution. The sclera of his eyes have a red tint to them, and he occasionally has watery eyes and itching. He has a stye to the superior eyelid on the left eyelid.

When initially working with this patient, he was extremely reactive and tender to palpation particularly to the left upper and lower quadrants, as well as to the hypochondriac region on the right side just inferior to the 10th rib. The patient would wince with pain upon palpation and needle insertion. Upon auscultation, hyperactive bowel tones could be heard in all four quadrants. The liver and gall bladder appeared to be inflamed and exceptionally tender upon examination. The patient was referred to the health post for lab testing to rule out possible cholelithiasis or hepatitis. Labs that were drawn included Bilirubin total and direct, AST, ALT and amylase. All were within normal range.

Pulse: wiry/slippery and bounding superficially, deficient at the base

Tongue: Red, No coat (peeling particularly on the left side of the tongue), with red prickles to sides and tip

ASSESSMENT

DX: Possible chronic parasitic infection, IBS, Malabsorption syndrome, H. Pylori-Gastric Ulcer, or Crohn's disease

TCM DX: Acute: Damp-Heat in the LR/GB overacting on deficient SP/ST (with possible deficiency heat)

Constitution: Spleen Qi deficiency leading to the accumulation of Damp.

PROGNOSIS: Due to the length of time that this patient has had this condition, it is likely that this will take a significant amount of time for the gastrointestinal tract to heal.

INITIAL PLAN

Treat with acupuncture 2 times per week for 10 treatments and then re-assess. Focus on points to tonify the spleen, move stagnation, and eliminate dampness in the middle jiao. Internal herbal treatments that have been utilized include: Huang Lian Jie Du Tang, Gui Zhi Gan Jiang Tang, Stomach Formula, Er Chen Wan, and Zi Sheng Wan, and Intestinal Fungus Formula. Warm needle moxa has also been used on ST36.

TYPICAL TREATMENT/Common combination of points used: ST36 (tonify qi and blood), SP6 (tonify qi and blood), ST25 (tonify intestinal function), SP15 (tonify intestinal function), CV6 (tonify sp/st), CV3 (reduce damp heat), CV12 (tonify yin organs and st), LI 10 (tonify), PC6 (tonify sp/st and reduce nausea), LR13 (reduce and harmonize the sp and lr), LR5 (reduce dampness and heat in the lower jiao), LR3->(angled towards)LR2 (reduce excess fire in the lr), LR14 (reduce excess in the liver), GB24 (reduce excess in the liver)

OUTCOME

After 11 treatments, the patient has denied significant improvement. Discussion occurred with the patient to complete further diagnostic testing (including eosinophils, Hgb, Hct) to evaluate for a possible chronic parasitic infection or possible gastrointestinal bleeding. Stool testing was done thought to evaluate for parasites. The patient was also told to bring a sample of the black/greenish liquid that he has in his mouth in the morning in a sealed container for examination and objective data. Upon additional testing, eosinophils, Hgb, Hct, and stool samples were all negative.

The patient has stated that he originally had bowel movements 6-7 times a day and now has bowel movements 1-2 times a day. It was discussed with the patient that normal frequency of bowel movements could help the body to heal and absorb nutrients more readily from food. Dietary considerations such as avoiding overly spicy foods, greasy foods, and uncooked meat were discussed. At this stage, frequency of treatments could be increased to 3 times per week, and a more solid and continuous herbal treatment could be initiated to observe improvements. The patient has also become much less needle sensitive as the treatments have progressed.

CONCLUSION AND REVISED PLAN

Further testing and continuity of care is necessary to properly evaluate this patient and appropriately come up with a treatment plan. Consistency and continuity of care for this patient is essential for progress to be made, and a healing and trusting relationship to be formed. Test with herbs for at least 2-3 weeks in addition to acupuncture 2-3 times a week for another 10 treatments and re-assess. Continue to provide encouragement, and also consider possible underlying emotions that may also exacerbate the patient's symptoms (when other diagnostic testing has ruled out other possible causes).

Discontinue Intestinal Fungus Formula.

Initiate Gallbladder Inflammation Test: patient was given ¼ cup of olive oil by mouth after treatment #12 and told to monitor for any changes in symptoms for the next 24 hours. If the test is in fact positive, refer for ultrasound of gallbladder.

On further treatments, Consider Jia Wei Xiao Yao Wan 10 BID for 2-3 weeks for both excess and deficiency symptomology. Explain clearly to the patient to take the herbs for a reasonable length of time to measure effectiveness

Patient is to be seen a minimum of 2 times per week for the next 10 treatments before proceeding to a revised treatment plan.

CASE STUDY: Chronic Headache (Typhoid Fever Sequela)

Stacey Kett MAcOM LAc

OVERVIEW

43 year old female presents with a severe headache. 9 months ago the patient contracted Typhoid Fever. During the illness she had a headache that covered her entire head and she had a mild fever for 5 days. She has had severe headaches ever since. Currently acupuncture is providing some relief from the headache pain but she continues to need more consistent treatment. Case analysis after 7 visits over two months. Chart number 09/11/1387

SUBJECTIVE

The patient presents with a headache that is mostly in the temporal and vertex regions. Light and sound do not trigger the headache. She has sinus pressure that contributes to the pain. Her sense of smell is inhibited by the sinus congestion. She also presents with occipital neck pain that also attributes to the headache. Her hands and feet are cold and sweaty during the day. She sweats a lot when the pain is severe and at night. Her digestion is normal. Menstruation is regular with 4 days of bleeding, 2 of which are heavy.

Medications: PRAN 10 (Propanolol HCL) a beta blocker used for hypertension, anxiety and panic. Depthyline 25 (Amitriptyline Hydrochloride) a tri-cyclic antidepressant. Paracetamol 500 mg (Acetaminophen/Tylenol). Something called Anims for pain that cannot be controlled by the Paracetamol. (The western equivalent was not able to be found in the available resources).

OBJECTIVE

Patient appears to be in good health for age and environment.

Tongue is dusky and red.

Pulse is deep and thin and rapid.

Blood pressure on first intake was 135/109 with a heart rate of 110. Two other BP measurements were 128/82 and 128/98.

The occipital and frontal sinuses are tender upon palpation.

An imaging study CT/MRI was done within the last 6 months and showed no abnormalities in her brain.

ASSESSMENT

DX: Headache from the sequella of typhoid fever, sinus blockage, occipital neck pain.

TCM DX: Blood Stagnation in GB/ LV channels, Blood Xu due to the febrile disease, phlegm in the LI and BL channels, Qi and Blood Stagnation in the BL channels.

Prognosis: This is difficult to treat due to the fact that the patient lives 2 hours away and is not able to come for consistent treatments. If she was able to come for more regular treatments the prognosis would be better.

INITIAL PLAN

Treatments 3 times a week for 10 treatments and then reassess. Focus on building and moving the blood in the channels. Clearing the blockage in the sinuses. Move blood and Qi in the occipital area. She was given a five day course of Xue Fu Zhu Yu Tang to help move the blood and stop the pain.

Typical treatment included:

Ht 8, Ht3, Sp 10, TB 5, GB 41, GB 20, BL 10, Bi Tong, BL 2, GB 8, Tai Yang, Yin Tang, BL 7, SP 6, ST 36, BL 60.

OUTCOME

The patient came to the clinic 7 times. She came in two sets of treatments. One was three treatments every other day and the next set was four treatments in a row. The treatment sets were about three weeks apart. She noticed after the first set of treatments her hands warmed up and she stopped sweating at night. Her headache was better and had less sinus congestion and pain.

The patient had taken pain medication the day before the first treatment and an hour before the first day of the second set of treatments. The second set of treatments yielded a reduction in

the pain and an increased sensation in her hands and wrist.

The severity of her headache decreased by half during the treatments showing that she responds well to acupuncture. She has been advised on the need for increased frequency of treatments. But because she lives so far away she is not able to come as often as would be necessary to get ahead of the pain.

The herbal patent medicine of Xue Fu Zhu Yu Tang was given for 5 days, 8 pills, three times a day before meals. No relief was noticed within the course of herbs.

CONCLUSION

This case is incomplete and more information is needed on several topics. The frequency of the headaches is not understood or charted. The medications that are used are not clear and were charted on two separate days indicating that we may not have all the information. The treatment that she received for the typhoid fever is not known, as well as what her other symptoms were from the Typhoid fever in addition to the fever and headache. The course of Typhoid fever can also include a dormant period of the pathogen. Thus, if there was no treatment given she may still be a carrier of Typhoid and it could present itself at a later date. More information is also needed for a clear TCM diagnosis. Are there other LV/GB signs? Are there true heat signs?

After analysis it is clear that acupuncture treatment had good results despite the lack of a full diagnostic workup, however, a more comprehensive exam is necessary to progress this case further. Herbal treatments may have been too short term to properly evaluate their therapeutic benefit.

CASE STUDY: Chronic Obstructive Pulmonary Disease with Osteoarthritis

Jennifer Rankin RAc

OVERVIEW

Sixty five year old female presents with dyspnea and continuous cough. The patient also presents with chronic severe pain and inflammation of all joints of the hands and feet. With regular acupuncture and herbal treatment the patient experienced a 6% O2 increase on the oximeter, more than a 50% reduction of pain and a 90% improvement in range of motion in her hands.

SUBJECTIVE

Sixty five year old female patient presents with chronic dyspnea and continuous cough. The difficulty breathing started 4-5 years ago and progressively got worse. The patient does not live in a high traffic area but has used an indoor fire to cook for most of her life. She now uses gas. The difficulty breathing is continuously present with no history of attacks and no history of fever and chills. The patient does not report chest tightness or coughing at night. The dyspnea lessens with rest. Occasionally cough is accompanied by small amounts of white or red phlegm. The dyspnea is the same with inhale and exhale. She reports not being able to walk from the microbus to the clinic (about 150 feet) without severe wheezing. She reports that it is hard to take a deep breath and she sometimes feels like she is unable to get enough air. She also reports waking up from difficulty breathing. The patient reports that the condition worsens in the winter, in the afternoon, and when walking or lifting things. The patient has a family history of breathing difficulty including both her mother and sister whom have had medical intervention concerning their conditions. The patient feels cold and gets common colds easily. She has spontaneous sweating.

The patient reports bilateral pain, inflammation and stiffness of all of the joints of the fingers and the feet including the ankles. The pain started about 4 years ago while she was still working in the fields and has gotten worse since. The patient reports warmth helps the pain and movement makes it worse. The pain is burning, tingling and "unbearable". There is no accompanying fever. The patient reports good energy and appetite. The patient reports severe pain, which interferes with walking and sitting. The pain is worse in the afternoon. She has no family history of pain and inflammation in the joints.

The patient also reports pain in the shoulders and knees and a heavy dull ache in the low back. The patient no longer does field work and does very little activity. The patient has not received other medical treatment or had a diagnosis for these conditions.

** Photos taken after treatment #5*

OBJECTIVE

The patient has difficulty talking due to breathlessness and audible wheezing. In addition, when she moves the wheezing increases. She has a weak and raspy voice with the occasional weak cough. She appears to be in average health for her age and environment. A strong wheeze can be heard through auscultation of her lungs. The first measurement on the oximeter is recorded as 91% O_2.

The patient is in moderate pain indicated by her ability to smile, laugh and respond to questions. However, walking and sitting down are difficult. All joints of the patient's hands are swollen 40% larger than normal and her feet and ankles are swollen 30% larger. Both the hands and feet are hot to touch. No bone deformities are present. The patient has an 80% reduction in the active range of motion of all her finger joints. The patient is unable to make a fist. She has a 30% reduction in the active range of motion of all the joints of her feet. The passive range of motion of her joints was not tested.

Pulses are deep, weak and soggy. Her tongue is pale and swollen.

ASSESSMENT

Dx: COPD and osteoarthritis (pronounced in the joints of the hands, feet, knees and shoulder)

TCM Dx: Lung and Kidney Qi Xu with Wind Cold Damp Bi in the joints.

Prognosis: Using regular acupuncture and herbal treatment improvement is expected with 10 treatments. However, due to the severity of the pain, inflammation, and breathing difficulty, more significant outcomes are expected over a longer course of treatment.

INITIAL PLAN

Treat with acupuncture 3 times per week for 10 treatments then re-asses.

Focus on reducing swelling and inflammation (Cold Damp Bi) first. As swelling is reduced add treatments to tonify the Lung (wei Qi) and Kidney Qi.

Typical Points include: Lu 1, Ren 17, Lu 9, Kd 3, Sp 6, Lu 5, St 36, LI 4, UB 13, UB 23, as well as local points at sites of swelling and pain.

Internally use formulas to reduce swelling and inflammation of the joints:

Du Huo Jie Xie Wan (8 TID) for first 2 weeks. Then switch to Ding Chuan Wan (8 TID) to tonify the Lung and Kidney Qi

B complex vitamin with 100mg B1, 100mg B5 and 100mg B6 to assists with wound healing and as anti-inflammatory agent.

Counsel the patient about proper ventilation of home if ever cooking with a wood fire and wearing a mask when in polluted or high traffic areas.

OUTCOME

After 9 treatments the patient reported major changes in her breathing, pain and inflammation. The patient's voice is stronger with less audible wheezing. The patient can now take a deep breath and no longer has times when she feels like she can't get enough air. She doesn't wake up wheezing, and she can now walk from the microbus to the clinic with a very small amount of wheezing. The patient continues to have a regular cough however it has decreased from being continuous to 2-3 times a day. When phlegm is present it is only white and not red. The pulse oximeter now generally reads between 95-97% O_2 and is only occasionally 92- 93% O_2.

The patient's hands have no swelling and there is only minor swelling of the lateral ankles. The hands are not hot to touch and the patient reports no feelings of heat in the joints. The pain has decreased over

50%. The patient has full active and passive range of motion in her feet and has a 90% increase in the active range of motion in her hands. The patient can now walk and sit without severe pain and can make a complete fist.

CONCLUSION

The effectiveness of acupuncture and herbal medicine for both COPD and arthritic pathologies is clearly outlined here. The importance of regular treatment and the use of objective measures to quantify progress is essential.

CONTINUED TREATMENT

This patient needs continued intensive acupuncture and herbal treatment for her lungs and arthritis. Objective measures of her progress would be beneficial such as continued use of the oximeter, auscultation of her lungs with a stethoscope and a chest x-ray to rule out more serious conditions. The patient has responded positively to treatment thus far and further improvement is expected.

CASE STUDY: Facial Paralysis (Bell's Palsy)

Jennifer Walker MAcOM LAc

OVERVIEW

35 year old female presents with left sided facial twitching and paralysis. After 7 acupuncture treatments the patient has regained over 50% of her facial functioning and 80% of the facial twitching has been resolved.

SUBJECTIVE

Patient presents with left sided facial twitching and paralysis of the of the face. There is twitching of the left eye that is also painful and tears frequently. The cheek and mouth also twitch, and feel as if "the face is twisted". She has moderate pain (5/10) with smiling that also interferes with sleep, concentration and in social situations, causing her not to want to interact with others. Nothing makes the pain worse and only acupuncture and herbal treatment has improved the condition. The quality of the pain is sharp. She reports that the twitching is activated when eating or doing other motions with the mouth. Patient also felt that the throat was sore and found it difficult to shout. Patient reports that she woke up with the condition 15 days prior. She has not received any other treatment or medication besides acupuncture and Chinese herbs for the condition. She is from a Tamang village and walks for about an hour to get to the clinic. There is no history of the condition in the past. At the time of the initial treatment the patient stated that on her side of the bed there is a window with a draft.

OBJECTIVE

Patient appears to be in good health for her age, cultural background and environment. She has a suppressed demeanor and it is difficult to maintain eye contact with her. She speaks very low and says few words when asked.

No visible facial twitching until after acupuncture needles were inserted. With Cranial nerve exam, Cranial nerve V, the trigeminal nerve, showed some laxity in the masseter muscle. Cranial nerve VII, the facial nerve, showed some difficulty in closing and keeping the left eye closed, pursing lips, baring teeth, flaring the nostril and expanding the cheeks with air and keeping the mouth closed when doing so. All sharp/dull sensory tests were negative. All tests were negative for any involvement of the right side of the face.

Pulses are thin and wiry. No visible deviation of the tongue or thick coat.

ASSESSMENT

DX: Restricted or impaired control and functioning found in the cranial nerve exam shows motor impairment of the following muscles: orbicular oculi (closes eyelids), levator labii superioris alaeque nasir + alar part of nasalis (flair nostrils), buccinator + orbicularis oris (puff out cheeks with air while pursing lips), risorius plus levator labii superioris + depressor labii inferioris (bare teeth). Based on the Cranial Nerve Exam, predominately the facial nerve is affected which leads to the diagnosis of Bell's Palsy.

TCM DX: LR Wind Rising due to LR Blood Xu

PROGNOSIS: The patient began treatment for the condition while in its acute stage. She has responded to the treatment thus far. Due to diagnosing this condition in its acute stage, she is expected for full recovery because of early diagnosis and treatment.

INITAL PLAN

Treat with acupuncture 3-5 times a week for 10 treatments then reassess. Focus on nourishing and building LR blood and eliminating LR wind. Use needles on the face to stimulate the multiple affected muscles. Internally use Dang Gui San 1tsp TID to tonify blood.

Typical treatment: Bilateral - ST-36, LI-4, LI-10, LR-3, LR-8, Yin Tong, GB-20; Left - 1 needle threaded from the midline just below the lower lip up to the left corner of the mouth, TW-17, SI-19, LI-19, LI-20, GB-1, ST-3, ST-4, ST-5, ST-6, ST-7, CV-24, Jia Cheng Jiang, all needles with strong stimulation.

After Treatment # 3 (11/21/11)

After Treatment # 6 (12/8/11)

OUTCOME

After 6 treatments the patient reported 1/3rd improvement in the condition. The facial twitching is reduced and is no longer visible after needles are inserted. The left eye closes without any difficulty and there is no longer any tearing of the eye during treatment. The patient reports no longer having a sore throat or difficulty shouting. There is no longer any laxity in the masseter muscle. Cranial nerve testing still shows some difficulty smiling, baring teeth and puffing out cheeks with lips pursed. Visually the patient can perform these tasks at least 50% better than during the first treatment. The patient will now make eye contact and is much more engaged during the treatment.

CONCLUSION

With continued care it is possible that this patient can expect to see a complete recovery. Her condition has already responded favorably to acupuncture and herbal treatment. During the last visit the patient was asked to start coming in for treatment every other day for 2 weeks to see what continued progress can be made during this time. In addition, her herbs will be increased to 2tsp of Dang Gui San TID. The patient was also counseled to move her bed to an area of the house where there are less windows and no draft.

Massage for Chronic Back Pain Associated with Spondylosis of the Spine

Brad Caroll LMT

OVERVIEW

Seventy-year-old male referred for massage treatments for pain associated with spondylosis of the spine and neuropathy. The patient was referred for massage therapy in combination with ongoing acupuncture treatments. At the time of the referral the patient had completed eighteen acupuncture treatments. The main objective for the patients care with the combination of massage and acupuncture is to manage pain while enabling an increased quality of life.

SUBJECTIVE

Patient's chief complaint is of severe pain in the low back and right shoulder. The patient defines severe pain as discomfort that inhibits and or terminates his daily functions such as walking without help from others. The patient defined moderate pain as a discomfort that is constant, distracting and interferes with his daily functions (ie.. walking) but doesn't require help from others. He defined mild pain as a discomfort he recognizes on a daily basis but doesn't complicate, interfere or inhibit his daily functions. He described that he experiences "tingling" sensations in both hands and this sensation radiates (instantaneously travels) posteriorly down both legs to the feet originating at the lumbar region of the back. The frequency of the overall pain is constant and increases with activity (walking and getting up from bed after sleeping), but the radiation sensation is intermittent and unpredictable. The onset of the radiating sensation is speculated to be correlated with severe levels of pain in the lumbar region of the spine. The intensity of the pain fluctuates from severe to mild daily depending on the amount of activity he engages in and the treatments he receives. In addition, the patient states that sitting in the direct sun alleviates the pain. He reports that the pain d interrupts his sleeping patterns when at a moderate level. The onset of the pain is unknown but has increased due to being hit by a car one year ago. Pain increases with cold temperatures and with coughing episodes. Patient stated that doctors recommended surgery for his condition for which he could not afford. He expressed he was afraid of becoming paralyzed from spinal surgery. Additionally, he communicated that he has been depressed and at times wishing he was dead because he feels like he can no longer provide for his wife and be useful to his family. He stated that he feels stressed and emotional most of the time especially when pain increases and his ability to be functional to his family decreases. Although he has never received a professional massage treatment before he uses self massage with Tiger Balm daily for temporary relief on his shoulder and low back.

OBJECTIVE

Visual observations indicating pain and stress while at the clinic include the following:

- Walking slowly with assistance of his wife and a walking stick.
- Facial expressions associated with pain when walking, attempting to sit or stand by himself or removing clothing preparing for a treatment.
- Tone and speed of voice increases with movements that indicate pain.
- Tears and crying present when answering questions about his pain and his perception of how this affects his wife and family.
- Muscle spasms on the bi-lateral wrist flexors including flexor carpi radialis, flexor carpi ulnaris, palmaris longus, flexor digitorum superficialis and flexor digitorum profundus as well as triceps brachii when lying in the prone position on the table

Postural analysis findings:

- Bi-lateral medial rotation of the shoulders. Mild.
- Right shoulder elevated. Mild.
- Posterior tilt of the pelvis. Mild
- Genu Varum. Mod.

Palpation:

- Hypertonicity of the erector spinae group, gluteal region and hamstrings.
- Tenderness to the touch on the right supraspinatus, infraspinatus, rhomboid major, minor, biceps tendon, teres minor and major and the anterior, middle and posterior fibers of the deltoid.
- Tenderness to the touch with increased pain on origins of bi-lateral quadratus lumborum, gluteus maximus, gluteus medius and gluteus minimus.

ROM: (active)

- Lateral flexion, rotation, flexion and extension of the head and neck (cervical spine) are all within normal limits with minimal discomfort.
- Extension and flexion of the cervical, thoracic and lumbar spine are within normal limits. Moderate pain occurs with flexion of the spine beginning with contraction of the action.
- Rotation and lateral flexion of the spine are all within normal limits with no pain indicated.
- Abduction, adduction, flexion and extension of the arms are below normal limits with pain increasing with extension and abduction.
- Increased pain at the biceps tendon on right shoulder with flexion of the right elbow.

PLAN

Continue Traditional Chinese Medicine treatments 2-3 times per week as recommended by acupuncturist. Massage treatments (approx. 30-40 min. each) at least two times per week for five weeks for increased relaxation, stress reduction and decrease overall tension and pressure of the muscles of the posterior spine, shoulders, pelvis and legs. These muscles include bi-laterally the erector spinae group, supraspinatus, infraspinatus, rhomboid major, rhomboid minor, biceps tendon, biceps brachii, teres minor, teres major, deltoid, quadratus lumborum, gluteus maximus, gluteus medius, gluteaus minumis, piriformis, biceps femoris, semitendinosus, semimembranosus, gastrocnemius, peroneus longus and peroneus brevis. Massage treatments include the following techniques and purposes for the muscle groups related bi-laterally to the posterior spine, posterior shoulders, posterior pelvis, posterior thigh and lower leg.

Efflurage: To relax the muscles, stimulate the peripheral nerves, increases lymph and blood flow, remove waste products and begin to stretch the muscle tissues.

Pettrisage: To increase mobility between tissues, stretch the muscle fibers, increase venous and lymphatic return, relax the muscles and aid in the removing waste products.

Compression:

- Hypertonic muscles soften and lengthen.
- Muscles are flushed with interstitial stasis reduced.
- Released histamines dilate capillaries with increased cellular nutrition.
- Muscles fire faster with increased amounts of acetylcholine.
- Muscle lesions heal faster with increased collagen production.
- Stretching muscle fibers increases capillerization.
- Fascia is rejuvenated and enlivened.
- Range of motion and freedom of movement increase.
- Myofascial pain and secondary autonomic phenomena caused by trigger points is usually eliminated.

Hot/warm hydro therapy:
Use of the warm singing bowl technique, warm compress with vapor wrap and prossage soft tissue lotion.

Heat therapy dilates the blood vessels of the muscles surrounding the lumbar spine. This process increases the flow of oxygen and nutrients to the muscles, helping to heal the damaged tissue.

Heat stimulates the sensory receptors in the skin, which means that applying heat to the lower back will decrease transmissions of pain signals to the brain and partially relieve the discomfort.

Heat application facilitates stretching the soft tissues around the spine, including muscles, connective tissue, and adhesions. Consequently, with heat therapy, there will be a decrease in stiffness as well as injury, with an increase in flexibility and overall feeling of comfort. Flexibility is very important for a healthy back.

Vibration:
Used to help sedate the patients nervous system and aid in general overall relaxation. Singing bowl vibration on the qaudratus lumborum, plantar surfaces of the bi-lateral feet and the sacrum.

Homework for patient:

- Stretches for flexion of the spine twice daily, being in the morning and at bedtime.
- Hot water bag before going to sleep each night.
- Continue to use Tiger Balm oil and self massage as needed for pain relief.
- Increase water intake by one liter for hydration.
- Rest as much as possible.

OUTCOME:

After a total of ten massage treatments, the patient reports a 15% decrease in overall pain. Patient states that he consistently experiences a 50% - 75% reduction of pain symptoms during the first forty eight hours after a massage treatment before symptoms gradually return. Pain tends to increase to severe levels with activity upon the onset of its return after the initial forty eight hours. The patient appears more relaxed when receiving treatment and when in the treatment room. His range of motion has remained the same, but with less pain. He walks by himself without the aid of his wife when at the clinic. He can sit, stand up, remove his clothing, and upright himself from a prone position on the massage table without assistance. Tenderness and pain with palpation and touch has decreased. He presents with less physiological mannerisms associated with pain when in the treatment room. He smiled for the first time during treatment nine. Muscle spasms occurring during the treatments have decreased moderately. Hypertonicty of the erector spinae group has decreased minimally.

CONCLUSION

This patient has completed the total of 40 acupuncture and massage therapy treatments over the a 3 month period. During this time the patient has responded well to pain relief, however for brief periods of time after the treatments. Consistently, within 48 hours of the treatment the patient's pain returns to severe levels interfering with his overall daily functions and decreasing his quality of life. Based on the patients age, severity of the physical condition, emotional health and socio-economic status, it is my opinion that the short term focus of care should consist of encouragement for improved emotional health to promote a better quality of life. Long term care for pain with acupuncture and massage is appropriate to provide pain relief, provide hope that supports his emotional health and contribute to his overall quality of life. With continued treatment, I believe that the patient would benefit from care focused on education of his condition including the objective and subjective observations, providing pain relief and recommending resources that can support a better quality of life.

CASE STUDY: Juvenile Rheumatoid Arthritis

Kimberly Shotz WHCNP MN MAcOM

OVERVIEW

10 year old female presents with active phase of Juvenile Rheumatoid Arthritis (JRA) as demonstrated by multiple articular bony joint deformities, severely limited range of motion in all affected joints and an history of recurrent episodes of alternating fever, chills, and profuse sweating immediately preceding joint inflammation and swelling. Within the course of nine acupuncture and moxabustion treatments plus Chinese Herbal and vitamin supplementation, the patient noted cessation of recurring episodes of fever, chills, and sweating, decreased heat sensation in joints with active inflammation, and temporary decreases in pain while walking.

SUBJECTIVE (AS REPORTED BY PATIENT'S FATHER)

This patient had been evaluated by allopathic medical physicians at a Kathmandu hospital at least two years prior to her first visit to VVHC. Blood tests and x-rays (not available for review) indicated Rheumatoid Arthritis. She was prescribed multiple medications which she took for two weeks. Medications included injections she was advised to have weekly for 4 weeks. She had two injections, which "had no effect." All medications were too expensive to continue. The patient's father refused to involve allopathic medicine in the current management of the patient's disease but agreed to update blood tests (CBC, ESR).

The patient was not attending school, and in fact had only attended school for one month of her life. Her father stated it was "too difficult to take her to school in a wheelchair."

At the patient's first visit to VVHC she described her ankles as swollen and hot. At her fourth visit this had resolved but her knees were swollen and hot.

Depending on how questions were posed to her she would either admit to pain or deny pain, such as with walking, sleeping, or with palpation of her joints.

O – The onset of patient's disease began 6 years ago, with 3-4 days of tidal fever, cough and "cold."

F – Fevers come every week, every 3 weeks, or every 3-4 months and last about 4 days. Fevers are preceded by a sensation of inflamed tonsils and are followed by joint swelling, "like water inside," a sensation of heat in the affected joints which are warm to touch but with or without redness and pain.

Q – The locations of the joint swellings vary with each (active) episode and tends to affects joints bilaterally. Most joints feel cold and stiff inside, but after fevers some joints will feet hot.

P – Cold weather and prolonged immobility such as bus rides seem to worsen her overall joint stiffness. Swelling increased with mobile activities such as walking. Wearing warm stockings helped reduce stiffness. Otherwise she did not know what

relieved the pain and swelling or improved her ROM. The steroid injections (2, per records) she received "had no effect."

S – Patient reported significant difficulty with ambulation due to both restricted ROM and occasionally severe pain.

T – The duration of active, inflammatory phases is unclear but seems variable.

OBJECTIVE

Upon initial presentation (11/1/11) patient's affect was flat, timid, with infrequent eye contact. She did not speak and looked to her father for answers to physician questions. She would nod occasionally. She ambulated slowly with rigid, erect posture, arms extended and inanimate at side, with somewhat of a shuffle and notably reduced knee and foot flexion.

Her tongue was purple red with a crimson tip and thin white coat at back. She had erythematous sublingual sores (ulcers). Her pulses were thin and rapid.

She displayed no observable expressions of pain during palpation of affected joints, but would quietly gasp and retract (i.e., guard) her limb with attempts to move a joint beyond its (passive) range of motion (ROM).

Elbows: lateral epicondyles were enlarged, rounded (2X normal), bony-hard, cool, without erythema or edema, and non-tender. Limited extension to ~145 degrees.

Wrists: mildly enlarged (<2X), bony landmarks obscured to palpation, non-tender. No active or passive extension. Active/passive flexion ~ 20 degrees. Inversion/eversion <10 degrees with mild crepitus of right wrist.

Hands/Fingers: mild bony enlargement of proximal and medial inter-phalangeal joints bilaterally, cool. Patient unable to flex fingers into fist.

Ankles: swollen, red, hot at initial visit, resolved by 5th visit.

Knees: soft swelling over medial and lateral femoral and tibial condyles (3X normal), warm to palption at 5th visit without erythema.

Active and Passive Range of Motion.

Neck: extension ~0 degrees, flexion ~10-20 degrees, lateral rotation ~10-20 degrees, lateral flexion ~30 degrees to pain.

Wrists: extension ~0 degrees, flexion ~45 degrees, inversion/eversion ~10 degrees

Fingers: DIP/MIP flexion <45 degrees, first and second MCP flexion ~20 degrees at first visit, ~30 degrees at ninth visit.

Knees: extension ~75-80 degrees at initial presentation (It is unclear what measurement made by this clinician), leg extension ~165 at 4th visit, full 180 degrees at 9th visit.

Ankles: dorsiflexion ~0 degrees at first visit, ~5 degrees at 9th visit, non-painful crepitus near talus with inversion 5-10 degrees of right ankle, eversion ~5 degrees, plantar flexion <45 degrees.

LABORATORY (2 YEARS AGO)

Hemoglobin (HGB): 8 (very low)

Neutrophils: elevated

White Blood Cell Count (WBC): 14 (elevated)

Erythrocyte sedimentation rate (ESR):30-50 (elevated)

LABORATORY (11/24/11)

HGB: 9.5 (low, improved)

Neutrophils: 81 (elevated)

WBC: 11 (mild elevated, improved)

ESR: 90 (significantly elevated, active phase)

Oral Temperatures (in sequence of visits): 94.4, 97.1, 95.5 (variable, low)

Weight: 22kg

ASSESSMENT

Allopathic: Polyarticular Arthritis, Systemic Juvenile Arthritis with Osteopenia (Still's Disease).

TCM: Shao-Yang or Blood Level Heat/Heat Bi syndrome. Bony Bi/Wind-Cold-Damp with Latent Damp-Heat Toxin (Maciocia).

PLAN

Treatment Principles: Warm and Open the Channels and Collaterals, Move Qi and Blood, Dispel Cold, Damp, Wind, Nourish Blood, Tonify Qi, Blood and 5 Zang organs (constitution). Induce prolonged remission phase of JRA, prevent recurrence of active phase of disease by strengthening constitution and promoting optimal immune function. Treatments consisted of combinations of in/out or sustained needle acupuncture, indirect moxabustion, and refilling herbal prescriptions and dietary supplements.

Dietary Advice: Nutritional suggestions were given to patient and patient's father which included avoidance of nightshade vegetable family, animal fats, greasy/fried foods, sugar, and spicy foods, increase oral hydration of warm fluids and incorporate cinnamon and turmeric into meals.

Dietary Supplements: Calcium 500mg with Vitamin D3 250 IU per tablet was provided and advised to take one tablet twice daily), B-complex one tab once daily, Ibuprofen 20-40mg/kg/day in 3-4 divided doses (not to exceed 880 mg in any 24-hour period) for no more than 5-7 days without clinic evaluation (liver and renal function labs need to be updated).

Herbs: Feng Shi Ding 2-3 pills BID was given at initial consultation. At her 6th visit the formula was changed to Xuan Bi Tang Wan 3 tablets TID.

A stronger Blood/Qi/KD nourishing herb was being considered for her 9th visit, now that the joint swelling and inflammation is waning. Liu Wei Di Huang Wan was chosen and dispensed to patient at ninth visit, 8 TID.

Acupuncture: Patient was initially advised to come for treatments 3 times per week.

Because it took 6 hours of public transportation to get to and from the clinic (>18 hours of missed work per week for patient's father), this schedule was not feasible. Patient received treatments every 3-7 days for 8 treatments.

The following acu-points were used: Sp9, LI11, LI10 TB5, GB34, BL11, LR3, LI4, TB3, LI 5, SI7, In/Out needling: DU14, ST34, SP9, ST36, BAXIE, ST36, KD3; in/out needling

The number of points used per visit were limited to 8-9 points each treatment.

Auricular Acupressure seeds (one visit): Shenmen, Kidney, Liver, Knee applied bilaterally to leave in place for 3-4 days.

Indirect Moxabustion: ST36, elbows, wrists, dorsal hand/MCPs, ankles.

OUTCOME

Patient noted reduction in both pain and difficulty with ambulation immediately following treatments. At her 8th visit, her father reported cessation of alternating fever, chills and profuse sweating episodes as well as an improvement in her energy. The duration of pain reduction benefit was limited to 2-3 days post-treatment. Patient's Shen appeared brighter and showed increased interest and attentiveness during her treatments. At her ninth visit she was able to actively extend her legs to 180 degrees.

CONCLUSION/DISCUSSION

This young patient has a severely disabling, progressive disease and lacks resources required for allopathic management regimens known to induce and prolong remission phase and reduce joint destruction associated with Juvenile Rheumatoid Arthritis (JRA). Each day that severe, active-phase joint inflammation continues indicates potentially permanent joint damage, reduced mobility, and reduced quality of life for patients with JRA.

The patient's father accompanied her to most clinic appointments and provided a limited and inconsistent history of her disease condition, possibly indicating cultural-conceptual and or practitioner-patient communication challenges. This definitely represented a barrier to optimal assessment of her condition. It was clear from his account of her history that he did not understand the disease process of JRA, its management, or the implications of ineffective management.

The long distance between home and clinic resulted in excessive time away from work for her father which severely limited treatment frequency and potential efficacy. This patient was unable to maintain the optimal 3-4 times weekly treatment schedule yet still noted both subjective and objective improvements during the course of her 9 visits over 6 weeks: increased joint range of motion, reduced joint inflammation, cessation of systemic inflammatory symptoms, improved constitutional energy and Spirit.

It is expected this patient would benefit from incorporating massage and Physical Therapy into her treatment regimen. Some of her reduced joint mobility seems to be from muscular contraction due to the combination of prolonged guarding of joints and limbs and reduced mobility. A more aggressive treatment plan using a greater number of acupoints with longer needle retention, plum blossom, Jing-Well acupoint bleeding, scalp acupuncture, and or electro-acupuncture may enhance treatment efficacy and may be employed as patient comfort permits.

CASE STUDY: Ganglion Cyst

Seven Crow MAcOM LAc

OVERVIEW

11-year-old female presents with large lump over left radial artery at radial styloid process, causing some pain to the local area. She did have minor surgery to remove a gelatinous substance from within the cyst; however she was advised by the doctor that it will keep growing back. After 9 acupuncture treatments, including internal and external herbal medicines, the cysts now presents with 70% reduction in size.

SUBJECTIVE

Patient presents with large, lump over left radial side of wrist. She reports (with the help of her mother) that it started to grow a year and a half ago, and refers to it as a "bone growth". She had seen doctor for surgery to remove the lump and was advised that it was not possible due to the innervation of the cyst.

There is no change to the pain or growth with temperature; however some stimulation via massage has been helpful to reduce pain and swelling. Patient states she visited a doctor to have it surgically removed, was prepped for the procedure, however the doctor opted not to do a complete removal due to innervation of the cyst by the radial artery. The doctor did remove a gelatinous substance from the top layer of the cyst, but the mass grew back. She states the size of the cyst at first visit to this clinic on January 17, 2012 has been the same for one year.

At age two she contracted pneumonia and since then catches colds easily, 3-4 times a year each lasting up to two weeks. These present with a runny nose with clear mucus, cough with some phlegm, body aches, headaches, loss of appetite, and slightly looser stools with frequent urination. Since beginning treatment she has had no common colds.

OBJECTIVE

Patient has a thin body, but appears energetic, smiling, talkative and open to conversation with full eye contact. She knows some English and answers the questions directly when she is able to. Palpating the skin it is warm, but not hot, tougher than the surrounding skin, and exhibits a hard central mass that is moveable. The cyst sits half an inch off the skin and about half an inch wide, on the crease of the left wrist, with localized sharp pain when palpated deeply, which she expresses through guarded behavior. There is also some additional swelling, and redness at the height of the mass, but no lack of range of movement in the joint.

TONGUE: Pink body with a red tip, white tongue coat, thicker at root

PULSE: Thin, slippery over all with deficiency in the right cun position, and deep in both chi positions

Patient records include:

X-ray of left wrist, July 20th, 2010 (1 ½ years prior to current treatments) - No abnormal bone growth is shown

Ultrasound of left wrist, July 4th, 2010 (1 ½ years prior to current treatment) - Reveals cysts growing on either side of radial artery, with possible nerve innervation.

Approximately 1.7 x 0.9 cm of cystic legion is noted in the volar-radial aspect of the wrist, with a smaller cyst measuring 0.6 x 0.3 cm rooted deeper. The left radial artery is intimately related to area of the posterior wall of the superficial cyst. It shows normal color and doppler flow in the radial artery.

Hospital visit, February 20, 2011 – check up (1 year prior to current treatment)

Swelling in left wrist for past 10 months, gradually increasing in size. Positive for pain, but no trauma indicated. At time of check up was 4 x 3 cm^2 in the wrist at the ventral surface and lateral margin.

ASSESSMENT

DIAGNOSIS: Two Ganglion Cysts growing around the left radial artery, with some innervation by the surrounding nerves of the local area.

TCM DIAGNOSIS: Mass due to Phlegm Accumulation in the Channels and Collaterals of the Lung with some Qi and Blood stagnation present by the fluid filled node over Tai Yuan (LU9) and slight compression of the artery. Condition is due to constitutional Wei Qi and Lung Qi Vacuity, with Spleen Qi Vacuity, allowing for retained pathogens to harbor within.

PROGNOSIS: Due to placement of the cyst it may not be possible to completely resolve the node. It is likely that herbal treatments, acupuncture, and self-massage it will reduce the size of the cyst, but it may not resolve completely.

PLAN

Patient to be treated at the satellite clinic 2 times a weeks for 10 weeks and reassess progress after a second ultrasound. The focus will be on constitutional points, surrounding the area with needles, herbal treatments internally and externally, along with self-massage and qi gong. Aim is to reduce pain and size of the cyst to avoid surgery.

TYPICAL TREATMENT

Acupuncture: Surround the Dragon technique with 5-7 needles includes LU7 (Lie Que), LU9 (Tau Yuan), and LI5 (Yang Xi) all threaded towards the center of the cyst; ST36 (Zu San Li), SP6 (San Yin Jiao), and SP9 (Yin Ling Quan), and KD3 (Tai Xi) to boost constitutional deficiencies.

Moxa: Indirect pole moxa for short duration has been helpful in reducing pain and swelling to the area. In the future I would like to try small rice grain moxa directly to the swelling.

Massage: Light Yin Tuina massage mixed with qi gong to the area to increase qi and blood flow.

Herbal Medicine: San Zhong Kui Jian Tang (Hai Zao, Kun Bu, Jie Geng, San Leng, E Zhu, Bai Shao, Gang Gui Wei, Hunag Qin, Huang Lian, Long Dan, Lian Qiao, Zhi Mu, Huang Bo, Tian Huan Fen, Chai Hu, Shang Ma, Ge Gen, Gan Cao) drains pus, reduces swelling, abcesses and hard nodes will be used 1 capsule 3 TID internally, and 1 capsule mixed with oil to make paste to apply externally over area morning and night. Once the cyst has shrunk by 80% Yu Ping Feng San (Huang Qi, Bai Zhu, Fang Feng) will replace San Zhong Kui Jian Tang internally for the constitutional deficiencies.

Lancet: At the 3rd treatment, the cyst was punctured with a lancet. A small amount of gelatinous fluid and blood was extracted.

OUTCOME

At this time the patient has had 9 treatments and the cyst has reduced in height and redness by 70% from initial inspection. The swelling has spread out in width but reduced in height size, has no hard mass underneath, and no redness to area. Palpation reveals little to no pain, and no guarding to area.

CONCLUSION

Continue care for 4-6 more treatments then follow up with ultrasound for further assessment. Prognosis is good revealing no current need for surgery, however it is unlikely the node will stay dormant without continued care, and attention to underlying constitutional deficiencies.

CASE STUDY: Rheumatoid Arthritis

Elissa Chapman BAppSc (TCM)

OVERVIEW

35 year old female presents with multiple bilateral joint pain beginning 18 months previously and had received a diagnosis of rheumatoid arthritis at the Arthritis and Rheumatic Disease centre in Nepal. After ten treatments of acupuncture in conjunction with herbal medicine she experienced a significant reduction in joint pain and inflammation.

SUBJECTIVE

Patient is a thirty five year old woman presented with bilateral multiple joint pain which began approximately eighteen months ago. She describes bilateral knee pain and shoulder pain, pain in her wrists, hands, and ankles. Her symptoms originally began with pain in the right shoulder, which after one to two months was followed by pain in her left shoulder. Within two to three months the pain spread to her wrists, then hands. The most recent development was the pain in her knees and ankles which began approximately six months prior to her first consultation at this clinic. She reports that the severity of the pain in each affected joint is intermittent and unpredictable, and has a tendency to move around. She described the pain as characterized by aching and stiffness which was worse at night and that she would take non steroidal anti-inflammatory medication (aceclofonac 200mg) each night in order to sleep. This allowed her to sleep an average of six to seven hours straight per night, whereas without it she would only manage to achieve five to six hours per night of broken sleep.

Prior to the onset of joint pain, the patient reports she had intermittent cold and flu symptoms over a period of twelve months which included nasal congestion, sore throat and generalized body aches. She did not consult any health practitioners regarding these symptoms.

She was prescribed medication approximately 12 months ago which she had been taking up until two months prior to this consultation. She reports that the medication has provided no relief therefore she has ceased taking it. According to the patient her symptoms have not noticeably worsened since ceasing the medication. She has been having Ayurveda oil massage and steam baths every other day for the past 12 days which she says has not provided any relief.

At the time of consultation, the patient reports that the most severe pain is in her right hand, in particular the fifth metacarpal joint, and in her left shoulder.

Bowel movements are one to two times daily and fully formed, and urination is three to four times daily and is pale to medium yellow in colour. Menstruation is regular with mild pain with medium to heavy bleeding for two days and light flow for three days. She says her sleep is only disturbed at night by pain for which she takes anti-inflammatory medication daily to manage.

The patient reports that stiffness and pain is worse in the morning and for the first one to two hours upon waking, is less in the afternoon and then worse again late at night.

OBJECTIVE

Patient's overall health appears to be above average for age and environment. Her demeanour is generally relaxed and cheerful but with a tendency to carry herself with a slight unease and occasionally winces due to pain. There is distinct rebound tenderness when palpating the joints of the right hand compared to the left, especially the metacarpal joints. There is also strong palpable tenderness when applying mild to medium pressure to the medial and superior borders of the scapula on both shoulders and when applying medium pressure to the posterior and anterior borders of the glenorohumeral joint of the left shoulder. There is distinct tenderness when applying moderate pressure to the lower

borders of the patella and medial epicondyle of the tibia on both knees. Ankles do not produce distinct tenderness when palpated.

The knees, ankles and fingers can be passively and actively moved through all range of movement without restriction with the exception of the left shoulder which triggers pain on passive and active lateral abduction above ninety degrees. There is no apparent swelling of the joints in the knees, shoulders and wrists and none appear misshapen. There is mild palpable swelling in the fifth metacarpal joint of the right hand. The joints of the hands and knees feel slightly warmer to touch than others.

Tongue is light red, with normal body and thick yellow root, and red tip. Pulse is rapid, and slightly slippery.

ASSESSMENT

DIAGNOSIS: Initial blood analysis taken at the Arthritis & Rheumatic Diseases Treatment Centre in Lalitpur twelve months ago shows elevated serum rheumatoid factor and raised white blood cell count. This result combined with symptoms of multiple bilateral joint tenderness and mild joint swelling (in greater than three joints including in the hands and wrists), and morning stiffness for greater than one hour, resulted in the patient meeting the criteria for a diagnosis of rheumatoid arthritis which was given at the above clinic where her initial assessment was carried out.

TCM DX: Wind damp bi syndrome due to Damp heat and wind heat toxin due to latent heat invading the joints causing Qi and blood stagnation and damp retention. Over time if left unabated, this typically would eventually lead to swelling and deformity due to phlegm stagnation and blood stasis.

PROGNOSIS: Besides mildly visible signs of synovial thickening in several small joints, the patient is otherwise free from any severe pathological tissue changes. Therefore successful management of systemic joint inflammation may help to preserve the mobility and dexterity of the joints. Depending on the outcome of acupuncture and herbal treatment this may include conventional drug therapy.

PLAN

Treatment principles: Dispel wind, resolve damp and clear toxic heat. Open channels and collaterals. Invigorate Qi and Blood.

Treat with acupuncture for two to three times weekly for ten treatments then reassess. Treatment approach is to use Shao yang channels to dispel wind and damp and Yang Ming channels to purge heat toxin and move Qi and Blood. Points are also used to nourish blood and qi to anchor wind and prevent pathogenic factors attacking the channels. A typical treatment consists of TB5 and GB41 needled contra laterally with Shao yang points such as TB2, GB39, GB35, GB36 and GB34 to dispel wind damp from the channels. LI11 and ST3 are used to expel heat. SP6 is used along with LI4 and LIV3 to anchor wind and circulate blood and qi throughout the body.

At the third consultation Shu Jin Huo Xue Tang was given as a powder with a dosage of 4g twice a day to dispel wind and damp, invigorate blood and remove blood stasis. The prescription is to be followed for ten days and then reassessed.

OUTCOME

At the third consultation she reported less pain in both knees and that she found it easier to walk for longer periods. She said she now had no pain in her ankles and only mild pain at the head of the first metacarpal joints on both feet when pressed with medium to heavy pressure. She reported mild stinging pain in her right shoulder and no pain in her right hand. Overall she said that she felt most of the pain now in her left shoulder in which there was still distinct palpable tenderness and pain on passive abduction above ninety degrees. There was mild to moderate pain in the metacarpal joints of the left hand when pressed.

After ten acupuncture treatments over five weeks, the patient reported had not taken painkillers for two weeks (prior to the tenth consultation) and was sleeping 6-7 hours per night without them. She reported only mild pain in her left shoulder (the initial site of most pain) with some mild to moderate tenderness when palpated around the medial and posterior borders of the scapula. She could now laterally abduct her left shoulder to 120 degrees and passive abduction was to 160 degrees with no pain. Palpation of the medial epicondyle of the tibia of both legs produced mild to moderate pain. She also reported that she could take a shower without pain whereas before this used to cause pain in her shoulders and hands. The palpable pain in the first and second metacarpal joints of both feet had increased significantly since the fourth treatment with distinct visible and palpable swelling whereas initially she had reported mild pain in these joints and no noticeable swelling.

From treatment to treatment the patient reported fluctuating levels of pain and inflammation in her left elbow and both hands. In particular the pain in her left hand would move from joint to joint sometimes over a period of 24-48 hours.

After the fourth acupuncture treatment the patient had been recommended by a friend to consult a Tibetan medicine doctor who specializes in the treatment of arthritis. It was agreed that she would cease the Chinese herbal medicine and proceed with the Tibetan herbal medicine prescribed to her alongside with acupuncture, as Tibetan herbal medicine would be more consistently available to the patient over a longer period.

CONCLUSION

This patient experienced a significant reduction in pain and inflammation within ten treatments, therefore is advised to continue treatment one to two times weekly for another four to six weeks with the hope of continuing to improve her symptoms. Whether or not acupuncture treatment and herbal medicine alone without conventional drug treatment will result in a full remission from symptoms is unknown. However it appears that acupuncture may be a useful therapy for managing pain, inflammation and preserving joint mobility and delaying long term cite and enzymatic damage which usually results from persistent and chronic inflammation and swelling of the synovium in the joints. It is possible also that her progress over the last six treatments was aided by the prescription of Tibetan herbal medicine. However as she experienced significant relief after the initial four acupuncture treatments, it is presumed that acupuncture has and may continue to play a significant role in managing her symptoms.

CASE STUDY: Parkinson's Disease

Jessica Maynard MAcOM LAc

OVERVIEW

72-year-old female presents with left hand tremors that extend up the arm and into her neck and jaw. Tremors have been present for 2 to 3 years. Hospital and doctor records report Parkinson's disease. Over the course of treatments, the patient experienced periodic relief, with regression and return of tremors. Overall her posture, mood, outlook, and sense of independence improved, leading to a significant improvement in personal aspect over time.

SUBJECTIVE

Patient presents with tremors in her left hand and arm, extending up through her neck and into her face and jaw. Hospital charting from 6 months prior shows a diagnosis of Parkinson's disease. The patient reports having taken tri-hexyphenidyl hydrochloride, propanolol hydrochloride, levadopa and carbidopa tabs previously, but states that she is not on them now, and is seeking a cure from Chinese medicine and acupuncture. She also reports having been diagnosed as a diabetic, and declares that she has blood sugar levels tested regularly, the most recent reading being 145 mg/dL

O-tremor symptoms have been present for 2-3 years.

P-patient reports that warm weather alleviates her symptoms and cold weather exacerbates.

Q-In addition to tremors, she experiences numbness in her tongue and has trouble speaking clearly, a symptom that fluctuates on a weekly basis. She also reports dizziness and blurry vision when walking, as well as mouth dryness.

R-Tremors began in her left hand, moved up into her arm, and eventually spread to her neck and jaw. During the course of treatment, the patient reported experiencing tremors in her right hand and arm as well.

T-The patient reports constant tremor while in a waking state throughout the day and evening.

OBJECTIVE

The patient presents with stooped posture while walking, arms held closely in front of her. While she sits in the treatment chair, her hand and fingers tremor with an inch of movement back and forth. Her lower jaw shakes when she is not speaking. The tremors disappear with movement, and her movements are bradykinetic. She exhibits signs of depression from day to day—diminished aspect, low voice, frequent sighing, and replies to questions that exhibit frustration with her condition.

From treatment to treatment her tongue changes from pale and dusky to more red, and sometimes purple-tinged. Her pulse is thin and easy to push through, but at times will have a wiry/tight quality, or will show a flooding or slippery quality superficially.

ASSESSMENT

DIAGNOSIS: Parkinson's Disease

In order to differentiate the patient's diagnosis of Parkinson's disease from Benign essential tremor, it is important to clarify the differences:

Benign essential tremor—typically hereditary, benign essential tremor is characterized by tremor present with movement, and is not present at rest. It is normally bilateral and increases with age (Merck, Mayo clinic). Essential tremors are not associated with stooped posture or shuffling gait, although they may cause other neurological symptoms. Benign essential tremors typically start in the hands, and can eventually affect the voice and head.

Parkinson's disease—Characterized by voluntary and involuntary movement affected by tremors, the symptoms typically begin

unilaterally, but can progress to affect the body bilaterally. Symptoms typically are mild at first, and the severity of the disease is quite variable from person to person. Cardinal symptoms are: tremors, rigidity, bradykinesia, postural instability, Parkinsonian gait (characterized by short, shuffling steps and diminished arm swinging). Secondary symptoms include: anxiety, confusion, memory loss, dementia, constipation, depression, difficult swallowing, slowed, quieter speech, monotone voice (http://www.medicinenet.com/parkinsons_disease/page3.htm).

To note, occurrences of misdiagnosis can happen. There are no medical tests for this disease and a definitive diagnosis of Parkinson's is not possible while a patient is still alive. The most accurate diagnosis would be made by a neurologist who specializes in movement disorders (http://www.medicinenet.com/parkinsons_disease/page4.htm), therefore the true diagnosis in this case study is speculative and is impossible to make.

The patient exhibited stooped posture, impaired gait (she stated requiring help walking to clinic on certain days), and held her hands stiffly in front of her while walking in a shuffling manner. She also experienced tremors while seated with hands in her lap (at rest) and so it appears likely that her condition is, in fact, Parkinson's disease. During the course of treatments she displayed intermittent confusion and memory loss, both in repetitive questions and need for counselling on her condition, and in clinic interpreters stating that she was not making sense while speaking. These are also indications of possible mental degeneration accompanying the Parkinsonian condition.

TCM ASSESSMENT: The patient shows a mixed excess/deficiency pattern--underlying deficiencies leading to uprising of excess: Kidney Yin deficiency and Liver blood deficiency, with an uprising of Wind in the channels, Liver Qi stagnation, and uprising of Liver Yang.

KI Yin deficiency is apparent with thin pulse, red tongue tip (empty heat), and low back pain, and can partially be assumed with age (72) of the patient. Liver blood deficiency is apparent in the thin pulse that is easy to push through, the dizziness and blurry vision with activity, and dryness of the tongue. Wind in the channels (due to blood deficiency) and uprising of Yang is exhibited by the tremors, and could be detected in the pulse. Liver Qi stagnation is exhibited by frequent sighing, and mood swings from day to day. Blood stagnation and empty heat alternate in her pattern, and tremors are observed by the practitioner as more pronounced when stagnation is present, indicated by the dusky and/or purple tongue, alternating with a redder tongue tip concurrent with less pronounced tremor of the hands and mouth.

INITIAL PLAN

Initially the patient was recommended treatment 3 times per week for 3 weeks. However, the patient proceeded to arrive for treatment daily for a total of six weeks. Focus over all was to diminish wind in the body while tonifying underlying deficiencies. Scalp tremor line was used in every treatment initially, later with electro-acupuncture, when patient would tolerate (she did not like scalp needling). Body points frequently consisted of ST-36, LR-8, SP-6 to nourish blood, and typically included KI-3. Additional points included LI-4 and LI-11 to diminish stagnation and clear heat, as well as locally to treat tremors in the arms. GB-20 was used to expel wind. In almost every initial treatment the patient received tiger warmer therapy applied to the left arm and often both arms, and the sides of the face and neck. Latter treatments (when the weather warmed up) included electroacupuncture typically connecting points LI-11 and Hegu (LI-4), or LI-5 if Hegu (LI-4) was difficult to maintain due to hand tremors.

She was prescribed Gastrodia 9 (Seven Forests formula) to diminish tremors and Tao Hong Si Wu Tang to move and nourish blood. Formulas were changed when supplies ran out to Tian Ma Gou Teng Yin (for wind) and Liu Wei Di Huang Wan (for Kidney Yin and blood tonification).

Patient was encouraged to engage in light movement of the body, and to receive massage from family members, and she was referred to the physiotherapist. Patient exhibited significant resistance to exercise, and went to see the physiotherapist only once.

Further treatments have included ST-3, ST-4, ST-41, and LR-3. One theory about Parkinson's in Chinese medicine is that it is a condition of reversal of Stomach channel Qi, which enters the GB channel through ST-8(Janice Walton-Hadlock). An intention of descending Stomach channel energy has come to be a focus in treatment.

OUTCOME

Given the advanced state of the patient's condition, it is clear that acupuncture may not decrease symptoms of tremor over the long-term, but may help on a short-term, symptomatic basis. Alternatively, the patient would experience relief after treatment at night, lessening of numbness in her tongue, and increased ability to speak clearly. However, her condition would subsequently relapse after each period of relief, so it cannot be known whether the acupuncture and herbs were helping, or if it was a natural regression of symptoms occurring with typical presentation of the disease. In addition, significant time was committed to answering the patient's (sometimes repetitive) questioning of her condition, educating her about the severity and irreversibility of the disease, and encouraging her to think positively and actively engage in her own process of healing.

What was striking over time was the improvement in the patient's mood and aspect. She began to walk to clinic on her own on a regular basis and was visibly happier over the course of treatments. Her posture improved also, and she became more engaging, which despite her shifting moods remained at a level higher than when she originally came into the clinic (although this can be due to trust and relationship that grows over time between patient and practitioner). As seen within the first five treatments, her mood changed significantly, and her speech clarified. She was more likely to engage in conversation, both with her healthcare provider, as well as with family, and began to open up.

In subsequent treatments she exhibited moods that showed a

decline in outlook, including frustration over not experiencing the amount of relief desired, and in the practitioner's view, over a lack of control over her body and her life. During the 4th week of treatment the patient reported a remarkable improvement and one day stated that she experienced the feeling of being "completely cured" following her treatment the day before. This type of relief, although short-lived, also added to the hope and positive outlook that overrode her frustration throughout the course of treatments. After seven weeks in treatment, she went home to her village in a warmer climate, returned to the clinic during the ninth week, and reported a complete disappearance of symptoms while she was home. This brings to question both the power and possibility of acupuncture, as well as what the role of stress-reduction can play in Parkinson's disease and other neurological disorders. Acupuncture and Chinese medicine has been shown to reduce stress, and if relief of symptoms from disease is a secondary outcome, then the importance of this therapy is of paramount significance.

In the Vajra Varahi clinic, this patient experienced periodic relief of symptoms, with relapse and gradual decline. Parkinson's is a degenerative disorder, and slowing the progression became the main the focus in direct treatment of the disease. In addition, the role of the acupuncture practitioner for this case has been one of guiding healthcare and outlook, counselling her towards a full understanding of her condition so that eventual acceptance is possible, and helping to facilitate a state of contentment and happiness that can be applied to her life as a whole.

CASE STUDY: Lumbar Stenosis due to Osteoartritis

Sarah Martin MAcOM LAc

OVERVIEW

36-year-old female with Lumbar Spinal Stenosis presents with severe low back pain with referred pain down the posterior left leg and anterior right thigh. The patient lives several hours from the clinic, but was able to stay in Kathmandu temporarily in order to get daily treatment for 2 weeks. After 12 treatments the patient reports 80% of her pain is relieved, which was sustained for 4 days after which the pain started to slowly return.

SUBJECTIVE

The patient presents with severe low back pain with referred pain down the posterior left leg and anterior right thigh. The patient complains that the pain interferes with her ability to walk without limping. The issue had a gradual onset beginning 3 years ago, continually getting worse, and within the last year it had increased to severe pain. Nothing had helped the pain thus far and the patient reports that it is made worse by bending, straightening, twisting, as well as standing, walking, and sitting too long. The patient described her pain as severe, with a sharp burning quality running from the left PSIS area down the posterior portion of the thigh to the middle of the posterior calf and down both the anterior-medial and anterior-lateral portion of the thigh just above the patella. The patient rates her pain as intolerable and constant. No muscle weakness or stiffness was reported.

The patient was evaluated at a hospital with an MRI, which showed compressed nerves due to the narrowing of disc space between Lumbar Vertebras 4 and 5. She was informed that the disc space is narrowing due to arthritis of the spine and surgery is necessary to scrape the bone away from her nerve. Due to the cost of surgery, the patient wanted to see if acupuncture could help her enough to avoid surgery and perhaps slow the long-term progression of the arthritis.

The patient reports no use of any prescription medications or OTC pain relievers.

OBJECTIVE

Patient appears to be in good health besides dealing with severe pain. Because of pain the patient appears to be severely distracted, however can answer questions competently. Upon the first visit, the patient arrived walking with a limp in her left leg and was not able to sit up without assistance after laying down for the treatment due to the severity of her pain rather than weakness. All transitions between positions - sitting, laying, standing were strained and painful.

The Valsava test was found positive with severe pain that referred down the posterior left leg and anterior right thigh.

Palpation showed no significant findings on her lumbar spine, but showed her pain starting at L3 to under L5 and surrounding the Posterior Superior Iliac Spine (PSIS) and down in the sacral foramen, especially S2. Her right PSIS was more proximal than the left and tension was found in the right Piriformis. Palpation down the left posterior thigh showed pain directly down the Bladder meridian to BL 57 and palpation at the right anterior thigh showed the pain running along both Spleen and Stomach meridians to Sp10 and ST 34 region.

Patient shows no signs of muscular atrophy and difficulty in walking was due to pain rather than weakness.

Her blood pressure and heart rate were within normal limits at 113/84 and pulse 72 b/m.

ASSESSMENT

DX: Lumbar Spinal Stenosis with narrowed disc space between L4 and L5. Possible Subluxation of the Sacral Iliac Joint. Due to her age it is hypothesized that she has the congenital form of Lumbar Spinal Stenosis.

TCM DX: Bone Bi Syndrome with Qi and Blood stagnation in the Bladder, Governing Vessel, Stomach, and Spleen Meridians with underlying Kidney essence deficiency and Liver blood deficiency.

Medical Recommendations from hospital: It is likely that the doctor at the hospital is recommending a laminectomy, foraminotomy, or a nerve block.

PROGNOSIS: Due to the severity of the condition and the nature of Lumbar Spinal Stenosis, the prognosis is fair with continual regular treatments. The patient is young and in the long run, the prognosis treating with just acupuncture and herbs is most likely poor. These modalities may delay surgery but chances are, will not eliminate the need for it.

INITIAL PLAN

Treat with acupuncture daily for 7 treatments and then reassess. The treatments focused on breaking up qi and blood stagnation in the Governing Vessel, Bladder, Stomach and Spleen Meridians with electro-acupuncture as the main modality. Internal herbal treatment started with Huo Luo Xiao Ling Wan and then changed to Xiao Huo Luo Dan Wan as supplies ran out. These formulas were used to break up blood stasis, open the collaterals and move qi and blood to stop pain. After 7 treatments the patient was satisfied enough with the results to stay in Kathmandu longer to continue the treatments for another week. The treatment plan was then extended to 13 treatments following the reassessment.

Typical treatment: Left: SI 3, Ashi BL 57, Right: BL 62, LI 4,GB21 Bilateral: HTJJ L3 – L5, Shi Qi Zhui Xia, Ashi PSIS area, BL 32 – 34, GB30, Huan Zhong , BL 40, BL 60. Electro from Left HTJJ L5 to Left BL 60, Right Ashi PSIS to Right BL 60, and Bilateral BL 32 to

BL 40, 5/100 Htz milliamp with mixed frequency. Pain patches and ear sees were utilized to increase the effects of treatment outside the treatment room. Salon Spa Pain patches with camphor and menthol to provide a cooling analgesic effect and ear seeds on lumbar spine, and sciatic points were also given at the end of each treatment.

Alternate treatments: Right ST34 and ST41 for right thigh pain, and superficial transverse needling with manual stimulation of ashi points surrounding the PSIS for sacral realignment.

OUTCOME

Due to the circumstance of the patient living several hours from the clinic, daily treatments were given for the first 12 visits. On the 7th visit the patient reported a reduction in pain to a moderate level that was only provoked by sitting or standing for long periods of time. Bending, straightening, twisting, and walking no longer caused her pain. Further, she no longer needed assistance in getting up from the prone position and her limp was 30% reduced and continued to reduce with each treatment thereafter. On the 12th treatment the patient reported 80% of her pain was relieved and was now tolerable. Further, the patient now walked without a limp. The 13th treatment was spread out to five days later to observe if the pain relief could be sustained. On the 13th treatment, the Valsava test indicated considerable treatment results with moderate pain only at BL32 rather than severe sharp, burning pain radiation down the posterior left leg and anterior right thigh seen on the first visit. It was reported at this visit that 80% pain relief was sustained 4 days after the 12th treatment, at which time the pain began to return slightly, however she felt enough pain relief to return home to spend the Dosain holiday with her family and start work for the harvest season. The outcome was better than I, the practitioner, initially expected; perhaps this means that the M.D.'s assessment for surgery was premature and the original prognosis could have been understated and with continued acupuncture and herbal treatment the inflammation and pain could be reduced long term and the degenerative nature of the disease might be slowed.

CONCLUSION

Due to the inflammatory process and degenerative nature of Lumbar Spinal Stenosis, continual regular acupuncture and herbal treatment might be the best option for long-term pain relief and slowing the progression of her arthritis. The patient was informed that regular acupuncture and massage treatment might be the only option to surgery; Due to the logistics of living so far from the clinic, if her pain returned or worsened, surgery might be her only option for sustainable pain relief.

CASE STUDY: Low Back Pain with Urinary Difficulties

Kelli Jo Scott MAcOM LAc

OVERVIEW

Thirty-two year old woman presents with constant low back pain and burning urination. She has been diagnosed with severe hydronephrosis in the right kidney and was recommended to have a nephrectomy due to pain. After 10 treatments with various Chinese Medicine modalities, her pain was reduced by 50% and the frequency of her pain was only every 2-3 days. The burning urination was gone.

SUBJECTIVE

A 32-year old woman presented to the clinic with a chief complaint of low back pain on the right side in the kidney area, which radiates up the thoracic region of the spinae erector muscles and over to the left kidney area and left thoracic region spinae erector muscles. The pain was described as constant and achy, with sharpness that comes and goes. The onset of this pain was about one year ago and nothing seems to change it. Her second complaint was continuous burning urination. She reports no urinary hesitancy, urgency, or frequency. The urine was clear to light yellow and output was equal to input. The patient also initially reported some dizziness when standing up and occasional night sweats (2-3 times a week). The patient reported at the initial visit that all of these symptoms had been present for a little over one year. Previous to the onset of these symptoms, the patient reported no prior history of trauma to the area or kidney problems, nor had any significant family history of disease.

OBJECTIVE

Patient appeared to be in good physical, mental and emotional health for her age and environment. She was soft spoken, but seemed educated, engaged and alert. She is the mother of two children, ages 2 and 6, and comes from a higher caste, which increases her access to healthcare. Her pulse was slightly rapid and slippery, her tongue red and quivering. Upon palpation of the area of chief complaint, bilateral moderate muscle tension along the thoracic region of the spinae erector muscles, more tightness on the right, was noted. On the ninth visit, the patient brought in lab tests and imaging that had been taken 13 months previous to initially being seen in the clinic. They revealed that her right kidney was smaller in size and significantly compromised in function. The left kidney measured 11.5 cm in length, while the left kidney measured only 7cm. A diuretic renogram taken one year previous, reported 94.1% differential function in the left kidney and 5.9% in the right. The glomerular filtration rate (GFR) of the left kidney was 88.8; the right kidney GFR was 3.5. The most recent imaging and urinalysis, 5 months ago, revealed that her right kidney has become even more compromised and surgery to remove the diseased kidney was recommended at that time.

ASSESSMENT

Western Diagnosis: atrophied, poorly excreting right kidney with severe hydronephrosis and a thin renal cortex, hypoplastic right renal artery

TCM Diagnosis: Kidney qi and yin deficiency (with deficiency heat), qi and blood stagnation in Bladder meridian

Prognosis: Originally, the prognosis for resolving the complaints of low back pain and burning urination in an otherwise healthy young woman was quite good. All of that changed on her ninth visit to the clinic, when upon our request, she presented her full history of medical reports and imaging studies to us for the first time. Due to the severity of her condition, the long-term prognosis for the health of the right kidney is poor. But due to her response to the treatment thus far, the prognosis for alleviating her symptoms with acupuncture and herbs is good.

INITIAL PLAN

Acupuncture treatments twice a week for five weeks and then reassess. Focus on tonifying kidney qi; nourishing yin and re-establishing the free flow of qi and blood to the local area. Herbs will be given to tonify kidney qi and yin and promote urination.

A typical acupuncture treatment includes points DU20, BL23, BL24, BL26, BL28, BL40, KI7, KI3, and SP6. On several treatments the inner bladder line was threaded all along the thoracic vertebral region due to tightness along the spinae erector muscles and referred pain, especially on the right side. Electro acupuncture (continuous @ 5 Hz and mixed 2/100 Hz) was also used in the low back area bilaterally, as well as localized massage.

Specific herbal formulas will vary based on limited clinical supplies at the time of each appointment. She was first given Ba Zheng San to clear heat and at the 10th visit she was taking Dao Chi Wan to promote urination.

OUTCOME

After 10 treatments, the patient reported significantly less intensity (50% less) and frequency of the low back pain and no burning urination. She also reported no more dizziness or night sweats. The low back pain was no longer constant or even daily in occurrence, sometimes only noticeable every 2-3 days. The best herbal formula results were seen with Dao Chi Wan, given at appointments 9 and 10. During her re-evaluation at treatment 10, the patient volunteered that she had good energy and feels strong.

CONCLUSION

As far as the medical reports for this patient conclude, the nephrectomy was recommended primarily due to the fact that she was experiencing pain. With ten treatments of acupuncture and herbs we have been able to reduce the pain significantly in both frequency and intensity (50%). She is also no longer experiencing any burning during urination. If at some point, she is no longer experiencing any pain or other symptoms and her bi-annual scans and tests reveal continued normal function in the left kidney, (which is the direction her course is currently taking), I feel it is reasonable to assume that she could potentially avoid the surgery all together.

CONTINUED TREATMENT

The patient is aware that there is a high likelihood that she will eventually need to have the kidney removed and plans to continue to be monitored by her medical doctor and have regular imaging done approximately every 6 months or if sooner, if symptoms increase, to assess the progression of the hydronephrosis. Acupuncture and herbs at this time are useful palliative care and should be continued at the current course, as long as the symptoms are present. When the symptoms are completely alleviated, a maintenance course of treatment (once per week) should be implemented to maintain the strength of the system and to potentially improve kidney function bilaterally.

CASE STUDY: Stroke Sequela

Jeanne Mare Werle MAcOM LAc

Overview

50 year old male presents with post stroke sequela symptoms manifesting as severe right side paralysis. After 10 treatments starting in September 2012, the patient exhibits improvement in his condition and fair measurable progress.

SUBJECTIVE

The patient had a stroke in November 2011. He received medical attention 24 hours later at the hospital and was treated with Western medical pharmaceuticals unknown to the patient. His hospital stay was 9 days. While at the hospital he learned of an acupuncture program in Kathmandu. He began getting treatments there 14 days after he left the hospital. He doesn't remember exactly how many sessions he had, about seven. He came to the Vajra Varihi Clinic in March 2012. Prior to my attending him, he had 15 treatments at the clinic. Current symptoms are paralysis of the right side of body, numbness in the hand and foot, inability to move fingers or toes, numbness of his lips (right side) and tongue, difficulty walking, an unsteady gait, the sensation of weakness in the right knee and ankle, stiffness in the shoulder, elbow, wrist, hip and knee joints, general fatigue and heavy sensation in the body. The patient is worse in cold weather, worse with fatigue, and worse when hungry. The quality of sensation that the patient experiences in his body is heavy, achy, tingling and weakness. As noted, the area affected is the right side. The severity of the condition and the impact on his life is immense due to his inability to work, care for his animals or farm his fields.

The patient reports difficulty in walking due to his toes having no ability to move. This requires the patient to lift his leg straight up and land the foot on the whole sole as opposed to heel to toe walking. This gives the patient an unsteady gait that he reports also makes his knee feel like it could give out. The distance the patient walks to the clinic from his home would have taken him 20 minutes prior to the stroke; currently it takes him close to an hour.

While in the hospital, the patient received 1 physical therapy session. The patient maintains an exercise routine based on what he learned in PT while at the hospital; he reports that he massages his foot and hand daily. He takes no western medication or supplements, just Tibetan herbs.

Despite the extent of his symptoms, the patient identifies that he would like to focus on improving his speech, reducing the swelling around his lips on the right side, re-gaining some use of his right hand, and improving his ability to walk and feel more balanced.

OBJECTIVE

Patient appears to be in good health with a strong spirit and determination to improve. He has spent his life working the land and raising animals that has taught him patience and endurance.

The patient's left arm is used to lean on a walking stick as he raises his right leg directly up from his hip and places his foot down on the whole flat of his foot, as if it were one solid block. He is unable to walk in a normal heel to toe stride. His right hand is contracted and he holds his entire arm tight against his belly. His face appears symmetrical and bright except for about 10 % swelling in the right upper and lower lips.

When seated, the patient uses his left hand to move his right hand into position. The right hand is contracted, however passive stretching of the digits and opening of the palm happens easily and reveals tremendous flexibility. The patient has a medium strength grip, about 50 % compared to the left. He has no ability to extend the fingers or even wiggle or twitch them. After opening the hand, it slowly folds back into a soft contraction within a few seconds.

Sensory testing using light, medium and heavy stroking of the patients affected areas while the patient has his eyes closed shows complete response. Hip flexion and extension has normal ROM, however the strength of the hip is reduced by 30 %. Hip flexion and extension are occasionally affected by stiffness in the hip joint from the action of lifting the leg to place the foot. Most of the stiffness remains in extension position. Although I do not speak the patient's language I can hear there is next to no slurring in the words. When the patient leaves the treatment he lifts his leg off the ground about 2 inches higher then when he came in.

After the last 2 treatments the patient is able to place his heel on the ground and land on his toes. There is a slight supination of the foot as he lands on the toes. He still has no sensation in the toes.

Tongue – swollen, pink, light white coat; Pulse – slightly rapid, superficial, and wiry

ASSESSMENT

DX: Post stroke sequela with paralysis of the right hand, fingers,

foot, and toes; Overall stiffness, weakness, and heaviness.

TCM: Qi & Blood XU, KD Yang XU. Wind & phlegm obstructing the channels and collaterals.

Prognosis: The prognosis for a full recovery is poor, however we would expect some hand movement to return and sensation to continue returning to the foot and toe's. As these functions return we would also expect to see less weakness and stiffness in the joints affected by the stress caused by the impairment. The treatment plan will need to be long term and the patient must remain hopeful and committed.

INITIAL PLAN

Treat with acupuncture 4x week for 3 months, then reassess. Focus on strong stimulation with electro acupuncture crossing affected joints. Use scalp points associated with motor function of upper and lower limbs using hand stimulation of needles. Typical treatment: Left: Dr. Zhu Motor Points for upper and lower limbs with deep insertion and heavy stimulation. Dr Zhu speech points on scalp.

Right Lower: Ba Feng, KD 1, LV 3, GB 41, KD 3, SP 3,Sp 6, St 41, GB 39, St 36, GB 34, KI 10, He Ding, Xiyan/Xiyuan, St 34. Right upper: Baxie, HT 8, PC 8, PC 6, Xu Duan – ten drains on the right hand and right toes,TB 5, LI 10 X 3, LU 5, Biceps ashi.

Electro: 2/100 mixed – Dr Zhu Scalp points, Biceps Ashi – PC 6, LI4 – LI 10, ST 34 – ST 36. Alternative treatment consists of similar points crossing joints such as KD 10 – KD 3, SP 6 to Sp3 and/or GB 34 to ST 34.

The patient was given a bottle of Posumon (aromatic oil) after the first treatment and instructed to use it with his home routine that includes daily massage and physical therapy. Included in home therapy are visual exercises to stimulate the brain and motor connection. The patient is instructed to perform the physical therapy routine with the unaffected side of the body while creating a strong eye connection with the movements. Then the patient performs the same movement therapy with the affected side, again keeping a strong visual connection.

The patient is also using Tibetan medicine as his herbal treatment and expresses positive feelings about this. Keeping detailed track of all changes and astute observations with each treatment is imperative. The smallest details are critical to observe and note, both for the clinician and patient. Constant encouragement through the likely long progress of healing must not be overlooked. Reminding the patient of all the changes at each session will help in the process of staying positive.

OUTCOME

Patient reports that the current acupuncture treatments are the first time he has noticed significant improvement. After each treatment he reports more nerve sensation in his hands and feet, with greater ROM in his knee and ankle. The swelling in his lips responded immediately to the treatment and the patient reports clear speech at this time. The patient had one 10-day lapse in treatment, which brought about 30% of the lip swelling and 5 % of the speech problem back. After one treatment clear

reports a tingling sensation in his 3rd & 4th fingers which may be a forerunner to nerve function returning. At this time the patient most hopes to get sensation and functioning in his toes so that he may improve his gait, as walking is the only option he has in his village.

CONCLUSION

In the past, this patient received acupuncture treatments of a more constitutional nature without any change to his symptoms. His current response to treatment has been exciting; he has had fair outcomes with measurable changes in symptoms. It is imperative for the patient to continue with regular treatment in order to maintain any ground gained thus far. In cases of stroke, it appears that focused, aggressive, and frequent treatments are critical. Using visual exercise where the patient first does the physical therapy with the healthy hand or foot - while keeping focused on the movement to imprint on the brain and then repeats the same exercise with the affected hand or foot, home massage and physical therapy in conjunction with acupuncture treatment are also very important. It is also important in working with post-stroke sequela that the practitioner employ careful documentation and critical observation so to better track changes, however big or small, in the patient's condition. Constant encouragement and reminders of change help to show the patient their progress, through the likely slow healing process.

CASE STUDY: Neck Pain with Radiation

Amy Schwartz MAcOM LAc

Overview

40-year-old male presents with right-sided neck pain without nerve radiculopathy down the arms bilaterally. He has seen his physician who diagnosed him with nerve impingement and wants to do injections of Xylocane and Tricant local to the area of pain, inferior and slightly lateral to his occiput. After 6 acupuncture treatments including electro stimulation, massage and topical pain patches, the patient reports improvement in pain frequency and quality.

SUBJECTIVE

Patient presents with right sided neck pain that has been present on and off for the last 5-6 years but has become constant over the last month. The pain can be worse with cold and heat packs alleviate the discomfort. There is no radiculopathy but he does notice that his left arm can feel weakness when he's walking up hill. When it is most severe he can feel pulling over his head to the frontal and parietal bones. He has had physio in the past for right shoulder muscle spasms and they have resolved. He has no history of heart palpitations or hypertension. He is currently talking no allopathic medications.

OBJECTIVE

The patient appears to be healthy and is comfortable answering questions about his discomfort. Upon palpation of his neck, tenderness was noted sub-occipitally at the origin of the traps and the insertion of the splenius capitus and cervicus. The scalenes are also tight and tender as well. Palpation reveals a slight anterior rotation on the right of the first cervical vertebrae. Cervical compression, distraction, and maximum compression tests were negative. His pulse is moderate but thin and his tongue is red with a greasy, yellow coat. An x-ray report shows no clear indication of a problem. His ROM on the right is decreased with lateral flexion and rotation compared to the left. The pain also increases with lateral flexion and rotation to the right. Grip strength in the left arm showed some weakness by comparison to the right and felt cooler to the touch.

ASSESSMENT

DX: Possible cervical rotation of C1.

TCM DX: Possible Bi syndrome due to Qi and blood stag in the Du and Bl channels.

Prognosis: Acute phase- good. Underlying chronic phase will take time to unwind the fascia and muscle spasm that tend to sublux the vertebrae.

INITIAL PLAN

Treat with acupuncture twice weekly for 4 weeks then re-assess. Focus treatment on loosening the muscles and fascia that are pulling the vertebrae out of alignment and impinging the nerve with use of acupuncture needles, electro-acupuncture and massage with traction and joint mobilization.

Typical treatment: GB20, 21, Bl10, An Mian, Ashi in cervical area and above occiput at the Trap origin, TB14, LI15, SI 12-13, LI4, LV3. Electro-acupuncture from GB20 to Ashi in cervical region. Massage sub-occipitally and into vertebrae with myofascial release techniques and traction. Also, the local application of Salon Spa topical patches with menthol and camphor to move Qi and blood thereby clearing stagnation and decreasing pain.

OUTCOME

After 6 visits the patient has reported 80% less pain in the localized right sub-occipital area and has noted that the pain has shifted to a broader area with less intensity. His Rom in lateral flexion and rotation to the right are equal to that of the left. He still feels a slight pulling in the muscles upon rotation to the right. He is encouraged by the treatments and has also noticed that his left arm feels better and the strength has returned.

CONCLUSION

This patient agreed to let us treat him in lieu of injections even after his Dr. told him there was no other care available to him for this issue. This case shows some of the strengths of acupuncture and massage in making changes in musculo-tendinous issues that are both acute and chronic in nature. He will continue to be seen twice a week until the pain is resolved, and the ROM becomes equal and the vertebral subluxation shifts.

CASE STUDY: Hemiplegia (Stroke Sequela) with Acute Lung Consolidation

Stephanie Grant MAcOM LAc

Overview

Eighty-one year old female presents with complete left sided hemiplegia following ischemic stroke two months ago. Over the course of seven weeks of acupuncture treatment the patient regained limited voluntary dorsi and plantar flexion of her left foot, flexion and extension of her knee and elbow, and increased sensation in her left arm. The patient also developed a cough due to fluid in the lower left lobe of her lungs five weeks after the stroke; a common concern for patients with limited mobility living in the cold and damp houses of Nepal. The cough was successfully treated with Chinese herbs.

SUBJECTIVE

Eighty-one year old female presents with hemiplegia of the left side as sequella of ischemic stroke. One week prior to initial assessment, the patient awoke from resting and was unable to move, her left arm and leg were numb, she could not talk nor open her left eye, and could not sit up by herself. Her family immediately transported her to the hospital where she was admitted for four days. At the time of discharge from the hospital, she had regained some limited speech and could open her left eyelid.

Initial exam is seven days after the stroke. She reports inability to move either left limb and has limited movement of the left side of her face. She describes her entire left side as feeling heavy and numb. The patient tends to feel hot, particularly in the evening, and experiences night sweats. She has no appetite, a slight thirst for cold drinks, blurry vision, dizziness, and complains of a dry throat.

Medications upon initial evaluation include Atorvastatin (Lipolow-10) 10mg QD, Aspirin 75mg QD, and Ranitidine (R-Loc) 150mg QD.

OBJECTIVE

Patient appears thin, weak and is bed-ridden at time of initial assessment. She is unable to sit upright without assistance. There is no atrophy of muscles on the left side. Her skin is dry to touch, and she exhibits some degree of hearing loss normal for her age.

The patient demonstrates no voluntary motor control of her left limbs. Her left forearm and hand is mostly contracted and cannot be extended with gentle force. Her left shoulder can be raised slightly, and the patient can easily move her left arm with her right. Her left hip joint is slightly mobile, and there is no apparent contracture of her left thigh and leg. There is no notable temperature difference side to side on palpation; both sides are warm when covered by blankets.

Deep tendon relfexes all measure +2 on the right and +3 on the left. Dull sensation is intact and equal on both arms and legs. Sharp touch is equal side to side on dermatomes C6, C8, and L5, but slightly decreased on dermatomes C7 and S1 on the left side at the distal tips.

The lateral corner of the patient's left eyelid droops slightly compared to the right, but she can raise and close both eyelids. The patient's left side of the mouth also droops, and she cannot

smile equally on both sides. She can puff out both cheecks. She exhibits slight aphasia and hardly responds to questions when asked. There is some moisture gathering at the lateral corners of her mouth and left eye.

Pulse is thin and taught across all positions, floating and rapid.

Tongue is thin and red with a thick, dry, yellow-grey coat.

ASSESSMENT

Dx: Left sided paralysis as sequella of an ischemic stroke.

TCM Dx: Sequella of Wind-Stroke, with pattern of wind-phlegm obstructing the channels and collaterals and underlying yin deficiency with empty heat.

Prognosis: Guarded as the patient is 81 years old and suffered an ischemic stroke. Factors in her favor include daily acupuncture treatments, continued progress in voluntary movement of her left foot over the first 30 treatments, and dedication from her family in assisting her recovery with constant care and physical therapy exercises at home.

INITIAL PLAN

Acupuncture treatments six days per week with regular reassessments at three-week intervals.

Focus acupuncture on clearing wind-phlegm from the channels and collaterals with continuous monitoring of vital signs for evidence of hypertension or pneumonia, both of which pose a greater risk to the patient's life than post-stroke sequella.

Typical points include: Jiao's motor region right side upper limb ~ lower limb, left Lr3 ~ ST36, GB41 ~ GB34, Ba Feng, GB39, Sp6, LI4~LI11, Ba Xie, Du26, CV24, ST4, ST3, SJ23, Yu Yao (~ indicates estim between points at 5Hz continuous for 5-8min). Total treatment time is limited to 10-15min as the patient is easily fatigued by acupuncture.

Counsel patient about twice-daily exercises to flex and extend left toes, foot, leg, fingers, hand and arm. Encourage routine exercises in spite of lack of joint movement. Encourage patient to go outside daily to sit upright in the sunshine and take short walks with the assitance of her family. Teach the patient's family to massage the patient's left limbs with mustard oil, gently moving the arm and forearm to full extension to reduce contracture.

CONTINUING TREATMENT PLAN

SUBJECTIVE

Four weeks into treatment, the patient develops a cough with inability to expectorate. She denies fever or chills, sore throat, headache, or tension in her neck and upper back. The little sputum she expectorates is thick, sticky and yellow-grey. She is living on the ground level of a brick and mortar house with hard pack dirt floors. She spends most of her time on a makeshift bed, consisting of a pallet of three blankets over top of a plastic tarp to protect her from the cold-damp weather of early-winter in Nepal. The patient's family describes taking her outside daily in the sun to do exercises and rest in the warmth for a few hours each day. Otherwise the patient spends most of her time lying on her back in this room without electricity or heat.

OBJECTIVE

Chest auscultation found high-pitched crackles in the upper lobes and percussion produced increased resonance in the lower left lobe of the lung. Blood pressure is 160/70mmHg, pulse rate is 68bpm, and pulse oxygen measures 92%. Oral temperature is 98.3 deg F.

ASSESSMENT

Dx: Diagnosis of the secondary complaint of cough is possible consolidation of the lower left lobe of the lungs, likely due to immobility and secondary pulmonary hypertension. The exact cause and severity of the fluid in the lower left lobe of the lungs cannot be determined without additional testing.

TCM Dx: Secondary complaint diagnosis is cough due to phlegm-heat in the lung.

Prognosis: Good as the condition was caught early and is monitored with auscultation of breath sounds at every

acupuncture treatment. The patient's living environment will not change, however, and will be a continued challenge throughout her recovery.

UPDATED PLAN

Points added to the initial acupuncture prescription include Lu5 and ST40.

Internal formula administered is Qing Qi Hua Tan Wan 8 pills TID (Plum Flower Brand) for three weeks. The patient is also immediately referred to her allopathic physician for uncontrolled hypertension and is prescribed Amlodipine 5mg QD.

Counsel the patient and her family on adequate water intake and proper diet to reduce phlegm and hypertension.

OUTCOME

After 36 treatments the patient exhibits major changes in the motion of her left foot, and marked improvement in auscultation and percussion of her lungs. She describes her limbs as feeling "lighter". She is now able to walk slowly with the assistance of a walking stick and two other people, and she can stand with a walking stick and the support of one other person. Her shen/mood is much brighter as indicated by her laughter and smiling during treatments. She describes looking forward to walking with her goats in the fields again.

The patient's left knee actively flexes and extends through 90 degrees range of motion, her ankle plantar and dorsiflexes flexes

5 degrees, her great toe dorsiflexes voluntarily, and the other toes dorsiflex with needle stimulation. Her left elbow flexes 10 degrees and extends 5 degrees, but she continues to be unable to move her left fingers and wrist. Contracture of the left forearm has significantly reduced with regular home massages, and the patient now reports pain and tingling in her left arm after massage and acupuncture. Sharp/dull touch is now equal side to side, while deep tendon reflexes on the left are still at +3. The patient is also able to sit upright on her own for long periods of time without assistance, and her speech is much clearer and easy to understand.

The patient describes her lungs as feeling less congested, and she finds it easy to expectorate phlegm. Her lungs sound markedly clearer on auscultation; high pitched crackles remain, but there is no longer resonance on percussion of the lower left lobe. However, the lower right lobe now exhibits some slight resonance with percussion. Her blood pressure is reduced to 130/72mmHg, pulse rate is 72bpm, and pulse oxygen is increased to 96%.

Her tongue is now thin and slightly red with a clear dry coat. Her pulse is slightly rapid, thin and taught across all positions.

CONTINUED TREATMENT

The patient needs continued daily acupuncture treatments with emphasis on clearing wind-phlegm from the channels and collaterals. The patient's blood pressure and lungs should continued to be monitored routinely. The patient's phyical abilities should be objectively measured every three weeks with emphasis on active range of motion, deep tendon reflexes, sharp/dull touch, and facial muscle testing.

With further resolution of the consolidation from her lungs, herbal treatment focus may shift from clearing phlegm-heat from the lungs to nourishing the patient's yin and clearing empty heat. The patient should be referred to allopathic care for more testing, diagnosis, and stronger medications if the consolidation in her lungs becomes more significant, spreads to more than one lobe, if she develops a fever, or if her blood pressure increases above 140/90mmHg.

The patient has responded well thus far to regular acupuncture and herbal treatments, and continued improvement is expected.

CONCLUSION

Routine acupuncture treatments are an effective method for regaining mobility post-stroke, particularly when used in conjunction with supportive home care and regular physical exercises.

In providing daily treatments the acupuncture physician is also in a unique position to serve as a primary care provider, monitoring for other physical ailments which may develop quickly and pose a significant threat to the patient's recovery. As demonstrated in this case study, routine auscultation of the lungs led to early diagnosis and treatment of fluid consolidation in this patient's lungs.

CASE STUDY: Palliative Care of Parkinson's Disease

Tara Gregory MAcOM LAc

Overview

62 year old patient was diagnosed with Parkinson's disease 8 years ago and has been receiving treatment in the clinic since 2009. This case explores the positive role that Chinese Medicine can play in providing palliative care to patients living with a chronic degenerative disease.

SUBJECTIVE

62 year old patient presents with a burning sensation in the body and bilateral trembling of the legs and arms. The burning sensation is felt in the head, the knees, and the soles of the feet. The burning sensation begins when he wakes in the morning, increase in severity during the day, and subsides when he goes to bed. Patient reports that during flair ups of the burning sensation his trembling and other symptoms deteriorate.

Patient also presents with bilateral trembling of the legs and arms and trembling of the mouth and tongue. Symptoms began 8 years ago with trembling in the 5th finger on the right hand. The trembling progressed up the arm and eventually lead to bilateral trembling of the arms and legs. Patient's family reports a lack of tremors during sleep which resume upon waking. The patient notices a feeling of stiffness in the whole body which is especially pronounced while walking. Patient expresses difficulty in remembering words and completing sentences and that other people have difficulty hearing him when he speaks. Patient reports that symptoms get worse with stress, sadness, fatigue, hunger, and goat meat.

Associated symptoms include: day and night sweats, vertex headache, positional dizziness, vertigo, excessive salivation, constipation, thirst, pain and hesitancy with urination, mouth sores, and difficulty with sleep. Patient expresses understanding about the chronic nature of his condition and is sometimes overcome by sadness, worry, and fear.

OBJECTIVE

The patient presents with visible bilateral trembling of the arms and legs, and trembling of the mouth. Trembling is more severe in the patient's arms in comparison to his legs. Patient's voice is noticeably diminished in both strength and loudness, demonstrating signs of hypophonia. Patient exhibits bradykinesia of the upper and lower limbs while walking, a slightly unsteady gait, and rigidity in movement.

Patient's tongue is purple with horizontal center cracks and a greasy yellow coat. His pulse is slightly rapid and wiry.

ASSESSMENT

Western Diagnosis: Parkinson's disease. The patient presents with the four cardinal signs of Parkinson's disease: resting tremors, rigidity, bradykinesia, and postural instability. Associated autonomic dysfunction is also present as seen in the patient's propensity to suffer from constipation and urinary

difficulties. Laryngeal dysfunction and dysphasia, commonly seen in Parkinson's patients, are observed with softness of voice, vocal tremors, and excessive salivation. Relief from symptoms with the use of Levodopa is often used as confirmation of a Parkinson's diagnosis, and the patient has experienced relief with this medication.

TCM Diagnosis: LR and KD yin xu leading to fire and internal wind.

PROGNOSIS

The prognosis for this patient must bear in mind the chronic and degenerative nature of his disease. The goal of treatment is to provide palliative care to help relieve the symptoms of the disease and the side effects of his medication. Treatment is also aimed to prolong the effectiveness of his medication and to slow the progression of his disease. Additionally, the goal of treatment is to help the patient psychologically cope with his condition, and will at some point transition into providing a form of hospice care. Given these conditions there is a good prognosis as Chinese Medicine is effective at meeting these goals.

PLAN

Treat 3 times a week to help moderate symptoms and slow the progression of the disease. Focus on reducing the burning sensation in the body by clearing heat and nourishing KD and LR yin. Internally use the formula Zhi Bai Di Huang Wan in a dosage of 8 pills 3 times a day. Acupuncture point selection includes KD 2, KD 6, LU 7, SP 6, LI 11, LR 2, GB 20, and Jiao's scalp tremor line.

As treatments progress and the burning sensation disappears, expand treatments to focus more on settling wind and helping

with speech. The patient is switched to the formula Tian Ma Gou Teng Yin in a dosage of 8-12 pills three times a day. Acupuncture points are expanded to include TW 5, DU 15, DU 16, CV 24, and Jiao's scalp speech zone.

Treatments can last indefinitely as long as the patient continues to experience positive symptomatic relief. Re-evaluate every 12 visits to assess progression of his condition.

OUTCOME

After three treatments the patient reports a 2/3 reduction in the burning sensation in the head and a complete absence of burning sensation in the knees and soles of the feet. Patient also exhibits a visible reduction in bilateral trembling during and after treatment. The patient reports that the effects of treatment last for about 2 hours and extend the effectiveness of his medication. Patient's demeanor and affect are visibly lightened after treatment.

CONCLUSION

The difficulty and question brought up by this case is the role that Chinese Medicine can play for patients suffering from chronic progressive diseases. This case demonstrates that the use of acupuncture and herbs can provide palliative care and help to increase the quality of life for patients by mitigating the symptoms associate with Parkinson's disease. Additional questions arise due to the nature of side effects caused by Levodopa, which can help to control trembling associated with Parkinson's but also causes trembling and other symptoms normally experienced by Parkinson's patients.

Therefore, it is difficult to assess proportionally how much of treatment addresses the symptoms associated with Parkinson's diseases versus the side effects of the patient's medications. Ultimately, the effects of treatment are beneficial as they provide symptomatic relief for the patient and may help keep the patient on the lowest dose of medication possible for a longer period of time. Furthermore, the effect of acupuncture and tri-weekly treatment on helping patients cope psychologically with the reality of their condition cannot be understated as many patients with Parkinson's disease are susceptible to depression. The patient expresses that while he has an understanding of the progressive nature of his condition, coming in for treatment not only provides him with relief from physical symptoms, but also provides him with a sense of hope.

CASE STUDY: Outer Ear Infection

Natalie Gregersen MAcOM LAc

Overview

A 52 year old male presents with right sided burning head and ear pain, right sided hearing loss, and anosmia. It is determined after an initial ear examination with an otoscope that the patient has a severe right side ear infection. After 12 treatments which includes the use of acupuncture, internal and external Chinese herbs, and antibiotics the patient reports a significant reduction in the burning sensation. Objectively the right side tympanic membrane shows a 90% improvement. There is no change in the anosmia and hearing loss.

SUBJECTIVE

The patient presents with right sided burning head and ear pain that started 6-7 months ago. His symptoms also include right sided temporal headache, an itchy sensation deep in the right ear, tinnitus that comes and goes, and right sided hearing loss. He reports he can hear people talking, but can not clearly understand what they are saying. Anosmia started 2-3 months after the burning head/ear pain started. The patient reports that it feels like he has a 'fire' inside his right ear and prior to the pain starting he heard a bug-like sound. He has moderate pain (4/10) which doesn't interfere with work when he is concentrating on a task, but when he is not distracted the pain is constantly present. Nothing makes the pain better or worse. Although he has loss of smell he can taste his food.

OBJECTIVE

The patient appears to be in good health for his age and environment. He's always in good spirits and maintains eye contact during the interview. He often is joking around with the other patients in the room while waiting his turn for treatment.

An initial right ear examination with an otoscope shows a purulent and inflamed tympanic membrane. The entire membrane is ringed with redness with bright red streaks throughout it. There is pus along the superior border and the entire tympanic membrane is severely scarred and cloudy. The left membrane appears normal and healthy.

A strong smelling substance called Tiger Balm is held under the nose while the patients eyes are closed. He reports that he is unable to smell it. Both sides of the nose are checked by holding the balm under one nostril while the other is plugged. Anosmia appears to be bilateral.

Hearing loss is checked by using a 128 hz tuning fork. Patient reports that he is able to hear the sound until it is six inches away from the right ear. The left ear is also checked and he can hear it until it is one foot from his ear.

Pulses are wiry, slippery, and rapid especially in the Liver position. Tongue shows a pale center with red sides and a greasy yellow coat.

ASSESSMENT

DX: Right sided severe ear infection with anosmia and auditory deficit.

TCM DX: Damp heat in the Triple Burner and Gallbladder channels

Prognosis: Using oral antibiotics, herbs, antibiotic ear drops, and acupuncture a complete recovery from the ear infection is expected. With the treatment of the ear infection there is a possibility the patient may recover his sense of smell but the outcome is uncertain. Due to the severe scarring of the right tympanic membrane full recovery of hearing is unlikely.

INITIAL PLAN

Treat with acupuncture and herbs 3 times a week for 10 treatments and then reassess. Include Western pharmaceuticals such as oral antibiotics and antibiotic ear drops to clear heat and reduce inflammation.

Focus on clearing dampness and heat in the Liver, Gallbladder, and Triple Burner channels.

Typical acupuncture points included: GB20, R-TB17, GB43, TB2, TB5, GB40, GB34, LV3, LI4, ST36, SP10, LI11

CONTINUING TREATMENT

Initial treatment: Includes oral antibiotics of amoxicillin 3TID for 5 days plus Huang Lian Ji Du Tang 3TID for 6 days.

Treatment 4: It is determined that the pus was reduced by 75%; therefore, the patient was switched to Long Dan Xie Gan Tang 3TID as it is more fitting to his pattern.

Treatment 2-9: An an external solution is made of one Huang Lian Ji Du Tang pill crushed and mixed with rubbing alcohol. From treatment 2-9 fifteen drops of this herbal solution is dropped into the patients right ear after his acupuncture treatment.

Treatment 9: It is determined that the patient has plateaued; therefore, the external herbal solution is discontinued and antibiotic ear drops at a dosage of 3 drops TID administered by the patient is added.

Treatment 12: Due to the significant reduction in the patient's symptoms the herbal formula Long Dan Xie Gan Tang is discontinued. The patient is asked to continue the use of antibiotic ear drops 3 drops TID for two more weeks.

OUTCOME

After 12 treatments the burning sensation is reduced by 80%. Patient reports there is still a constant mild burning and itchy sensation deep inside the right ear, but it no longer feels like he has a 'fire' in his ear.

His tinnitus and temporal headache still come in go, but he also has hypertension which could be contributing to these symptoms.

Objectively the tympanic membrane is 90% improved. It is no longer purulent and the redness is concentrated to the upper right quadrant of the membrane. There are no longer streaks and the redness has changed from bright red to a dark red that looks like a scab.

There has been no change in the hearing loss, though the patient was seen talking on his cell phone with his right ear. When questioned about this he reports that he can make out what people are saying if the phone is held close to his ear. There also has been no change in the anosmia.

CONCLUSION

After 12 treatments the right sided burning head/ear pain is significantly reduced. By week 10 the patient's visits are reduced to 2 times a week. He seems much less concerned about his head/ear pain and asked to work on other conditions. The the patient is using antibiotic ear drops during a three week break from treatment and his condition will be reassessed when the new team of practitioners arrive.

This case demonstrates the importance of understanding how to use diagnostic tools such as an otoscope in the treatment of certain conditions, This is especially relevant in Nepal where the acupuncturist is often the patients primary care physician. The diagnosis and objective observation of an inflamed tympanic membrane provided a clear picture of the patient's presenting symptoms which guided the treatment plan. Also the use of chinese herbs in conjunction with western pharmaceuticals greatly improved the outcome.

CASE STUDY: Low Back Pain with Radiation

Sarah Richards LMT

Overview

30 year old male presents with severe back and left leg pain, exhibiting postural deviation as a way to relieve pain from an L5/S1 disc herniation. When prescription of daily acupuncture and massage was followed specifically, patient experienced a more dramatic reduction in pain, improved posture and attitude.

SUBJECTIVE

30 year old male patient presents with severe back pain and leg pain on left side, with severe postural deviation to relieve pain. Symptoms began 7 months ago with no known cause; however patient does say that throughout his life he has carried heavy bags of rice on his back and head. He complains of sharp pain and stiffness with movement; when standing from sitting or squatting and when walking up stairs. Sharp pain will also wake patient at night with movement of left leg or twisting to turn over.

After getting an MRI patient was told that he has a "compressed bone" in low back but does not know anything more specific. He expresses his desire to delay or avoid surgery for his condition.

The patient says that pain medication does not provide any relief and also that he intentionally stands "crooked" to alleviate severe pain in his low back, but then tries to over correct it in order to look "normal"; he denies experiencing pain or discomfort in upper back or neck. (See photos)

OBJECTIVE

An MRI taken 15 weeks ago appears to show L5/S1 disc herniation with L4/5 disc desiccation, as reported in radiology report. Visual observation of the torso shows lateral curvature of the spine and depression of the left scapula (see photos). When not weight bearing, lying on massage table prone or supine, spinal curvature corrects to more normal alignment and shoulder blades relax in neutral position.

While standing, and asked to actively straighten his spine, patient feels pain in lower back on the left side with radiating pain in the left lower leg. Trunk flexion produces pain when patient's fingers are 8 inches from the ground and pain is again felt in lower back on the left side with radiating pain in the left lower leg. Trunk extension produces pain in low back only, without radiation, and a left straight leg raise elicits pain at 45 degrees. A left side bend test produces pain again in low back with tingling and radiating pain to lower leg, while right side bend elicits no pain.

Mood changes are noticeable and vary depending on level of pain each day, ranging from sullen, angry to hopeful and excited.

ASSESSMENT

Dx: L5/S1 disc herniation with L4/5 disc desiccation causing severe lower back pain with radiating symptoms to left lower leg.

Prognosis: In order to have a long term positive impact on the patient's condition it will likely require frequent treatments for many months. Since the patient travels more than one hour to

the clinic, often by foot, it is improbable that compliance to a long term, daily treatment plan is realistic; consequently, a significant long term result is doubtful.

INITIAL TREATMENT PLAN

Daily acupuncture and massage therapy focusing on pain relief for 10 treatments and then reassess.

Typical massage Tx: 30-40 minute sessions focusing on releasing fascial and muscular restrictions to reduce compressive forces on affected disc and nerve root, thereby decreasing pain and inflammation giving the disc a chance to heal and allow the patient to stand with proper alignment and return to work and regular activities.

OUTCOME

After 14 acupuncture treatments and 11 massage sessions patient reported mixed results based on frequency of care. Missing only one day of massage or acupuncture did not produce a significant set back. However there was a 5 day break in co-treating, in which the patient received only 3 acupuncture treatments, no massage therapy and experienced a decrease in progress. Subsequently, after missing massage appointments 5 days in a row, the patient returned complaining of an increased pain level, a level similar to which he had been experiencing prior to beginning treatment, stating a pain level of 6 out of 7. Upon returning to the subscribed daily treatment plan, after only 3 treatments consisting of both modalities on the same day, patient was reporting improvement of low back pain from 6 down to 4; as well as an improvement in posture and mood. As seen in the before and after photos the change in posture is significant; these pictures were taken on the same day following an acupuncture treatment.

Massage techniques that provide the most relief and change for the patient include friction to address bilateral lumbar paraspinal and erector spinea musculature, compression and friction of the sacral origin of gluteus maximus, tensor fasciae latae and quadratus lumborum (QL). Fascial release to the thoracolumbar region utilizing flexion of low back in child's pose (a pain free position for this patient) proves to be particularly helpful and is thought to be most productive by the patient. In addition while in child's pose, having the patient flex laterally allows good access for addressing the transverse processes insertion of QL. In a side lying position, inferior distraction of the left ilium provided significant and immediate relief to patient. Passive stretching of the left side body, including obliques, QL and latissimus dorsi while patient was supine, added to the ability of the patient to stand taller and straighter.

It is interesting to note that working primarily on the painful left side, improved posture and decreased pain more quickly and efficiently than working primarily on the right side or more bilaterally. (See photos)

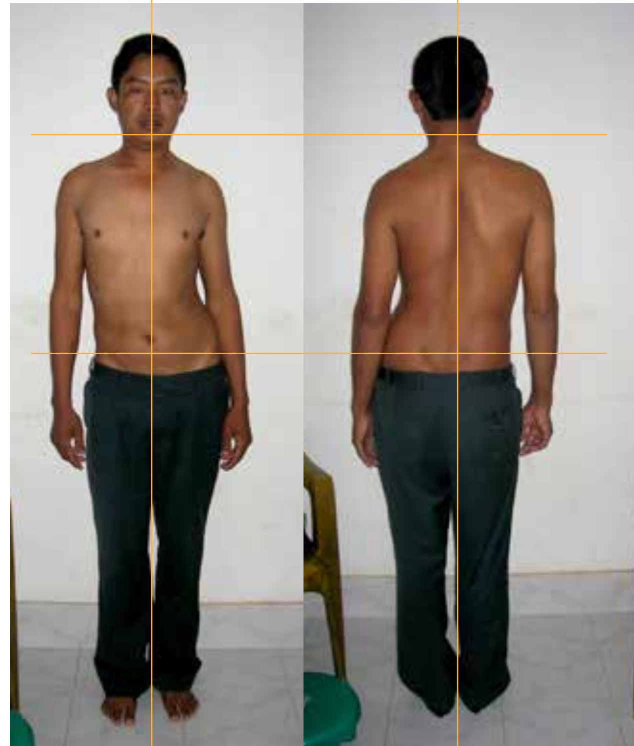
Patient was advised to avoid twisting movements and carrying heavy objects, he was also counseled that creating lasting reduction of pain would take many treatments and that in order for treatment to have a chance to help him avoid surgery he would have to take it easy and not push himself to do heavy work, even once he starts feeling better allowing the tissues enough time to heal.

CONCLUSION

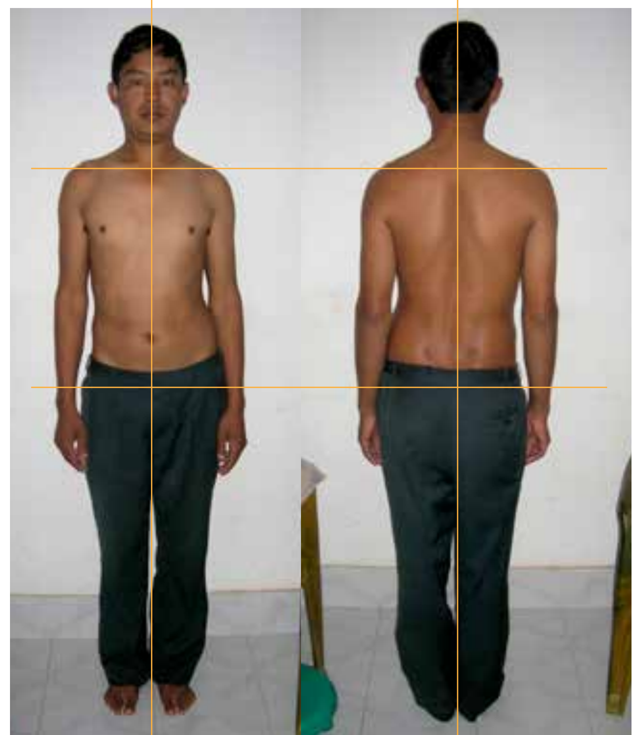
Unfortunately more data could not be collected in this case since the patient discontinued care after only 3 weeks of treatment in order to visit family. Had I been able to continue to treat this patient, I would add abdominal and spoas major releases, I would recommend a course of anti-inflammatory medication and add a component of self-care and education in order to avoid further or reoccurring injury to the disc over time.

With frequent visits, his acute symptoms responded to the co-treating plan of daily acupuncture and massage fairly quickly - within 3 visits; the two modalities combined show more promising results than just one or the other on their own. Overall, it is promising to see how co-treating, specifically with acupuncture and massage therapy, can have a positive short-term outcome on pain and posture associated with this disc herniation.

BEFORE MASSAGE



AFTER MASSAGE



CASE STUDY: Ischemic Cereborvascular Accident

Emma Goulart LAc

Overview

A sixty year old male presents with sudden onset of motor deficit of right hand, tingling and weakness of right foot, as well as marked changes in function of glossopharyngeal and hypoglossal nerve. Within the course of 15 acupuncture treatments including electric stimulation and moxabustion, there are marked improvements in motor function testing of right hand, a decrease in sensation of tingling and pain in right foot, reduced pain in the ball of right foot and a cessation of headaches.

SUBJECTIVE

Patient is a sixty year old male who presents with compromised motor function in right upper limb. The onset of symptoms started 7 months ago, reaching maximal deficit over a half hour period, affecting the right upper and lower limbs and suspected glossopharyngeal and hypoglossal nerve involvement due to changes in throat and tongue function.

At his hospital visit, he was diagnosed with left sided ischemic stroke, prescribed six different medications as well as shown several physiotherapy exercises to do at home.

Prior to his stroke, he had no symptoms of dizziness, pain in the chest, nausea and vomiting, nor any other abnormal signs. Patient was actively being treated for hypertension prior to his stroke.

Upon arrival to our clinic, the patient is mostly concerned about his right hand, since it is keeping him from being able to work. Most of his frustration is due to the loss in control of movement in his right hand. He also mentions right leg weakness and slight tingling and pain on the dorsal aspect of the foot. Further questioning specifies that the feeling of weakness is caused by painful knotting on the ball of his foot.

He explains that after the incident there was more difficulty in speaking, which he describes as a tickle in the back of his throat. This sensation in his throat came on during the stroke along with the loss of motor function in his right hand. In addition, he notes short term memory impairments since the incident as well, described as an inability to remember details.

Patient is currently taking four medications: Amlodipine, Clonazepam, Aspirin and Atorvastin.

Bowel Movements are formed but feel incomplete and are difficult to pass. Normally he passes stool daily, though he can go up to 3 days without a bowel movement. Patient reports scanty urination as well. He can sleep through the night and usually gets between 7 and 9 hours per night. He reports feeling cold inside, especially on fingers and toes. He does not perspire, no matter the level of exercise exerted. He experiences occipital headaches regularly and relates them to his high blood pressure. His eyes feel burning and irritated.

OBJECTIVE

Patients overall health is above average for age and environmental factors. The patient seems to be strong constitutionally, with a demeanor that is generally quiet. He

seems hopeful of the acupuncture treatments and open to any way he can participate in the process, including a dedication to coming for treatment daily.

Hospital records on June 2012 {7 months prior to treatments} were three weeks after the incident. On this day a CT scan was administered showing evidence that suggests ischemic stroke. The carotid doppler report is normal, as well as lipid testing. The color doppler echocardiography report showed aortic valve and mitral valve are thickened, the mitral regurgitation grade is II-III, the tricuspid regurgitation grade is II. Fair left ventricular systolic and diastolic function. Right upper limb testing showed flaccid tone, power of 0/5 and hyper reflexion, however all other limbs have normal scores.

Upon arrival to our clinic, there were several tests done to assess patient.

Facial testing:
Sharp/Dull testing - no clear findings along trigeminal nerve pathway; He is able to feel light touch bilaterally on face, though sharp/dull testing is inconsistent along his right side.

Facial nerve testing is inconclusive. Expressions are all normal; he is able to raise his eyebrows, close his eyes and grimace. However, his smile appears slightly slanted down on right side.

Glossopharyngeal nerve testing is inconclusive. Speech is normal when saying O, La and Cha, though he has trouble saying 'E.' Patient is constantly clearing his throat while talking and has asked for water on multiple occasions due to dryness.

Hypoglossal nerve deficit is positive with a deviated tongue.

Right Upper Limb:
Sharp/Dull testing - shows sensory deficit distal to wrist joint. Patient is unable to distinguish between sharp and dull in this area.

Full AROM in both shoulder and elbow joints bilaterally. On the affected side, his wrist function is compromised with extension at 30 degrees. Flexion - 70 degrees. Additionally, 1st to 4th fingers slant 30 degrees laterally.

Isolated finger extension - 0/5 in 3rd to 5th digits, with no movement at all. 1st and 2nd digits - 2/5, with minimal movement but not against gravity. Isolated finger flexion - 3/5 in all fingers with movement against gravity but not against resistance.

Grip strength is roughly 30% weaker on the right side and wiggling fingers - 3/5.

VITALS: Blood pressure is 160/90.

TCM: Tongue is deviated, overall sticky white coat, yellow at root. Scalloped edges with red body on sides.

Pulse on right is thin and wiry; the left is full and surging but weak in chi position.

ASSESSMENT

Allopathic Diagnosis: CT scan taken 3 weeks after incident shows evidence of left ischemic CVA. These medical results combined with a decrease in motor function of upper right limb, a notable change in throat and memory impairments, meet criteria to confirm diagnosis given by hospital of Left ischemic CVA with right hemiparesis.

TCM Diagnosis: Blood stasis pattern causing blockage of channels and collaterals resulting in internal wind. Underlying Liver Yin deficiency causing Liver Yang to rise.

Prognosis: At initial consultation, patient has already regained motor and sensory deficits since his hospital visit 7 months prior. Due to these changes, combined with patient's strong constitution and dedication to physiology exercises, further recovery seems promising. It is hopeful that acupuncture and physiotherapy exercises will continue to aid successful management of motor and sensory deficits, though full neurological recovery may not be possible.

PLAN

Treatment Principles: move blood stasis, open channels and collaterals, and nourish the Liver Yin.

Treat with acupuncture 6 days a week for ten treatments before full reassessment, however long term treatment is likely needed three days a week. Treatment approach is to open right sided Yang Ming and Shao Yang channels, unblocking qi and blood in collaterals. Scalp points along primary motor cortex on left side to stimulate right sided motor function, occasionally with electric stimulation. Local points on right side around affected area of mouth and throat to stimulate affected nerve pathways.

A typical treatment consists of Bilateral treatment: LI 4, Lv 3, Du 26, Ren 23, Ren 24, Du 15, Du 16. Right sided: GB 34, Ba Xie and Ba Feng, electric stimulation between LI 12 and LI 4, LI 11 and SJ 3, UB 60 and LV 3, GB 40 and GB 43. Needling along the motor cortex line on left side of head, roughly between Du 20 and GB 6. Most treatments consist of stick moxa along his right metacarpal phalangeal joints to open blockage in channels and collaterals.

Additional physiotherapy and coordination exercises are provided for at-home treatments: Making a fist and opening it for motor function, touching thumb to each finger to improve coordinated motor function and touching hands behind back and above head for proprioception. Patient was sent with a moxabustion stick to use for warming the Yang Ming and Shao Yang channels on his right hand.

OUTCOME

The patient came almost every day our clinic was open for four weeks, even though his home is an hour and a half away. There is significant visible progress over the 4 weeks of acupuncture treatment, as well as physiotherapy exercises of the motor function in his right hand.

After the second treatment he reports an easier ability in moving his right fingers, noticeable while getting dressed and tying his shoes.

After the 8th treatment, during our second week, there is marked improvement in isolated finger extension. He presents - 4/5 rating on all digits except the 4th, having the ability to maintain position against gravity and against minimal resistance applied. His 4th digit - 2/5, unable to move against gravity. This is a great improvement from 0/5 on his first visit to the clinic 2 weeks earlier. Additional new testing was done on his 8th visit. Touching

each finger to thumb - movement is slow, though possible on all fingers except his thumb to 5th digit.

At treatment 10, a reassessment of sharp and dull testing on the affected hand was completely normal aside from his first finger which had unclear results, showing some areas with lack of sensory function. This is an improvement from his first visit which showed sensory deficit distal to wrist joint. Overall he feels that there have been improvements in movement of fingers. His main concerns at our re-evaluation are his persistent headache and the stiffness he feels in fingers of affected hand.

At treatment 15, patient feels positive about his hand, though he notes swelling in his third and fourth digit at second interphalangeal joints. The area of tingling on his right foot has decreased by 50%, and the pain on the ball of his foot is intermittent. Testing touching thumb to fingers is the same as our testing at treatment 8, with an inability to touch thumb to 5th digit.

CONCLUSION

Patient sought acupuncture 7 months after his stroke and within 15 treatments has seen marked improvement in motor function of his right hand as well as further sensory function in right foot. His headaches have subsided within the last three treatments. The patient has been advised to come three times a week for another month, with the hope of continuing to improve motor function. This will hopefully maintain slow and steady improvement with his recovery. It is unclear whether the acupuncture will allow full recovery of motor function of his right hand; however it can certainly be a means for managing the deficits caused by the stroke.

CASE STUDY: Facial Paralysis (Bell's Palsy)

Joey Chan BHkin Dip AOMj RAc

Overview

A 50 year old female presents with Bell's palsy presenting with hemi facial paralysis involving the eye and the mouth. After 5 weeks of a ten course acupuncture treatment and Chinese herbal medicine she experienced a 90% recovery.

SUBJECTIVE

Patient is a 50 year old female presenting with right side paralysis of the face involving the forehead, eyes, and mouth. The paralysis developed suddenly one week prior to her first consultation at the clinic. Patient recalls having a low fever and chills for 3 days with a slight sore throat and cough. On the 4th day she woke up with the hemi facial paralysis marked by an inability to close her right eye, with additional tearing and swelling of the right eye. She reports she is not sleeping at all for 7 days because her affected eye will not close. Patient describes symptoms of forehead pain and tightness, which can lead to twitching of the eye during severe pain. She also reports her eye twitches when she is in a cold environment.

She reports constant vertex and occipital headache, described as deep and moving pain. She also experiences sharp pain behind the right ear. She reports the left side of her mouth is pulling and tight and the right side of the mouth is painful. She describes her face being numb and is drying up. She also feels chills and dizziness usually in the morning and evening. She states that her overall body temperature alternates between hot and cold, though her hands and feet always feel cold. She reports her energy is very low, her body feels heavy and she has no appetite. She also reports losing her sense of taste. She states that there have been no improvements since the incident and she has not seen any other health care providers.

OBJECTIVE

Patient appears to be weak and has low energy. She is thin with her cheekbones protruding. She talks in a quiet and slow voice. She looks tired and her eyes are always looking down. The right side of her face is expressionless and the left side is tight. The patient's right eyelid droops down covering ¼ of her eye. The patient's right eyebrow and eye is asymmetrical to the left with the right side sitting ¼ inch lower than the left side.

Facial expression test of the 7th cranial nerve preformed were blinking the eyes, closing the eye, wrinkling the forehead, smiling and frowning. Patient is unable to close her left eye and is unable to blink. She can only close it ¼ of the way. The patient's right forehead does not wrinkle when compared to the left side. The patient refused to smile and frown when asked to. Sharp/dull sensory test showed lack of differentiation on the right side of the face. Motor facial tests of saying the sound "E" and "O" show asymmetry of the mouth. Saying "A" was symmetrical.

Patient's demeanour appears low and her eyes dull. Her face color is dark and dull and her nails are pale. Her tongue is dry with a red heart tip, white coat and quivers. Her pulse is deep and weak and very faint on the right.

ASSESSMENT

DX: Asymmetrical facial expressions of the right side of the forehead, eyebrows, eye and mouth and the loss of taste shows that the 7th cranial nerve is affected which leads to the diagnosis of Bell's palsy. Damage to the orbicular oculi is shown from the lack of passive eyelid movement. Occipitalis and frontalis muscles responsible for lifting the eyebrows and wrinkling the forehead are also affected. Mentalis, risorius, levator labii superioris and depressor labii inferioris damage is seen from the asymmetrical facial expressions of saying E, O, and smiling.

Damage of the 7th cranial nerve will affect the taste sensory of the anterior 2/3 of the tongue.

TCM DX: External Wind Cold attack of the Bladder Taiyang channel leading to blockage in the Bladder Taiyang and stomach Yangming channels with underlying Qi and Blood deficiency and Dampness from Spleen Qi deficiency.

The patient's symptoms began with a Wind Cold attack, presenting with fever and chills, slight sore throat and cough. The wind cold entered the Bladder and Stomach channel of the face, leading to Wind invasion and blockage of these channels. Wind Cold symptoms shown are vertex and occipital headache around Bl10, pain at SJ17 on the right side, twitching of the eye and twitching is worst in a cold environment and a quivering tongue. Blockage along the Stomach and Bladder channel on the face is shown by hemi facial paralysis and lack of sensation on the face.

Qi and Blood deficiency signs and symptoms are fatigue, poor appetite, dull eyes, dull and dark facial complexion, pale nails, numbness of the face, dry tongue and a deep weak and faint pulse.

Dampness signs were shown on the tongue with a white coating and a heavy feeling of the body.

PROGNOSIS: Patient seeks treatment at this clinic after one week from onset of initial symptoms. Improvement is more likely due to early diagnosis and treatment. Significant improvement may be possible with a course of 10 acupuncture treatment and 2 months of Chinese herbal medicine.

PLAN

Treatment principle: First expel Wind Cold then tonify Spleen Qi and Blood and resolve Damp.

Treatment: Acupuncture 2-3 times a week for 10 treatments, then

revaluate. Herbal treatment for 2 months.

Treatment approach is to expel Wind Cold in the Bladder Taiyang channel, treat locally on the face to unblock channels, tonify Qi and Blood and resolve Damp. Initial treatments focus on expelling Wind, followed by tonfiying Qi and Blood and resolving Damp.

Typical treatment points consists of Bl 2, Bl 10, GB8, St4, St5, St6, Du 14, Du 20, Sj 17, yu yao, Sp 6, St 36, LI4. Other points included are St40, Sj5, Si19, Sj23, Du16, GB2. A technique of pulling the drooping eyelid up and needling it up was used. Local eye and mouth points were used on the right side. Electro-acupuncture was used on the face from the 8th treatment onwards when she had more Qi and Blood to support stronger stimulation. The electro-acupuncture setting use was 100/2 hertz with mixed setting macro amp for 20 minutes. Typical electro acupuncture points connected SJ 17 to Du 16 and St 3 to St 5.

Jing Fang Bai Du San and Chuan Xiong Wan given to expel wind cold for 2 weeks. Jing Fang Bai Du San tablets were given for 3 days, taken 3 times a day. Then Chuan Xiong Wan tablets were given for 11 days, taken 3 times a day.

The expelling Wind Cold formulas were used when expelling Wind was the main treatment principle. The formula was then switched to Gui Pi Wan for two weeks to tonfiy Qi and Blood. Xiang Sha Liu Jun Zi Tang was given for a week after to tonify Spleen Qi and move Damp. Three weeks of Yu Ping Feng San is given after the last acupuncture treatment to tonify Wei Qi.

Patient was advised to eat more meat, egg or alternative protein in order to increase her energy, Qi and Blood. Patient was also advised to do facial exercises of saying "A, E and O".

OUTCOME

At the fourth consultation the patient reported that there is no more pain in her forehead and there is only an occipital headache. She reports she can sleep now due to improved symptoms in her eye and she reports she has more energy. She states that her sense of taste has returned and her appetite has improved. She reports having no sensation of the needles on the right side of her face during initial treatment and now she can feel the needles. She feels chills sometime and her eye twitches when she is in a cold environment.

Her demeanour and energy appears much better. Her eyelid droops down and covers 1/8 of her eye and she is able to close her right eye ¾ of the way. She is willing to show me her smile today but it is asymmetrical. Motor facial test of the mouth saying "E" and "O" is also asymmetrical. The right side of her mouth is still expressionless and the left side tight. The patient can now differentiate between sharp/dull sensations on the affected side. The patient's tongue has a red tip, thick white coat and no tremor.

From treatment to treatment there has been a considerable improvement. There are visible improvements of the eye and the mouth and she has more strength in her voice and color in her face within each visit.

By the 7th treatment only a small gap was left when told to close her eyes. On the 8th treatment she asked if she could discontinue treatment since she feels 80% better. Her eye and forehead has most significant improvements. The patient's mouth was still asymmetrical. The patient reports her mouth feels less tight. Her pulse was weak but stronger than before. Her right pulse was still weaker than the left pulse.

She was advised to come for the full 10 treatment since she is not fully recovered yet and will be revaluated from there. At the 10th treatment all tests were re-tested and an improvement was shown in all the tests. The patient can close her eyes fully and blink properly. Facial expressions of raising the eyebrows were symmetrical. Sharp/dull sensory test were showing the same sensations on both sides. Motor facial tests of saying the sound "E" and "O" showed slight asymmetry of the mouth. Patient reports that appetite is good, she sleeps 9 hours a night without interruption, she has more energy and her body feels lighter. There is a slight pain behind the right ear and the left side of the mouth is slightly tight.

After 10 acupuncture treatments she is not able to come anymore, therefore 3 weeks of Yu Ping Feng San was prescribed.

CONCLUSION

This patient showed rapid improvement from acupuncture and herbal medicine for Bell's palsy. This patient showed a significant improvement from acute Bell's palsy with herbal medicine and 10 acupuncture treatment 2- 3 times a week for 5 weeks. The patient was given 3 weeks of herbal medicine to boost her immune system after her 10th acupuncture treatment. For this patient, 20 acupuncture treatments would be a more appropriate course of treatment. 90% recovery was shown with 10 treatments. If recovery is to follow the same course, full recovery may be possible at 15 acupuncture treatments; and 5 more treatments after to strengthen her immune system. This case demonstrates that with early diagnosis and continuous and frequent treatment of acute Bell's Palsy using acupuncture and Chinese herbal medicine, significant result is highly possible.

3rd visit - eye closed half way

8th treatment - eye closed with no gap

More color in face, more energy, gained weight

6th treatment - saying the sound "E"

10th treatment- saying the sound "E"

CASE STUDY: Ankylosing Spondylitis

Lindsey A Thompson MAcOM EAMP LAc

Overview

25 year old male presents with low back and sacral-iliac pain beginning approximately 15 months prior to consultation at this clinic and had received a diagnosis of Ankylosing Spondylitis at a hospital in India. After eighteen treatments with acupuncture in conjunction with moxibustion and cupping therapy the AROM of the back and degree of pain significantly improved.

SUBJECTIVE

Patient is a twenty-five year old man presenting with low back pain and sacroiliac joint pain. The pain began after an injury to the low back approximately fifteen months prior to consultation at the clinic. The injury was reported at the initial consultation. The initial consultation was performed by a different practitioner. Pain is worse with cold and stress, while improved with heat, massage, and yoga. The location of the pain is reported by the patient in the low back, sacral region and the mid- to upper back. On the initial visit pain severity is reported at a 4/10 with pain medications and at a 7/10 without medication using the globally accepted NRS-11 rating system. At its worse, the pain can be so sever that it interferes with all daily activity and breathing. This would be a 7+/10 on the NRS-11 scale and concurs with the patient's self-reporting. Pain is worse at night and makes it difficult for the patient to sleep.

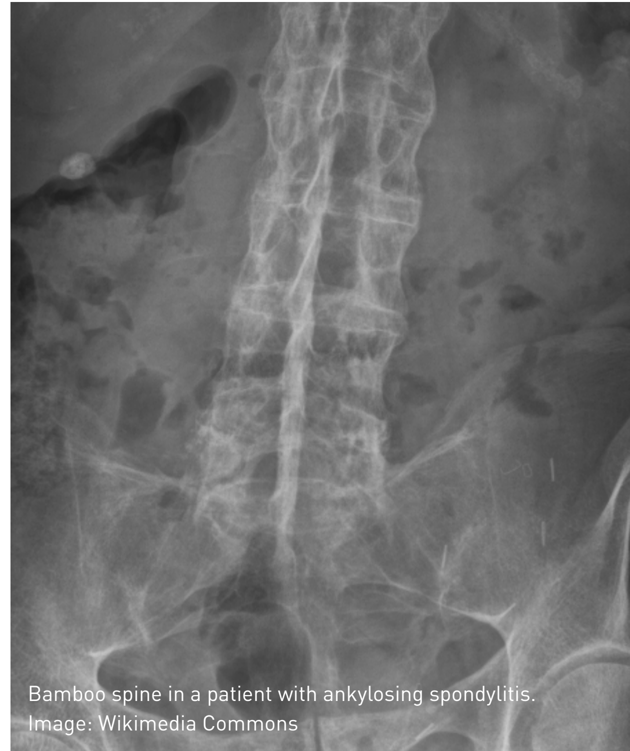
Patient has previously sought care at a hospital in India on April 9, 2012 where he did laboratory exams that include a C-reactive protein assay and radiographic imaging. The patient was given Indomethacin, an NSAID, to take 50mg QD when pain is at its worst. At the initial consultation, patient is taking the prescribed daily dose.

OBJECTIVE

Patient's overall health seems to be above average for overall environment in Nepal. Patient is of slight build, lean, with a cheerful and hopeful demeanor. Patient is a pre-med student in his fourth year and has a great deal of mental stress revolving around school.

Patient brought in radiographic imaging of the lumbar spine and pelvis taken from anterior to posterior view. The X-ray shows calcification of the anterior and posterior longitudinal ligaments of the lumbar spine with bilateral sacroiliitis. Both of these findings are suggestive of AS. The imaging also shows a reduction in bone density. The image shows normal hip joints.

Examination of the area of purported pain with palpation shows the location of the pain is limited to the sacroiliac joint and the lower vertebra of L4, L5, and S1. Pain at L4, L5, S1 is elicited with moderate to mild pressure. Palpation of the spine demonstrates hardening between the vertebra of the lumbar and sacral spine in concurrence with the calcification of the longitudinal ligaments shown on x-ray. Lumbar lordosis is reduced with significant flattening of the spine lumbar spine. Palpable tenderness is felt in the erector spinae, quadratus lumborum (QL), and trapezius muscles. Muscles are hard and rigid upon palpation.



Bamboo spine in a patient with ankylosing spondylitis.
Image: Wikimedia Commons

Examination of the active range of motion (AROM) of lumbar spine on initial visit is significantly effected. Patient demonstrates 30 degree flexion of lumbar spine with 10 degree extension, 45 degree rotation, and 10 degree lateral flexion.

ASSESSMENT

Diagnosis: Initial blood analysis taken at the hospital in India in April 2012 tested positive for C-reactive protein at a value of 12mg/L. A normal level of C-reactive protein is considered <6 mg/L. C-reactive protein is sometimes elevated in patients with active AS. The radiographic imaging that shows bilateral sacroiliitis , calcification of the lumbar anterior and posterior longitudinal ligaments, and the inflammatory back pain worse at night are all considered diagnostic for Ankylosing Spondylitis. This method of diagnostics is based on the modified New York criteria for AS, as laboratory testing can be inconsistent with AS. The modified New York criteria is as follows: The patient must have radiographic evidence of sacroiliitis and one of the following: 1)restriction of lumbar spinal motion in both the sagittal and frontal planes, 2)restriction of chest expansion, adjusted for age, and 3) a history of inflammatory back pain. The determining factors for inflammatory back pain include onset of paint at < 40 years of age, morning stiffness, improvement with activity and duration of > three months of pain. Since the patient is presenting with two, possibly three of the New York Criteria along with radiographic evidence of sacroiliitis, the patient meets the diagnostic criteria for Ankylosing Spondylitis according to the Merck Manual.

TCM Diagnosis: Liver Qi stagnation with Wind-Cold-Damp Bi syndrome, cold predominant in the Governing Vessel and Bladder meridians.

Prognosis: Due to the presences of calcification in the lumbar anterior and posterior longitudinal ligaments the prognosis is guarded. Acupuncture will not reverse the pathologic tissue changes that have already occurred, but may effectively increase

flexibility and decrease pain. Successful management of the inflammatory process in the lumbar and sacral-iliac joint, may prevent or slow further pathologic damage to the spine and surrounding tissues.

PLAN

Treatment principles: Dispel wind, resolve damp, disperse and warm cold, move liver qi and strengthen the Governing Vessel. Invigorate Qi and Blood.

The treatment plan is to treat with acupuncture for two to three times weekly with reassessment at the tenth and twentieth treatments. Treatment approach is to use Shaoyang channels to dispel wind and dampness and open up the belt channel (Dai Mai).

The back-shu points for the six yin organs are utilized on the Bladder Taiyang channel to nourish blood, yin, and the six yin organs. The Taiyang channels are also utilized to move qi and blood throughout the back. Points to strengthen and move qi through the Governing vessel are also used to promote proper bone development in the spine.

A typical treatment consists TW5 and GB41, SI3 and BL62 needled contralaterally to activate the Belt and Governing meridians, along with bilateral BL58. Other points used alternately during treatments are Hua Tou Ji Ji points for L3,4,5, S1 to move Qi and blood through the local spine or a selection of the following back- shu points BL23, BL20, BL18, BL14, BL13 to nourish the respective yin organs associated with each back-shu point. These points are used to build qi and blood, nourish the spine via the Kidneys, calm the shen and move Liver qi and liver blood. Tiger warmer moxa or direct moxa is applied to the SI joint, and along the QL muscle, and occasionally the lumbar and sacral spine to disperse cold and warm the channels. Acupuncture and moxa treatment is followed with cupping of the mid and upper thoracic spine.

For the first two months of treatment, the patient also received a weekly massage.

OUTCOME

At the third treatment the patient reported a 60% improvement in back and neck pain. He also had no stiffness upon getting off of the treatment table. On the seventh treatment the patient reported a decrease in pain medications, but did not quantify the degree of decrease in medication. Between the seventh and eleventh treatments the mid to upper thoracic muscle pain and QL muscle spasms fluctuated. At the eleventh consultation, the patient reported that back pain is much improved and is noticing an increase in flexibility. The patient also reported reducing their dose of 50 mg Indomethacin NSAID from a daily dose to only one 50mg pill in the last seven days.

The patients lumbar-sacral AROM was reassessed at the thirteenth and twenty-second consultations due to time constraints in the clinic on the patient's tenth and twentieth visits. On the thirteenth consultation, lumbar flexion was 80 degrees, extension 15 degrees, lateral flexion 5 degrees and spinal rotation at 45 degrees.

AROM on the twenty-second consultation with lumbar extension measuring 40 degrees and lumbar flexion measuring 85 degrees. Lateral flexion and spinal rotation were neglected in the assessment. AROM at the initial consultation was 30 degree flexion of lumbar spine with 10 degree extension, 45 degree rotation, and 10 degree lateral flexion.

Normal degrees of lumbar flexion are 60 degrees, extension 25 degrees, lateral flexion 25 degrees, rotation 30 degrees. At the twenty-second consultation, the patient was well above normal degrees of AROM in extension and flexion. On the 13th consultation, the degree of rotation was above normal with lateral flexion still below normal and below that of the initial consultation. It is unfortunate that lateral flexion was neglected to be assessed on the 22nd consultation.

From treatment to treatment the patient reported fluctuations of pain in the muscles of the mid- to upper thoracic spine and intermittent muscle spasms in the left QL. At times the patient was excited about the increase in flexibility, but disappointed in the slow nature of progress on his case. The patient also expressed disappointment in the frequent return of muscular pain in the mid-thoracic, trapezius and QL muscles. The patient spends a great deal of time at a desk, studying and in a high stress environment with his medical pursuits in school. The patient also typically studies until 3AM, only sleeping from 3AM to 9 or 10AM. The patient's lifestyle of prolonged sitting, poor ergonomics, late night studying, and stress are more likely to contribute to the frequent return of muscle pain and spasm in the mid- to upper back than to be a complicating factor of AS.

CONCLUSION

The patient experienced significant reduction in pain and increase in AROM of the saggital plane, therefore it is advised to continue treatment one to two times a week for the next four to ten months to continue improvement of his symptoms. The increases of AROM along the saggital plane is particularly exciting because the patient developed AROM greater than normal AROM for the general populace. However, the patient lacked improvement along the frontal plane, and it is hoped with continued treatment that positive changes in AROM would increase as did those of the saggital plane. The muscular pain of the mid- to upper back improved at each treatment, but returned within a few days each time. The return of muscular pain most likely related to the poor ergonomics, prolonged sitting, and stress of studying for medical school and exams. The reduction in frontal plane AROM could relate to the frequent recurrence of spasm in the QL. Until the ergonomics of studying can fully be addressed, it is likely that muscles spams will intermittently come and go.

At the time of writing this case study, the patient ceased treatment of his own accord, against advice of the practitioner. The patient did have a month to study before taking his final examinations for the scholastic portion of his medical education. After the exams he will enter into his hospital rotation. The timing of his examinations could also have caused the patient to cease treatment temporarily, but this was not communicated to the practitioner.

With a complicated illness such as Ankylosing Spondylitis, a normal course of treatment would involve six months to a year of regular acupuncture treatments. Given that the patient had such great successes in frontal AROM in under two months, it is likely that the patient would receive significant benefit from a full course of treatment of six months to one year.

CASE STUDY: Bilateral Leg Weakness and Paralysis

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Overview

42 year old female presents with an inability to walk due to partial bilateral leg paralysis with a slow onset occurring over a 15 year time span. After 23 treatments focussing on strengthening the Du and Kidney channels with acupuncture, electro-stimulation and moxabustion, the patient gained a significant degree of improvement in both sensory and motor function in her lower limbs.

SUBJECTIVE

Patient believes her condition originally started 15 years ago while she was living in the mountains in freezing cold weather for a year and a half. Often she would become so cold that her limbs would go numb. Symptoms started 12 years ago while she was 5 months pregnant with her second child. She noticed having a difficult time walking up hills and would have to stop regularly because she was experiencing low back pain and her whole body felt heavy, especially her left leg and arm. After the birth of her son she considered seeking help for these symptoms because the severity was increasing and slowing her daily chores, but she reports she couldn't due to her responsibility to her family. Her strength progressively decreased over the next few years until she had to start using a cane to walk around due to the weakness in her legs and arms.

Patient reports she had treatment from a Korean medical practitioner which ended 30 days prior to beginning treatment at the Vajra Varahi Medical clinic. Treatment consisted of massage with heat daily for 60 days which according to the patient resulted in a significant recovery of strength in both arms.

Finally she sought medical help 9 years ago. A complete X-ray, CT scan and MRI were performed at the Blue Cross in Kathmandu. Patient reports she has misplaced the CT scan so is only able to produce her MRI reports and the attached paperwork is mostly eaten up by rats.

Patient reports that she experiences the occasional cold hands and feet. Her urination and bowels are appropriate and regular. She sleeps easily with mild fatigue in the mornings. She has no headaches, dizziness, or ringing in the ears. She has a 30 day menstruation cycle, with mild breast tenderness for 2 days prior and the flow lasting for 4-5 days, and dime size clots with no cramping before during or after the cycle. Her vital signs are normal.

Patient also has a sharp local pain bilaterally at the lumbosacral area which rates a 7 in accordance with the standard NRS-11, and posterior knee pain, which rates at a 5.

OBJECTIVE

Patient is roughly 5'5, 130lbs, with a happy go lucky attitude. When she speaks she has a sweet high pitched voice which is reminiscent of a small child. She is extremely proud; not accepting any assistance in or out of the treatment room. She appears optimistic that acupuncture will help her.

At this time she cannot stand on her left leg or flex from that hip or knee while walking, as it drags behind her while she walks. She can stand on her right leg as well as flex the right hip about

5 degrees to take a small step but has to gain momentum using a twisting swinging motion as well as her upper body strength and gravity to kick forward. Her legs tremble slightly while attempting to stand still.

Comparing the left leg to right, patient can feel light touch bilaterally on all dermatomes, with no differentiation between sharp/dull sensations, or hot/cold from L5-S1 dermatomes bilaterally up to patient's knees.

While lying supine she cannot actively flex, extend, adduct or abduct the hip, knees, or ankles bilaterally or flex the abdomen to perform a sit up. While sitting she can actively flex the knees 15 degrees, as well as extend the knees 45 degrees. Patient cannot wiggle toes bilaterally while sitting or lying supine.

Active and passive range of movement is normal in the shoulders

and elbows. Active wrist flexion is normal, active wrist extension is compromised at 5 degrees. All passive ROM in upper limbs are normal. Active finger movements are inhibited with the left index and middle finger, and right index finger flexion decreased to 15 degrees. Patient cannot straighten these 3 fingers either. Grip strength is decreased 50% on the left compared to the right.

Patellar reflex: 1+ Bilaterally, Achilles reflex: 0 Bilaterally.

Testing passive proprioception of the big toe showed no differentiation between flexion or extension. Babinski test is unresponsive.

Pulse is thin and deficient on left, disappearing with strong pressure. Stronger on the right with a slightly wiry quality, especially in the middle position.

Tongue is thin, pale, especially in the center with red dots on the tip.

ASSESSMENT

DX: The MRI performed by the Blue Cross of Kathmandu showed no evidence of inflammation or lesions in the brain or spinal cord or evidence of upper motor neuron damage. She was diagnosed with a probable primary demyelinating of L5-S1 nerve root of which the cause is unknown. According to the Merck Manual primary demyelinating disorders are suggested by diffuse or multifocal deficits, and demyelination should be considered in any patient with unexplained neurological deficits.

TCM: Kidney Yang deficiency, Cold stagnating the Du channel.

Prognosis: Due to the fact she has gone untreated for 12 years it is unlikely this patient will fully recover from acupuncture alone. Being that this patient has reported that she has recovered significant improvement in function of her arms with massage/heat alone, one month prior to consultation at this clinic, it is hopeful that with acupuncture treatment that this patient will regain some degree of motor function in her lower limbs as well as a decrease in the sensory deficit associated with her neuropathy. It is also hoped that she will experience some reduction in knee and back pain.

INITIAL PLAN

Patient recommended initially to receive acupuncture 3-4 times a week re-evaluating at treatment 20. Typical points include KD 3 with UB 58 with moxa to tonify the kidney, and warm the Du channel. UB 40 to bring qi and blood to the knees, SI 3 with UB 62 to open the Du channel. Huatojiaji points from L4-S2 to KD 3 with electro-stimulation at 100hz continuous for 20 minutes to stimulate S1 nerve root.

Lower 1/3 of scalp motor points were used in the first few treatments with strong stimulation.

OUTCOME

After 20 treatments this patient reported being able to stand for a few minutes without a cane and being free of her leg trembling. She can also stand for a few seconds on her left leg and a few more seconds on her right leg compared to her initial presentation. Patients back pain has reduced to a 2 compared to previously being a 7.

She is able to slightly flex her left hip 5 degrees and extend the knee while walking whereas before she had to swing her leg completely from the right hip to take a step. Her right hip is now able to flex 30 degrees to take a larger step. No change in ankle flexion and dorsiflexion. Both knees are free of pain, and active global ROM is now normal in the knee while sitting.

Sharp/dull tests still shows no change in sensory deficit from the dermatomes L5-S1, however, patient reports she is now able to feel temperature changes in her first and second toes on the left side, as well as gained more feeling in general in both legs.

CONCLUSION

Even though it is unlikely that this patient will regain full strength in her legs again it is recommended she continue acupuncture 2x weekly for at least another 2 months or until patient reaches a plateau. After 20 treatments with acupuncture she has experienced a 100% reduction in knee pain, 90% in her back pain, and regained some ability to feel temperature changes as well as experienced improvement in strength and ROM in both legs. Also, this patient feels lighter in her body all of which add to the quality of her life. As a result of the improvement so far it is quite possible she will continue to regain further sensory and motor function in both legs.