Compendium of Clinical Case Studies

Vajra Varahi Clinic, Chapagaon Nepal

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 tonifiy 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 excercises 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 sympotms. 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 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 Sequella)

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

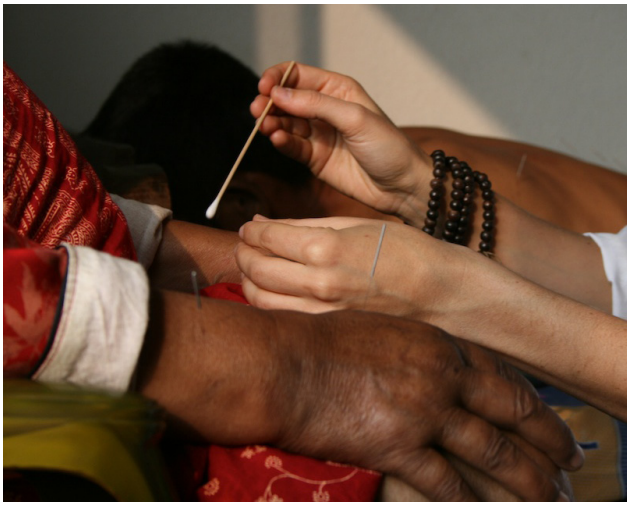
Sixty five year old female presents with dyspnea and continuous cough. The patient also presents with chronic severe pain and inflammation of all joints of the hands and feet. With regular acupuncture and herbal treatment the patient experienced a 6% O2 increase on the oximeter, more than a 50% reduction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

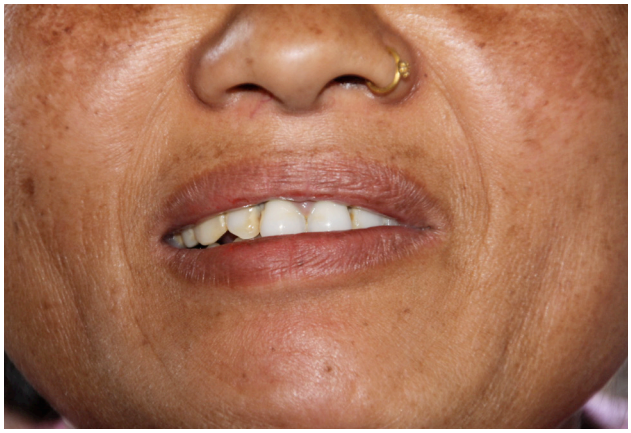
TCM DX: LR Wind Rising due to LR Blood Xu

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.

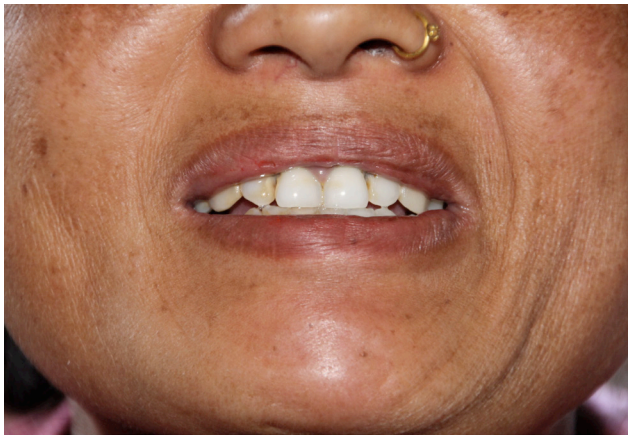
INITAL PLAN

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.

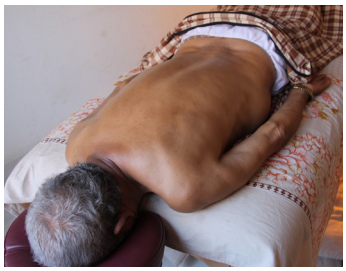
Massage for Chronic Back Pain Associated with Spondylosis of the Spine

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).

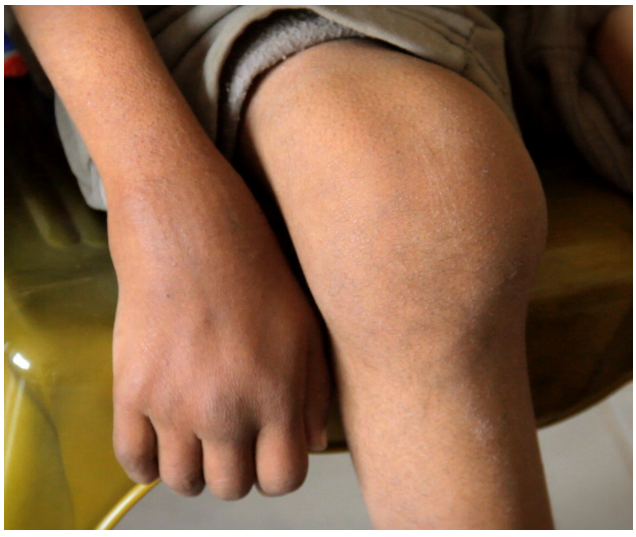
Elbows: lateral epicondyles were enlarged, rounded (2X normal), bony-hard, cool, without erythema or edema, and non-tender. Limited extension to ~145 degrees.

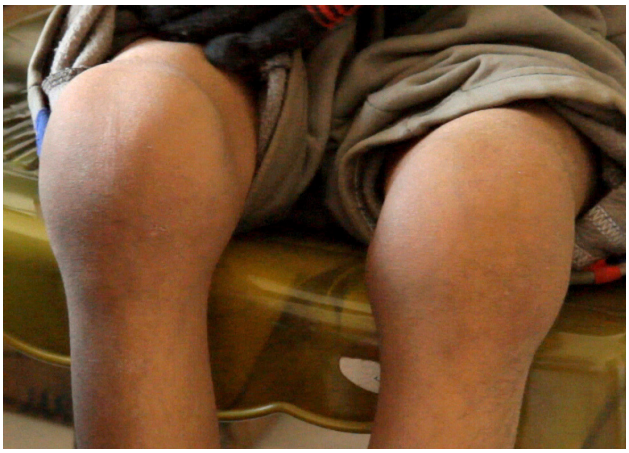
Wrists: mildly enlarged (<2X), bony landmarks obscured to palpation, non-tender. No active or passive extension. Active/passive flexion ~ 20 degrees. Inversion/eversion <10 degrees with mild crepitus of right wrist.

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:

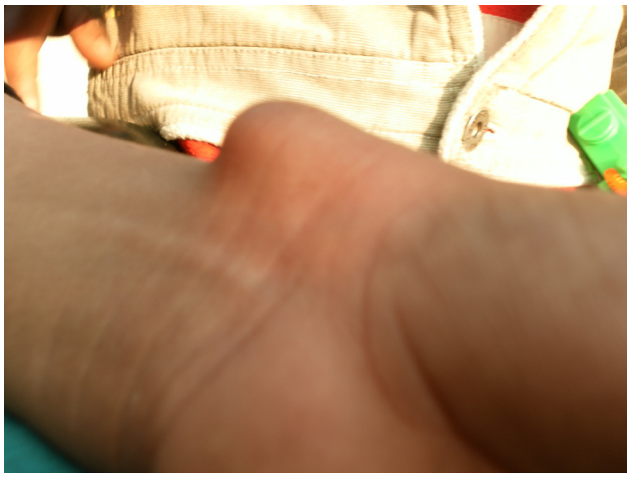
X-ray of left wrist, July 20th, 2010 (1 ½ years prior to current treatments) - No abnormal bone growth is shown

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.