

ISSN: 1745-6843
Volume 24 Issue 1
第24卷 第1期



英国
中医
针灸
杂志

**The Journal of Chinese Medicine
And Acupuncture**

An Official Academic Journal of
Association of Traditional Chinese Medicine and Acupuncture UK

30th March 2017

英国中医药学会会刊

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	rhinitis, sinusitis, loss of smelling sense				LV3, BL13, BL2, LU7
49	Aphasia (loss of speech) / loss of voice	Over 60	231	12	LI4, Ren23, DU15, KI1, PC6, Jin Jin Yu Ye, DU26, Ren22, LI6, HT7, HT5, LU7
50	Throat disorders	Over 60	328	12	LI4, LU11, LI11, DU14, Ren22, ST9, Ren23, KI6, KI3, ST44, LU10, LU5

Notes:

*: the figures are the total numbers of individual acu-points used in all studies for the disease. Repetitively used points in different studies are counted only once.

***: the figures are the total numbers of all acu-points used in all studies for the disease. Repetitively used points in different studies are counted repetitively.



Treating Tension-Type Headache with Acupuncture: Evidence from Research and Methodological Pitfalls

Attila Szanto PhD

Abstract

The aim of this paper is to assess the available evidence on the efficacy of acupuncture in the treatment of tension-type headache (TTH). The paper reviews six randomised controlled trials (RCT) that compare verum acupuncture (defined as the needling of TCM acupuncture points) with sham (blunt needling or superficial needling of non-acupuncture points). As the discussion below reveals, the results are somewhat mixed. Some studies have identified a significant benefit of verum acupuncture over sham while other studies conclude that verum acupuncture is not superior to sham. Nevertheless, all studies acknowledge that both verum and sham acupuncture have significant clinical benefits in reducing the frequency and/or severity of TTH. A closer look at the studies, however, reveals significant methodological shortcomings of the RCT trials conducted on this topic to date. These trials operate with an overly simplistic notion of acupuncture that disregards core TCM principles such as differential diagnosis and individualised point selection to the extent that doubts regarding the validity of findings arise. Inevitably, more and better-designed studies are required to assess the efficacy of TCM acupuncture in the treatment of TTH.

Keywords: tension-type headache, acupuncture

Introduction

Tension-type headache (TTH) is the most common form of headache and according to the International Headache Society affects up to 80 percent of the population at some point in their life (IHS 2013, p. 659). It is a common cause of occupational absence and has a substantial economic impact; a longitudinal study revealed a 10 percent increase in the occurrence of TTH between 1989 and 2001 (Davis *et al.* 2008, p. 667).

Tension-type headache in Western medicine

The National Institute for Health and Care Excellence distinguishes three types of *primary* headache: tension-type headache, migraine and cluster headache (NICE 2016a). These differ from *secondary* headaches that may have similar symptoms but are caused by an

underlying health problem, injury or medication. Once the diagnosis of secondary headache has been ruled out, TTH can be diagnosed and distinguished from other headaches as follows: (see Table 1 on next page)

Little is known about the causes of TTH (IHS 2013, p. 659) but it is suspected that poor health status, stress and insomnia contribute to the condition (Davies *et al.* 2008, p. 667). TTH is commonly treated with painkillers such as Aspirin, Paracetamol or NSAIDs. For sufferers of chronic TTH (i.e. headaches on 15 or more days per month), NICE (2016c) recommends up to ten sessions of acupuncture.

Headache type	Location	Type of pain	Intensity	Duration
Tension-type headache	Both sides of head, face or neck	Sensation of pressing or tightness around the head	Fairly painful	30 minutes or longer
Migraine	Either one or both sides of head, face or neck	Pulsating, throbbing or banging Sensitivity to lights or sounds Nausea or vomiting	Very painful	4 hours to 3 days
Cluster headache	One side of head or face and around one eye	Sharp, burning, throbbing, drilling or tightening pain. Restlessness. Sweaty forehead or face. Red or watering eye on the side of the headache.	Extremely painful	Up to 3 hours at least every other day, for at least 2 weeks

channel, patterns and pain²

In treating headaches, acupuncturists consider all the above factors and subsequently devise a treatment tailored to the unique combination of symptoms and underlying patterns present in a patient.

Table 1: Types of primary headache¹

Headaches in Traditional Chinese Medicine

By virtue of their widespread occurrence, headaches assume a prominent position in Traditional Chinese Medicine (TCM). In diagnosing and treating headaches, TCM practitioners distinguish between a number of factors, such as the nature and location of the pain, the acupuncture channels involved and the underlying patterns of disharmony (see Maciocia 2008, p. 1-65). Table 2 summarises the main types of headache recognised by TCM.

Location	Involved Channel	Main Patterns and Type of Pain
Top of the head	• Liver Channel	• Qi and/or Blood deficiency (dull pain) • Liver Yang rising (throbbing pain)
Sides of the head incl. temples	• Gallbladder Channel • San Jiao Channel	• Liver Yang rising (throbbing pain) • Liver Fire (throbbing pain)
Behind the eyes	• Liver Channel	• Liver Blood deficiency (dull pain) • Liver Yang rising (throbbing pain)
Forehead	• Stomach Channel • Large Intestine Channel	• Stomach deficiency (dull pain) • Stomach Heat (sharp pain) • Dampness/Phlegm (dull pain, head feels heavy) • External Pathogenic Factor (EPF) (acute pain)
Occiput	• Bladder Channel	• Kidney deficiency (chronic dull pain) • EPF Wind (acute pain, stiffness)
Whole head		• Kidney Yin deficiency (chronic dull pain) • EPF Wind (acute pain)

Table 2: Headaches by location, involved acupuncture

That is, there is no standardised TCM treatment for headaches and the points needled will differ from patient to patient. Nevertheless, one might assume that, whatever the location of pain, practitioners will consider needling both local and distal points. For example, a frontal headache might be treated by needling ST 8 (Touwei) and ST 44 (Neiting), while GB 8 (Shuaigu) and SJ 5 (Waiguan) might be selected in the case of a temporal headache.

Methods

In order to assess the available evidence on the efficacy of acupuncture in the treatment of TTH, a systematic search for peer-reviewed research papers containing the words “acupuncture”, “tension” and “headache” in the title was conducted in February 2016 using Google Scholar, Acupuncture in Medicine (www.aim.bmj.com), European Journal of Oriental Medicine (www.ejom.co.uk), The Journal of Chinese Medicine (www.jcm.co.uk) and PubMed (www.ncbi.nlm.nih.gov/pubmed). Overall, 93 potentially relevant papers were evaluated using the following criteria for inclusion:

- Articles that report the outcome of a randomised controlled trial (RCT), whereby patients in the treatment group receive verum acupuncture and patients in the control group receive sham acupuncture;
- Articles that reports the findings of primary research or conduct a meta-analysis of such articles;
- The entire article (not just the abstract) is available in English.

Case reports or pilot studies with less than ten participants; trials that compare acupuncture with

¹ This is a condensed version of the table published at NICE (2016b).

² Table compiled by the author based on Maciocia 2008, p. 6-16.

other therapies (e.g. physiotherapy); articles that focus on research methodology rather than the outcome of research; and trials involving electro acupuncture were not included.

The following eight articles were identified to meet the above criteria.

- **Davis, M et al.** (2008) Acupuncture for Tension-Type Headache: A Meta-Analysis of Randomized, Controlled Trials. *The Journal of Pain*
- **Endres, H et al.** (2007) Acupuncture for tension-type headache: A multicentre, sham-controlled, patient-and observer-blinded, randomised trial. *Journal of Headache Pain*
- **Hansen, P and Hansen, J** (1985) Acupuncture treatment of chronic tension headache: A controlled crossover trial. *Cephalalgia*
- **Karst, M et al.** (2001) Needle acupuncture in tension-type headache: A randomized, placebo-controlled study. *Cephalalgia*
- **Linde, K et al.** (2009) Acupuncture for tension-type headache (Review). *The Cochrane Library*
- **Melchart, D et al.** (2005) Acupuncture in patients with tension-type headache: Randomised controlled trial. *British Medical Journal*
- **Tavola, T et al.** (1992) Traditional Chinese acupuncture in tension-type headache: A controlled study. *Pain*
- **White, A et al.** (2000) Acupuncture for episodic tension-type headache: A multicentre randomized controlled trial. *Cephalalgia*

Results

The discussion focuses on six articles that report the findings of primary research, while the two articles that conduct a meta-analysis of RCT trials (Davis *et al.* 2008 and Linde *et al.* 2009) will be discussed in the next section.

Endres *et al.* (2007) report the outcome of a randomised, controlled, multicentre, patient- and observer-blinded trial carried out in Germany on 409 patients with a long-standing history of TTH and ten or more headache days per month (Endres *et al.* 2007, p. 307). 209 of these patients received verum acupuncture while 200 received sham acupuncture consisting of superficial needling at non-acupuncture points. Each patient received ten 30-minute sessions over a six-week period. Verum treatment consisted of needling DU 20 (Baihui), LI 4 (Hegu), LIV 3 (Taichong) and GB 20 (Fengchi), but practitioners were allowed to select additional points.

Treatment success was measured as the reduction in headache days. Six months after commencement of treatment, 66% of verum patients reported a reduction in headache days per month by at least 50%, compared to 55% of sham patients. On average, verum patients reported 1.8 fewer headache days than sham patients

(Endres *et al.* 2007, p. 312). The authors conclude that '[b]oth true and sham acupuncture led to persisting, clinically relevant improvements in outcome' (ibid., p. 310), with acupuncture offering a statistically significant benefit over sham.

These results are consistent with those of an early patient- and observer-blinded Danish study (Hansen and Hansen 1985). This study looked at a relatively small sample of 36 long-term TTH sufferers each of which were subjected to both verum and sham treatments: 18 patients received six sessions of verum acupuncture over a three-week period, followed by a three-week break and a further six sessions of sham; the remaining 18 patients received six sessions of sham acupuncture followed by six verum treatments. A fixed set of points – GB 20 (Fengchi), LI 4 (Hegu) and BL 60 (Kunlun) was needled in the verum group. Sham treatment consisted of superficial needling of nearby non-acupuncture points (Hansen and Hansen 1985, p. 137-139).

Outcome was measured as the combined frequency and intensity of pain (the so called Period Index) during the three weeks before the first course of treatment (Period 1), the three weeks between the two courses of treatment (Period 2) and the three weeks following the second course of treatment (Period 3). The results showed a greater and statistically significant reduction of pain frequency and intensity in patients who received verum acupuncture.

Table 3: Effects of verum and sham acupuncture on pain frequency and intensity*

Treatment Sequence	Period Index		
	Period 1	Period 2	Period 3
Verum followed by sham treatment	42.2	26.4	30.1
Sham followed by verum treatment	40.7	35.2	30.9

* Table adapted from Table 3 (Hansen and Hansen 1985, p. 140)

Despite their different research design, both studies discussed above conclude that both verum and sham acupuncture have a significant positive effect on pain frequency or intensity. That is, patients benefit from being needled even if non-TCM points are needled. Yet while both Endres *et al.* (2007) and Hansen and Hansen (1985) conclude that verum acupuncture is significantly more effective in treating TTH than sham, the results of the four studies discussed below are somewhat mixed.

In a patient- and observer-blinded study conducted in Germany by Karst *et al.* (2001), 69 TTH patients received ten 30-minute sessions of acupuncture over a five-week period. The study trialled a new placebo method that causes a pricking sensation to the skin

without actually penetrating it. Verum treatment consisted of needling GB 20 (Fengchi), LI 4 (Hegu) and LIV 3 (Taichong) and optional additional points up to 15 needles in total (Karst *et al.* 2001, p. 637-639).

Outcome was measured as a reduction of pain intensity on the visual analogue scale, ranging from 0 (no pain) to 10 (strongest pain). Five months after the last treatment, pain intensity decreased in both verum and sham patients significantly, from an average of 6.4 to 4.4 in the verum group and 6.4 to 4.8 in the sham group (Karst *et al.* 2001, p. 640.). Headache days per month decreased in both verum (from 21.1 to 16.7) and sham groups (from 20.5 to 17.2) (*ibid.*). Six weeks after the end of treatment analgesics intake decreased by 41% in the verum group but increased by 66% in the placebo group (*ibid.*, p. 639). However, the apparent benefits of acupuncture were statistically not significant.

The issue of statistical significance is even more pronounced in a study conducted by Tavola *et al.* (1992). In this patient- and observer-blinded study 30 patients with eight years of TTH on average were randomly assigned to two groups of equal size. All patients received 12 treatments over an eight-week period. Sham patients received up to 12 needles inserted superficially into nonacupuncture points. The authors do not specify the points needed in the verum group but claim that '[t]he choice of points was made on an individual basis relative to the evaluation of the patient's 'energy' status according to the criteria of traditional Chinese acupuncture' (Tavola *et al.* 1992, p. 326).

Table 4: Design of the six RCT trials(see above)

One month after the last treatment, headache frequency decreased by 44.3% in the verum group compared to 21.4% in the sham group. The Headache Index (computed as headache Intensity x Duration x Frequency / 30) decreased by 58.3% in the verum group compared to 27.8% in the sham group. Analgesic consumption decreased by 57.7% in verum patients compared to 21.7% in sham patients (*ibid.*, p. 327). However, the authors argue that the seemingly spectacular benefits of verum acupuncture are statistically not significant due to the small sample size and 'the wide dispersion of the values of the parameters considered able to nullify even the

differences of 48%, 46% and 23% between acupuncture and placebo-treated patients' (*ibid.*, p. 328).

Study	Treatment	Acupuncture Group		Sham Group	
		N	Points needed	N	Method
Endres <i>et al.</i> (2007)	10 sessions over a 6-week period	209	DU20, LI4, LIV3, GB20 plus optional points	200	Superficial needling at nonacupuncture points
Hansen & Hansen (1985)	6 sessions over a 3-week period	18	GB20, LI4, BL60	18	Superficial needling at nonacupuncture points
Karst <i>et al.</i> (2001)	10 sessions over a 5-week period	34	GB20, LI4, LIV3 plus optional points	35	Blunt needling (skin not penetrated)
Melchart <i>et al.</i> (2005)	12 sessions over an 8-week period	132	GB20, GB21, LIV3 plus optional points	63	Superficial needling at nonacupuncture points
Tavola <i>et al.</i> (1992)	8 sessions over an 8-week period	15	Unclear	15	Superficial needling at nonacupuncture points
White <i>et al.</i> (2000)	6 sessions over a 6-week period	23	GB20, LI4, BL60 plus optional points	23	Blunt needling (skin not penetrated)

Table 4: Design of the six RCT trials

In conclusion, both Karst *et al.* (2001) and Tavola *et al.* (1992) argue that both verum and sham acupuncture have significant clinical benefits for TTH but that the apparent benefits of verum over sham are statistically not significant. In this respect their conclusions differ from the two RCT studies yet to be discussed.

Like Endres *et al.* (2007), Melchart *et al.* (2005) designed a decentralised study with a large sample size of 270 participants, carried out across 28 outpatient centres in Germany. 132 patients received verum acupuncture consisting of GB 20 (Fengchi), GB 21 (Jianjing) and LIV 3 (Taichong), with additional points needed as appropriate. 63 patients received sham (superficial needling at non-acupuncture points). As a unique feature of this study, 75 patients were placed on a waiting list and received no treatment at all. Both verum and sham patients received 12 treatments over an eight-week period and were allowed to treat acute headaches with analgesics provided they recorded this in a headache diary.

Treatment success was measured as the reduction of headache days during the four weeks following the last treatment. In the acupuncture group, headache days decreased by 7.2 per month compared to 6.6 in the sham group and 1.5 in the waiting list group (Melchart *et al.* 2005, p. 3-5). 46% of patients in the acupuncture group, 35% in the sham and 4% in the waiting list group experienced a reduction in headache days of at least 50% (*ibid.*), but the differences between verum and sham acupuncture were statistically not significant.

The final RCT study discussed here is that of White *et al.* (2000) and was carried out across multiple NHS funded health centres in the UK. The study involved 50 participants, of which 25 received verum and 25 sham

treatments. Like in the study by Karst *et al.* (2001), sham acupuncture involved blunt needling at non-acupuncture points using a cocktail stick. Patients received six treatments over a six-week period. Verum patients were needled at GB 20 (Fengchi) and LI 4 (Hegu), but in some cases GB 20 was substituted for a nearby tender spot. Practitioners were allowed to select up to four optional points on the head and shoulders. The study involved an unusual needling technique: points were needled in succession with a single needle; each point was stimulated for 15 seconds and no needles were retained.

Outcome was measured as a reduction in headache days, duration and severity, comparing the three-week pre-study period with the three weeks following the first six treatments. Findings revealed a reduction in headache days per week from 4.3 to 2.7 in the verum and 3.6 to 2.5 in the sham group. Headache duration decreased from 24.4 to 10.7 hours per week in the verum and 19.9 to 11.6 in the control group. 60% of verum patients reported a decrease in headache days by 50%, compared to 40% of sham patients (White *et al.* 2000, p. 634). However, these differences were statistically not significant and led the author of a review article comment: 'A cocktail stick is as good as brief acupuncture in episodic tension-type headache' (Cummings 2001, p. 56).

Table 5: Summary of the main findings of the RCT trials discussed above

Study	Main findings
Endres <i>et al.</i> (2007)	<ul style="list-style-type: none"> Both TCM and sham acupuncture reduce number of headache days/month TCM acupuncture is more effective than sham acupuncture
Hansen & Hansen (1985)	<ul style="list-style-type: none"> TCM acupuncture is significantly more pain relieving than sham
Karst <i>et al.</i> (2001)	<ul style="list-style-type: none"> Both TCM and sham acupuncture reduce pain frequency and intensity TCM acupuncture is more effective than sham acupuncture (but the difference is statistically not significant) Analgesics intake decreased in the TCM but increased in the sham group
Melchart <i>et al.</i> (2005)	<ul style="list-style-type: none"> Both TCM and sham acupuncture have clinical benefits over no treatment TCM acupuncture is not more efficient than sham acupuncture
Tavola <i>et al.</i> (1992)	<ul style="list-style-type: none"> Both TCM and sham reduce headache frequency and analgesic intake TCM acupuncture is more effective than sham acupuncture (but the difference is statistically not significant)
White <i>et al.</i> (2000)	<ul style="list-style-type: none"> Both TCM and sham acupuncture reduce headache frequency and severity TCM acupuncture is not more efficient than sham acupuncture

Discussion

What do the RCT trials discussed above reveal about the efficacy of acupuncture in treating TTH? The results are, as it might have been expected, mixed. All six studies conclude that both verum and sham acupuncture have significant clinical benefits for patients with TTH and help reduce the frequency and intensity of headaches, or the intake of painkillers. Yet which method is more efficient: verum or sham?

- Two studies (Endres *et al.* 2007; Hansen and Hansen 1985) conclude that verum acupuncture is

significantly more beneficial in the treatment of TTH than sham;

- Two studies (Karst *et al.* 2001; Tavola *et al.* 1992) conclude that although verum acupuncture appears to have benefits over sham, the differences are statistically not significant;
- Two studies (Melchart *et al.* 2005; White *et al.* 2000) argue that the differences between verum and sham acupuncture are too small to be clinically relevant.

Overall, the results suggest that verum acupuncture is efficient in treating TTH and also appears to have some advantage over sham. This is consistent with the findings of two meta-analyses (Davies *et al.* 2008; Linde *et al.* 2009). Based on complex statistical calculations with aggregated data from eight and eleven RCT trials respectively, both papers conclude that verum acupuncture has a small but statistically significant benefit over sham regarding headache frequency and intensity (Linde *et al.* 2009, p. 2; Davies *et al.* 2008, p. 675). Long-term pooled data of five high quality RCTs demonstrated 1.34 fewer headache days per month and 3.74 points lower headache intensity (Davies *et al.* 2008, p. 674). Inevitably, more studies are required to support this conclusion and resolve the discrepancies between the studies conducted to date.

There is, however, more to be said about the subject. The discussion so far has implicitly accepted that the above studies are of a sufficiently high quality to make

statement
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as a measure of quality.

An essential quality criterion for any RCT trial is that of validity, 'defined as the extent to which a concept is accurately measured in a quantitative study' (Heale and Twycross 2015, p. 66). That is, a survey designed to measure the efficacy of TCM acupuncture but which operates with a simplified notion of acupuncture could not be considered to meet the validity criterion. The above trials claim to measure the efficacy of TCM acupuncture and hence, in order for their findings to be valid, their methodologies must conform to those of TCM. This is important since the consequences of

operating with an oversimplified notion of acupuncture would not only be detrimental to TTH patients (who

Table 6: Evidence of the application of TCM principles in the studies discussed above

Publication	TCM diagnosis	Point selection	Background of study authors*	Background of practitioners administering treatment
Endres et al. (2007)	No evidence	Fixed (DU20, LI4, LIV3, GB20); flexibility for optional points	Western medical doctors	Physicians with specialist acupuncture training
Hansen & Hansen (1985)	No evidence	Fixed (GB20, LI4, BL60)	Western medical doctors	Most likely physicians with specialist acupuncture training
Karst et al. (2001)	No evidence	Fixed (GB20, LI4, LIV3) with flexibility for optional points	Western medical doctors	Unclear
Melchart et al. (2005)	Evidence	Fixed (GB20, GB21, LIV3) with flexibility for optional points	Western medical doctors	Most likely physicians with specialist acupuncture training
Tavola et al. (1992)	No evidence	Points selected by practitioner	Psychiatrists	Unclear
White et al. (2000)	No evidence	Fixed (GB20, LI4, BL60) with flexibility for optional points	Western medical doctors	Physicians with specialist acupuncture training

would not receive the best available treatment) but also negatively impact on the perception of TCM acupuncture in the Western scientific community.

I will therefore conclude this paper by highlighting four methodological shortcomings of the above studies.

First, five of the six RCTs lack evidence of the application of TCM principles in the diagnosis or treatment of TTH. These studies do not differentiate TTH by its location (e.g. *shao yang* as opposed to *yang ming*); affected acupuncture channels (e.g. *Stomach* as opposed to *Gallbladder* channel); its type (e.g. a *deficiency* type headache resulting in dull pain as opposed to an *excess* type headache resulting in sharp pain); or cause (e.g. *Liver Yang Rising*) (see Table 6 below).

Second, a key principle of TCM acupuncture is the individualised selection of points, based on the differential diagnosis of patterns and causative factors, the location and nature of pain and affected acupuncture channels (see Maciocia 2008, p. 6-16). Ignorant of this imperative, five of the six studies involved the needling of fixed points (with some flexibility for selecting additional points); only one study (Tavola *et al.* 1992) allowed practitioners to select points freely but did not specify which points these were. While points such as GB 20 (Fengchi), LIV 3 (Taichong) or LI 4 (Hegu) may in some circumstances be indicated for TTH, the very notion of fixed points is at odds with the TCM principle of tailoring treatments to the individual and the unique way in which his or her symptoms manifest. For example, GB 20 (Fengchi) may be indicated in TTH affecting the lateral side of the head but would not be the first option in treating frontal headaches. Standardisation, which is key to Western medicine, is at odds with the highly individualised discipline of acupuncture that its most distinguished practitioners would liken to an art (Kapchuk 2000, p. 283).

* As indicated by authors' institutional affiliation

Third, one might argue that in order to assess the efficacy of TCM acupuncture in the treatment of TTH, studies ought to be designed and carried out by TCM acupuncturists rather than Western medical doctors. However, all studies discussed above were authored by Western medical doctors (neurologists, psychiatrists, anaesthesiologists), and in four studies treatments were performed by Western medical doctors (with the background of practitioners being unclear in the remaining two studies). These practitioners received specialist acupuncture training, but the extent to which they embrace TCM principles remains unclear.

Fourth, none of the studies discuss the peculiar role of placebo in acupuncture. From a TCM perspective, the placebo effect is both desirable and intrinsic to treatment success: the patient's expectation to benefit from acupuncture aids relaxation, which in turns helps relieve Qi stagnation that is often implied in TTH. Therefore, one might argue that in the studies discussed both "verum" and "sham" patients in fact received *verum* (albeit not necessarily TCM) acupuncture. Arguably, any needle inserted into the body will produce at least some physiological effect, that is, it will move Qi.

In conclusion, while all RCT trials claim to make statements about verum or TCM acupuncture, the above analysis suggests that this claim is largely unjustified. It is important to note that the needling of TCM acupuncture points does not necessarily constitute a TCM treatment. Rather, one might conclude that the studies discussed have measured the efficacy of an oversimplified notion of acupuncture, rather than of TCM acupuncture itself. Therefore, more and better-designed studies are required to assess the efficacy of TCM acupuncture in the treatment of tension-type headache.

References

- Cummings, M (2001), A cocktail stick is as good as brief acupuncture in episodic tension-type headache (Research Review). *Acupuncture in Medicine* 19(1), 56-57.
- Davis, M *et al.* (2008), Acupuncture for Tension-Type Headache: A Meta-Analysis of Randomized, Controlled Trials. *The Journal of Pain* 9(8), 667-677.
- Endres, H *et al.* (2007), Acupuncture for tension-type headache: A multicentre, sham-controlled, patient-and observer-blinded, randomised trial. *Journal of Headache Pain* 8, 306-314.
- Hansen, P and Hansen, J (1985), Acupuncture treatment of chronic tension headache: A controlled crossover trial. *Cephalalgia* 5(3), 137-142.
- Heale, R and Twycross, A (2015), Validity and reliability in quantitative studies. *Evidence Based Nursing* 18(3), 66-67.
- International Headache Society Headache Classification Committee (2013), The international classification of headache disorders, 3rd edition. *Cephalalgia* 33(9), 629-808.
- Kaptchuck, T (2000), *Chinese Medicine: The Web that has no Weaver*. 2nd edition, New York: Rider.
- Karst, M *et al.* (2001), Needle acupuncture in tension-type headache: A randomized, placebo-controlled study. *Cephalalgia* 21(6), 637-642.
- Linde, K *et al.* (2009), Acupuncture for tension-type headache (Review). The Cochrane Library 2009, Issue 4.
- Maciocia, G (2008), *The Practice of Chinese Medicine*. London: Churchill Livingstone. Second edition.
- Melchart, D *et al.* (2005), Acupuncture in patients with tension-type headache: Randomised controlled trial. *British Medical Journal* [Online] 331(7513) available from www.ncbi.nlm.nih.gov/pmc/articles/PMC1184247/pdf/bmj33100376.pdf [Accessed 30/04/2016].
- NICE (2016a), *Headaches*. [Online] Available from www.nice.org.uk/guidance/cg150/ifp/chapter/Headaches [Accessed: 12/05/2016].
- NICE (2016b), *Diagnosis*. [Online] Available from www.nice.org.uk/guidance/CG150/ifp/chapter/Diagnosis [Accessed: 12/05/2016].
- NICE (2016c), *Treatments for tension-type headache*. [Online] Available from www.nice.org.uk/guidance/cg150/ifp/chapter/Treatments-for-tension-type-headache [Accessed: 12/05/2016].
- Tavola, T *et al.* (1992), Traditional Chinese acupuncture in tension-type headache: A controlled study. *Pain* 48(3), 325-329.
- White, A *et al.* (2000), Acupuncture for episodic tension-type headache: A multicentre randomized controlled trial. *Cephalalgia* 20(7), 632-637.

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试论中医脑为神五脏

徐廣文 伦敦

摘要: 本文根据《黄帝内经》，中医经典医著和医圣医家对脑功能的认识，试从脑与五脏、五官与脑、五脏与目、经络与脑、脑与髓、髓与肾等方面，探讨阐述五脏藏神，神脏聚脑，脑为神五脏。中医五脏是“形神合一”，脑脏合一，是形五脏（血肉之五脏）和神五脏（脑）合而为一“以五脏为中心”的生命整体。形五脏在胸腔腹腔，神五脏聚于头内脑神。神五脏所主的生理功能是脑的功能，故脑为神五脏。脑神五脏主宰和调节生命整体。

关键词: 中医理论 研讨 脑 神五脏