Medical Acupuncture

A Practical Guide

An illustrated companion to *Acupuncture in Practice*

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Chapter 1

Introduction

This book is an illustrated companion to my textbook of modern acupuncture, A*cupuncture in Practice: Beyond Points and Meridians*. That is the book I use on the courses in modern acupuncture which I give for health professionals such as doctors, physiotherapists, osteopaths, chiropractors, nurses, and podiatrists. So the intended audience is primarily people who have attended one of these courses, but it should also be useful for practitioners of the modern version of acupuncture who have attended other courses.

Modern acupuncture is the kind that has arisen in the West in the last few centuries (it goes back further in time than one might think). Whereas traditional acupuncture is based on ideas derived from ancient Chinese philosophy and talks in terms of yin and yang, chi, meridians, and points, the modern version largely or completely ignores all this and assumes that acupuncture works by stimulating the nervous system. It is therefore easily assimilated by a modern health professional.

Why did I write it?

The approach I use has naturally evolved a lot in the almost thirty years that I have been teaching acupuncture. There is now an increased demand by students for note-form summaries and I cater for this by supplying a CD summarising the main themes. But I have been rather reluctant to go too far in that direction, because I was afraid it might encourage a 'cookbook' mentality. There are books available for acupuncture which list 'points' to use in treating various disorders. They provide, in essence, a highly simplified version of the traditional system, without any of the underlying theory. I dislike cookbooks, not only because of scepticism about the existence of points as usually understood, but because they discourage thought. If you follow cookbook recipes you have no idea why you are using the treatment described, and if it doesn't work, what do you do? Try a different cookbook?

I should be sorry to encourage this way of doing acupuncture so this is not a cookbook. It doesn't tell you what you *must* do but it illustrates some common ways of using needles. My view is that success in acupuncture does not depend on following rules or prescriptions. *Rather, you should grasp the basic principles and then apply them to what you see in front of you in the clinic*. My aim in teaching is to set out these basic principles and then to show how they can be applied in practice.

I don't want to say that what I describe is the right way to practise or the only way. Every practitioner will encounter different kinds of problems and will need to develop his or her own solutions for them. Students sometimes ask: 'Can we do x, y,or z?' To which the answer is 'You can do anything you like *provided it is safe*'.

The safety proviso is obviously essential. Acupuncture is an invasive technique and although, done responsibly, it is remarkably safe, the potential for causing serious injury or even death is there. The way to avoid this is to keep the anatomy in mind. You should always ask yourself: 'Where is my needle point now?' Provided safety is ensured, however, practitioners can, should, and do make up their own treatments in the light of the four basic principles described below.

Simple but not too simple

The position I start from is that we can forget about the traditional apparatus of 'points'. Many modern acupuncturists, including me, find that it often makes little or no difference exactly where the needles are inserted. This departs radically from the traditional approach, of course, but many of the clinical trials done in the West in recent years support the idea. The most recent example comes from a series of large-scale trials done in Germany, which found that although patients treated with acupuncture did considerably better than those who had no treatment or conventional treatment (physiotherapy), it made little or no difference exactly where the needles were inserted or how deeply.[1] The inevitable conclusion from such studies is either that acupuncture is a complicated placebo (as its critics maintain) or that needling does work but there is a non-specific effect largely independent of where and how deeply the needles are inserted. Personally, I am open to both possibilities but I tend to favour the second.

If it is indeed true that the site of needling is largely irrelevant in many cases we can simplify acupuncture very considerably *without losing any clinical effectiveness*. Advocates of the traditional system often concede that acupuncture done in the modern way works for 'simple' problems but insist that to treat more complicated disorders you have to use the traditional methods. But many of us have found that this isn't true. For example, back pain due to ankylosing spondylitis or osteoporosis can be treated effectively by needling the paraspinal muscles without troubling to identify individual 'Bladder points' (Chapter 5). And in over 75 per cent of cases one can get a good response in a serious disease such as ulcerative colitis with the treatment I illustrate in Chapter 6 (superficial needling over the lower abdominal wall). So acupuncture can be made simpler than many people suppose without becoming simplistic.

On the other hand, you do have to think about what you are doing. You have to decide, for example, whether a pain is likely to respond to local needling or is being referred from a distant site. Success in acupuncture depends a great deal on the practitioner's knowledge of pathology and underlying disease mechanisms. Your success rate in acupuncture will be similar to your success rate with the other forms of treatment you use.

[1] Cummings, M. Modellvorhaben Akupunktur – a summary of the ART, ARC and GERAC trials. *Acupuncture in Medicine* 2009;27:26-30.

Often, *where* you needle is less important than *how* you needle. Success in acupuncture, I believe, largely depends on learning to interpret the subtle signs that tell you how big an effect you are having. Look at the patient's face more than the site where you are needling!

I should say that there are four ways of choosing where to needle. I refer to these as the *basic principles* of acupuncture.

The basic principles

1. ***Needle the site of pain.***

This is the simplest form of acupuncture**.** You place your needle or needles at the site of pain. Example: you can treat a localised painful area in the chest wall by needling it subcutaneously (Chapter 5).

Purists sometimes object that this is not 'true acupuncture'. This seems to me an absurd objection (the word acupuncture, after all, is simply an anglicised version of the Latin for sticking needles into people), but in any case, if you want to be pedantically traditionalist there are ancient Chinese texts describing the use of this technique.

2. ***Needle an area remote from the site of pain which may influence that site.***

Note that the remote site may or may not be tender. If it is tender it can be described as a trigger point (TP – discussed below). Example: needling the neck muscles can affect pain in the arm (Chapter 2).

3. ***Needle the periosteum somewhere near a joint* (*not* into *the joint*).**

This is my standard method of treating joint pain due, for example, to osteoarthritis. Example: needling the flat area on the medial side of the upper tibia relieves knee pain (Chapter 8).

4. ***Central stimulation.***

Feelings of relaxation and well-being occur quite often during and after acupuncture and these, as well as other less usual effects, are due to central stimulation, probably involving the limbic system. Although in some patients central effects can be obtained by needling almost anywhere, the hands and feet seem to be the most effective areas. I prefer to use the feet. The traditional site here is known as Liver 3 (**LR3**), and while I am not convinced that one has to be precise (perhaps anywhere on the dorsum of the foot would work in many people) there is no reason not to use it. Example: needle **LR3** to treat hot flushes (Chapter 10).

Trigger points

Many modern acupuncturists talk a lot about trigger points (TPs) and I used to emphasise them myself, but now I tend to do so less. The TP concept largely owes its existence to the work of two American physicians, Janet Travell and David Simons, though it has now been taken up by others. In brief, a TP may be described as a hyperirritable point located in taut bands of muscle or in fascia.[2] TPs are tender when pressed and refer pain and

[2]Tough, EA, White, AR and others. Variability of criteria used to diagnose myofascial trigger point pain syndrome: Evidence from a review of the literature. *Clin J Pain* 2007;23(3):278-286.

other sensations to distant areas. Activation of TPs is said to give rise to the *myofascial pain syndrome*; activation may be due to injury or muscle overload, acute or chronic. There are claims that the majority of musculoskeletal pain is caused by myofascial trigger points.

The TP theory remains controversial and doctors generally learn nothing about it in their standard training. And although practitioners of modern acupuncture often rely on it heavily, the criteria for diagnosing TPs are quite variable and it is still uncertain whether they can be inactivated by needling.[3] Although I do use the TP concept myself I now prefer to speak of *Acupuncture Treatment Areas* (ATAs), a theory-neutral term.

ATAs

An ATA is a site anywhere in the body where an acupuncture needle can be inserted to influence symptoms.

- ATAs may or may not be tender. Thus the definition includes TPs but is wider in scope. The illustrations in this book are mainly of ATAs, although where they are tender I tend to call them TPs. *In short, a TP is a tender ATA.*
- ATAs are variable in size, ranging from about a centimetre in diameter up to a much larger area. The depth is also variable although they are always deep to the skin.
- The effects of needling an ATA may be local, at a distance from the site, or generalised (central).
- Examples of ATAs include a locally painful area (what is called an Ah Shi point in the traditional system), a TP, periosteum near a joint, and sites for central stimulation such as **LR3**.

Please note that this is not an acupuncture theory but simply a description of what many modern acupuncturists do in practice. My purpose in using it is to shift the emphasis away from concentration on exact needling towards a more flexible approach.

How many, how long?

Most traditionalists and some modernists insert a large number of needles (20 or more in most cases) and leave them in for at least 20 minutes. I use few needles: seldom more than four, sometimes only one. And each needle is left in place, with manual stimulation (twisting), for a short time: almost never more than 1 to 2 minutes and sometimes only a few seconds. (This description applies to soft-tissue needling; periosteal needling is always very brief.)

Brief needling surprises many people, yet I don't see why it should. To my mind, it is remarkable that acupuncture works at all, but given that it does, I don't see any good reason

[3]Tough EA, White AR and others. Acupuncture and dry needling in the management of myofascial trigger point pain: A systematic review and meta-analysis of randomised controlled trials. *European Journal of Pain* 2009;13:3-10.

why leaving needles in place for 20 minutes should work any better than doing so for 20 seconds. We know that the nervous system adapts very quickly to a new stimulus, which is why you don't feel your clothes throughout the day. And my understanding of acupuncture is that its effects depend mainly on *switching* the patterns of nerve impulse transmission in the spinal cord and brain. The important word here is 'switching'. When you turn on a light you don't have to keep your finger on the switch for 20 minutes; you press it and it's done. The same is true of needling.

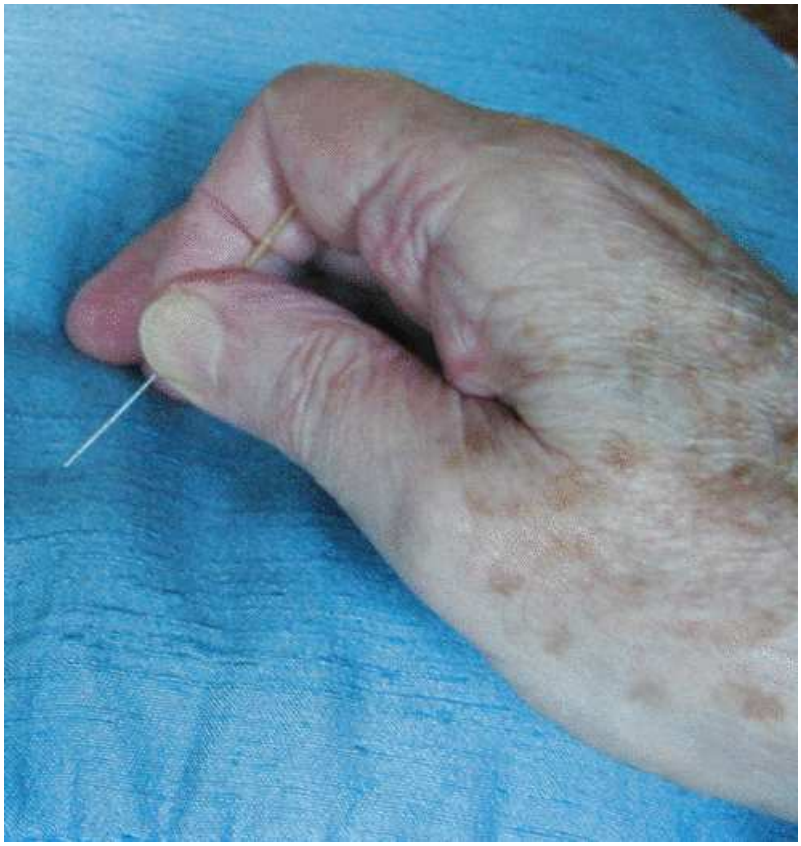

Figure 1.1: Holding the needle

Needle sizes

Figure 1.1 shows how to hold the needle to prevent slipping, with the base of the handle pressing against the proximal phalanx of the acupuncturist. Note that the needle is held so as to make it shorter and so more rigid; this helps for periosteal stimulation.

Unless otherwise indicated, a 30 x 0.30 mm needle should be used. Short (15 x 0.20 mm) needles are better in potentially dangerous sites such as the chest wall or over the spine. (Of course, if you don't happen to have one available you use a 30 mm needle and don't put it in very far!) A long (50 x 0.30 or 50 x 0.35 mm) needle is required for deep needling, for example in the gluteal region or the sole of the foot. Please understand that these are recommendations, not absolute rules. In all cases one should take the size of the patient into

account: in a very thin individual a short needle may be preferred even where a longer one would normally be used, and short needles should also be used for children.

Note: *The illustrations mostly use a bicycle spoke instead of an actual needle. This is a teaching device I use on my courses to make the direction of needling clear.*

How to use the book

I assume that you are a health professional who has already attended a course in modern acupuncture, either mine or a different one. (You can't learn acupuncture adequately just from books.) The book will then remind you of what you have already learned but may have forgotten.

The chapters are arranged by regions. Each chapter starts by listing some symptoms or disorders that can be treated by needling in the area in question. Next come illustrations of commonly used sites, and these are followed by notes giving further information. So the main way of using the book is by reference to the region in which symptoms occur, but the index provides another way of finding treatments for particular disorders or symptoms.

Traditionalists and even some modernists may be surprised at the almost complete omission of traditional names for 'points'. The reason, of course, is that I am sceptical about the real existence of these entities. To be entirely logical I should have left them out altogether. Some modernists have done this, and have published books in which the traditional nomenclature is replaced with a different one invented by the author. This tends to be cumbersome and has never really caught on. So I use a few traditional names simply as shorthand to describe the site of insertion. *This does not imply any belief in their real existence.* But their names and locations are so well known, even to modernists, that it seems perverse to avoid mentioning them. The following are the main traditional 'points' cited: **GB20, GB21, GB30, LI4, PC6, SI3, SP6, LR3.**

For a detailed explanation of the approach to acupuncture I use, please refer to my textbook of acupuncture, *Acupuncture in Practice.*

Safety issues

Normal needling sites are shown in **green**. Sites requiring particular care are shown in **red**.

Potentially risky treatments are italicised in the notes and marked as follows:

♣ *Care required when needling here.*

♣♣ *Fatal results have occurred from needling wrongly here!*

Chapter 2

Head and Neck

Summary of conditions treated

1. Neck and shoulder pain
2. Midline superficial neck pain
3. Headaches
4. Vertigo arising from the neck
5. Trigeminal neuralgia
6. Recurrent sneezing
7. Pain in root of tongue
8. Temporomandibular jaw problems

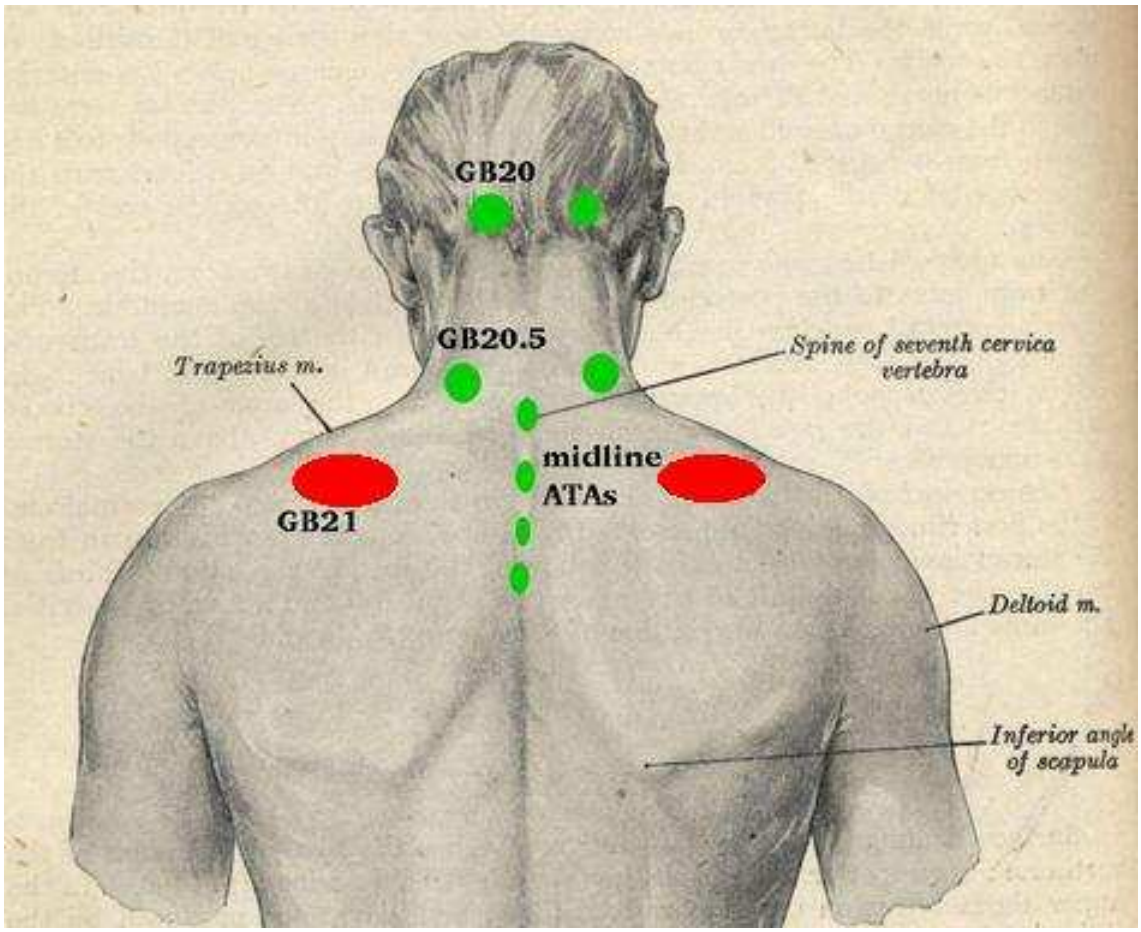

Figure 2.1: Head and neck (surface markings)

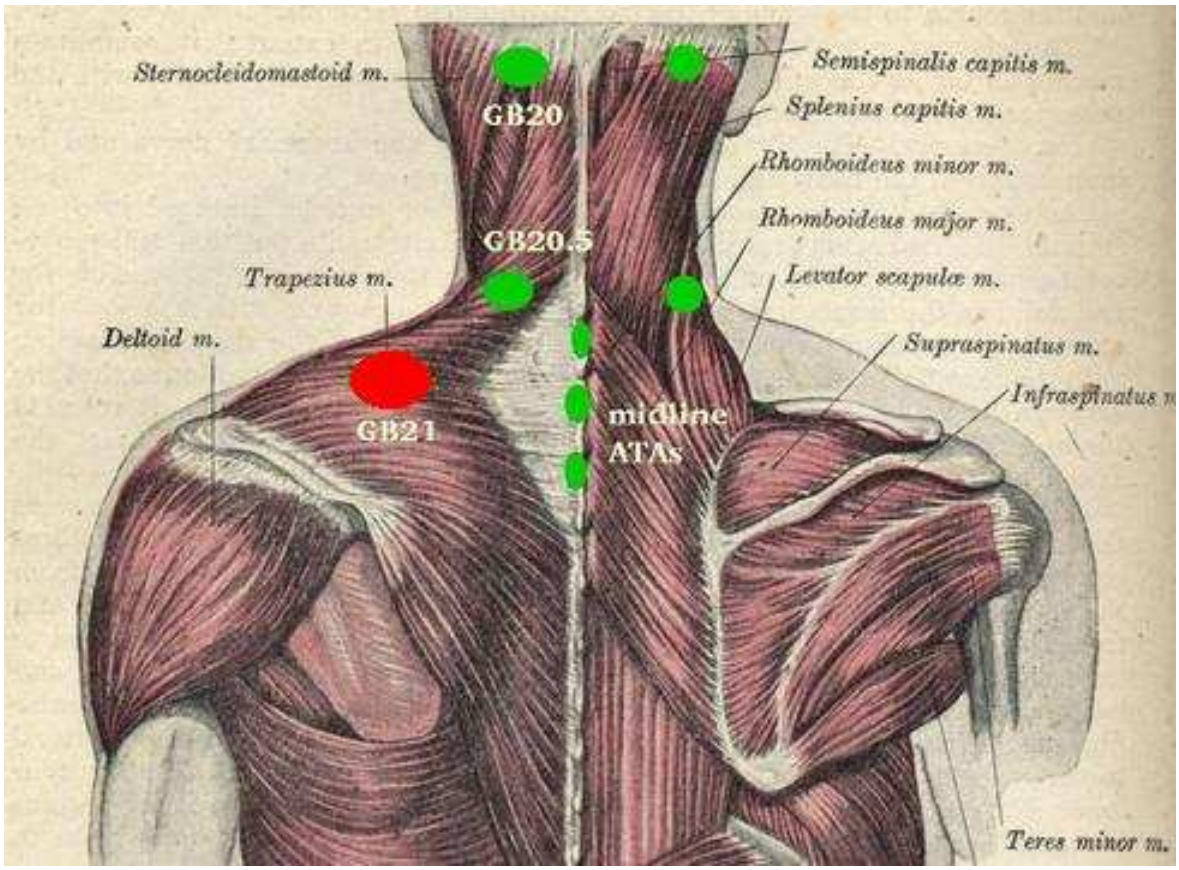

Figure 2.2: Head and neck (muscles)

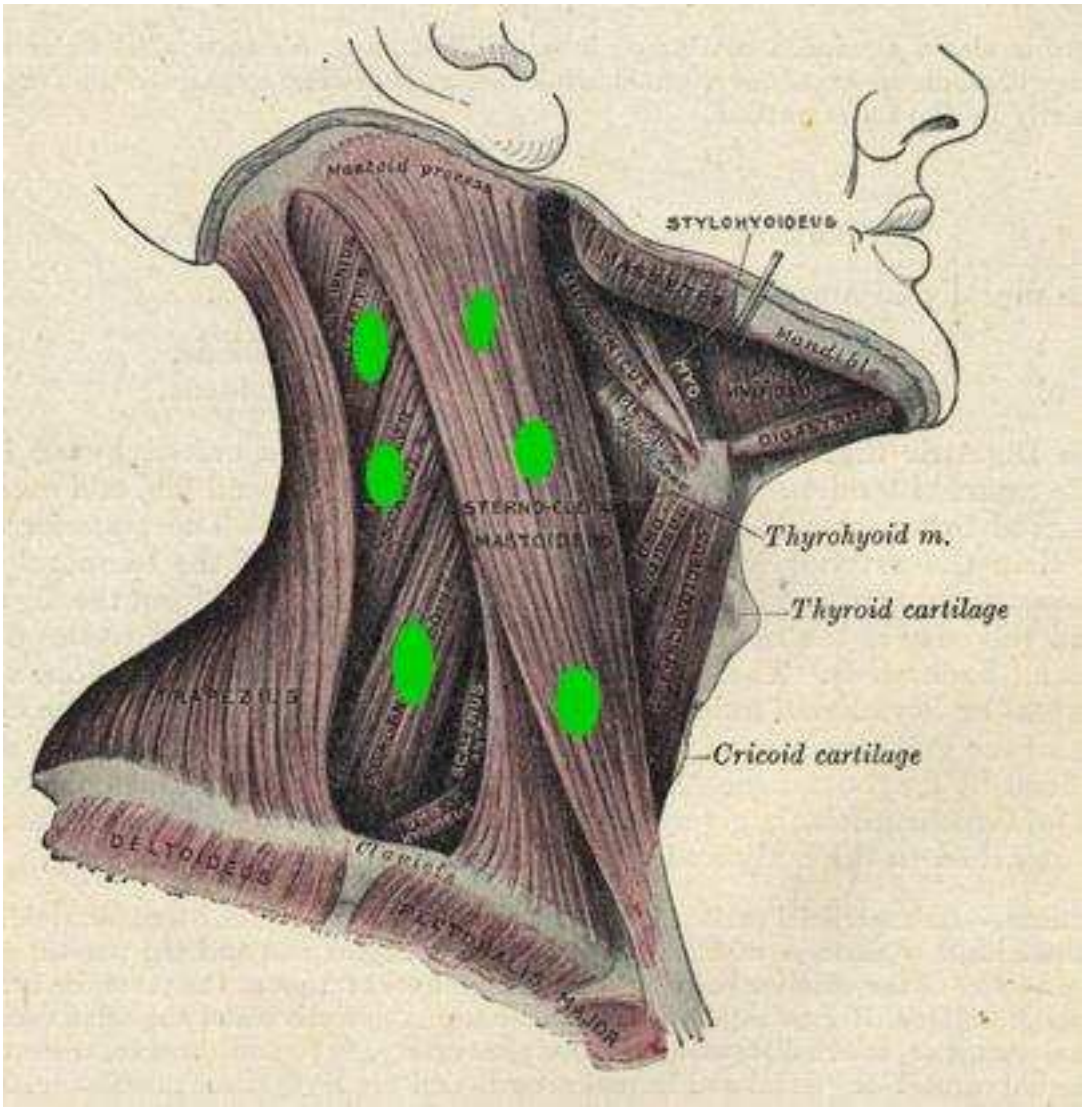

Figure 2.3: Posterior triangle; sternocleidomastoid

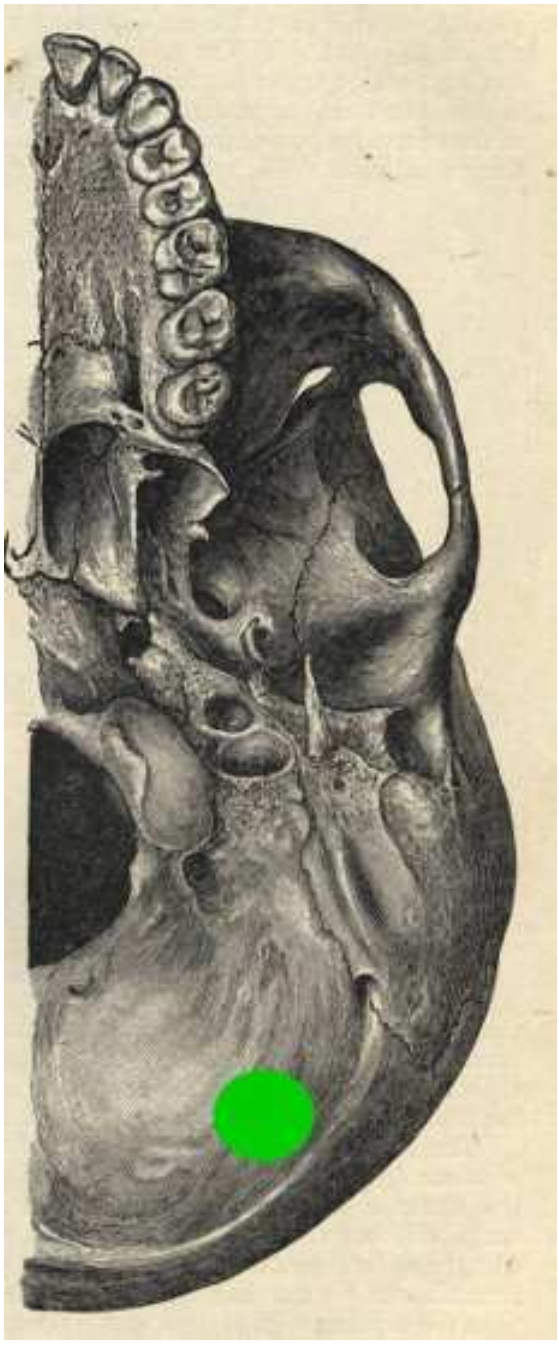

Figure 2.4: Skull base; GB20

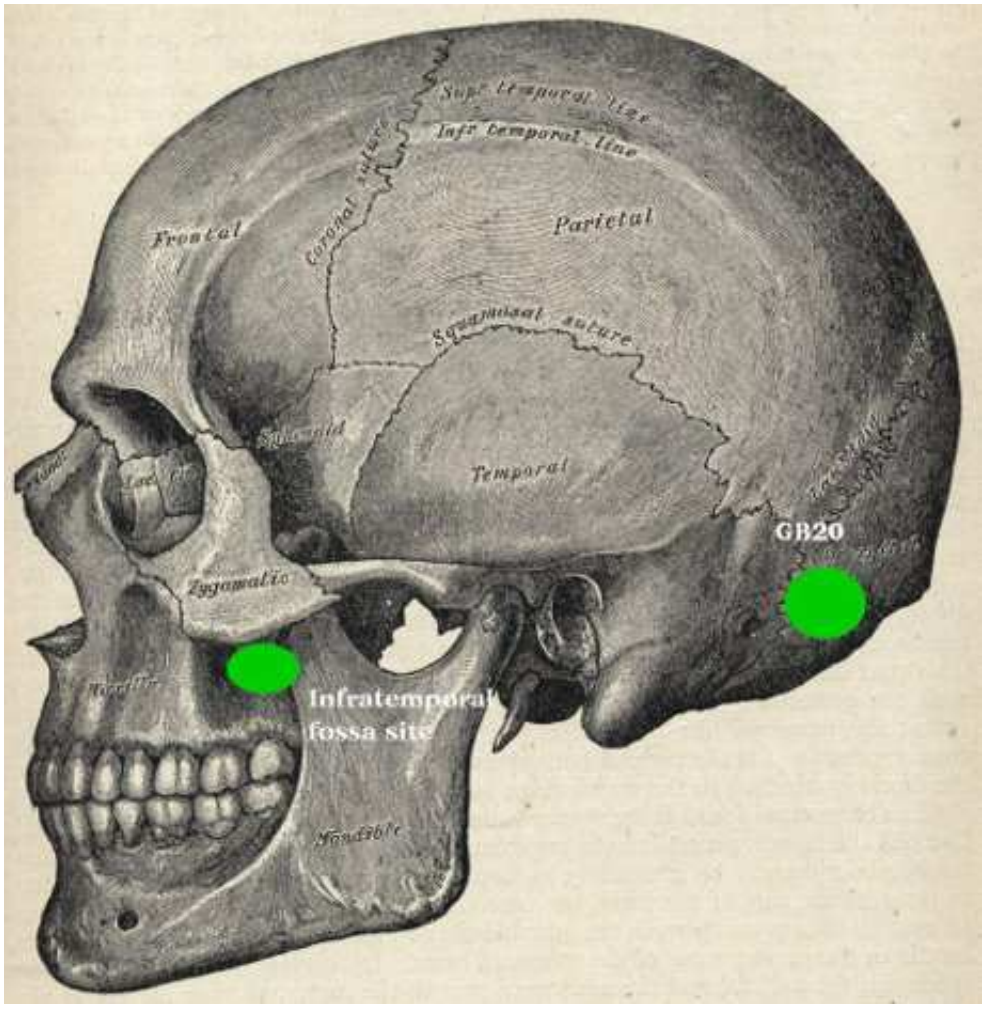

Figure 2.5: Infratemporal fossa; GB20

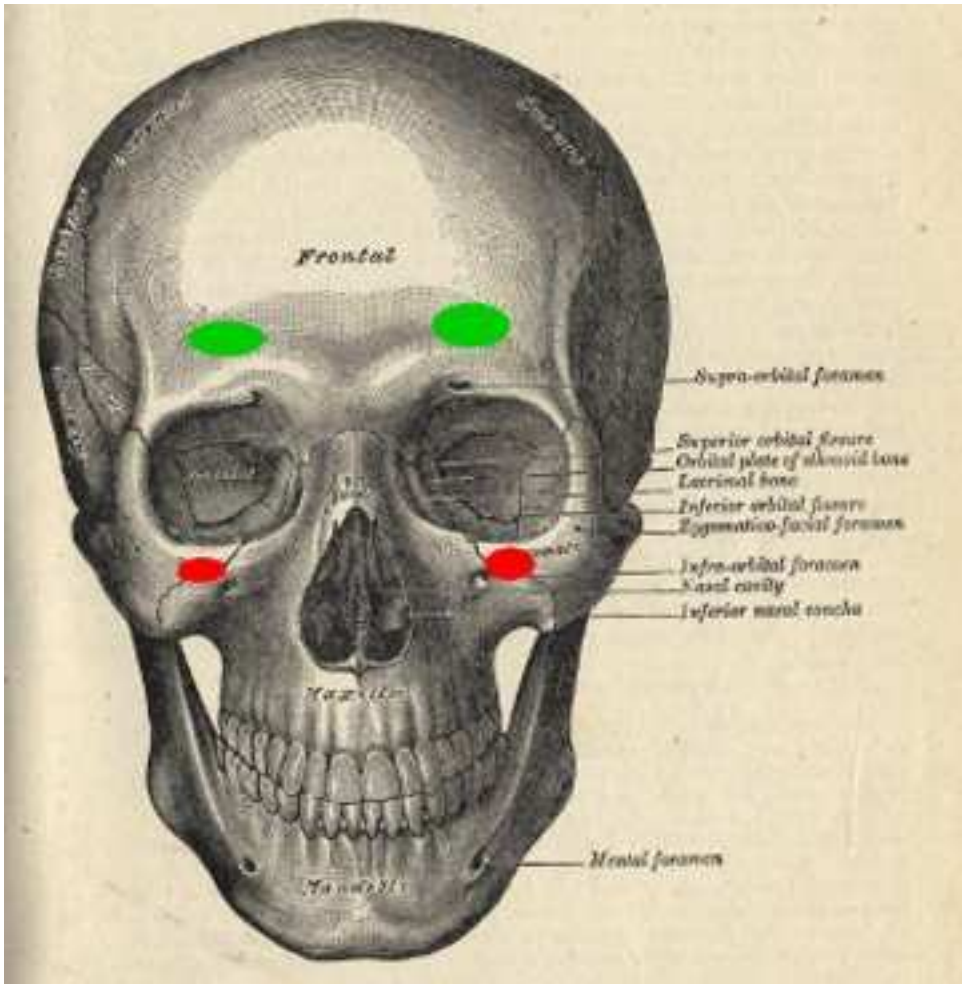

Figure 2.6: Sinus sites

Notes

- Figures 2.1 and 2.2 illustrate some commonly used needling sites. **GB20** and **GB21** are classic acupuncture points: '**GB20.5**' in *levator scapulae* is also commonly used though it is not listed in the traditional system. Note that I have drawn **GB21** quite large, to show that it is not a small area. One is guided more by local tenderness than anatomical location. Radiation from here may be into the head or down an arm.

♣♣ *It is easy to cause a pneumothorax by needling **GB21** and (to a lesser extent) **GB20.5**. To avoid this, lift the trapezius and direct the needle forwards from behind. That is, in a sitting patient the needle is horizontal (parallel to the floor); if the patient is lying prone the needle is directed towards the couch.*

- **GB20** (Figures 2.1, 2.2, 2.4, 2.5) is a periosteal site, most easily treated with the patient lying prone. The palpating fingers start on the skull and slide downwards to where the skull is felt to fall away from the surface. A 30 mm needle is then inserted, aiming towards the opposite eye. The under-surface of the skull will be reached at a depth of about 15-20 mm and the periosteum is pecked quickly. A common mistake is to start inserting the needle too caudally, in which case the periosteum will not be reached. This is a reactive point so the needling is brief. **GB20** is one of the main **headache** treatment sites (see below).

- Figures 2.4 and 2.5 show how much distance there is between the site of needling and the spinal cord. There is therefore no risk of damaging the cord in this region if a 30 mm needle is used.

- The **midline sites** (Figures 2.1, 2.2) are located over the tips of the vertebral spines. In some thin patients the spines can be needled periosteally, but this is not essential and in most cases it is the interspinous ligament that is reached. Needling in the midline is performed over the spinal cord. To avoid any risk to the cord, use a short (15 mm) needle and direct it caudally, because of the way the spines slope. These sites are used for **superficial localised pain** over the spine.

- There are needling sites in muscles in the **posterior triangle** (Figure 2.3 – *splenius capitis*, *splenius cervicis*, *semispinalis capitis*). They may or may not be tender so are ATAs and possibly TPs. Needling the muscles in the posterior triangle can be done with 30 mm needles to a depth that depends on the size of the patient's neck (Figure 2.3). It is generally most easily done with the patient sitting, the head being braced against the acupuncturist's chest. These areas are indicated for **neck pain**, with or without radiation down the arm.

- Needling the muscles in the *posterior triangle* can help some patients with **vertigo** or **unsteadiness** arising from the neck. There are many possible causes for vertigo, for many of which acupuncture is unhelpful. Some elderly patients have unsteadiness or slight vertigo on turning the head, which may be due to abnormal proprioceptive impulses arising from the facet joints or the neck muscles. In such cases needling the neck can help for about 12 weeks at a time (Figure 2.3).

- Needling *sternocleidomastoid* (Figure 2.3) is done with the patient supine; the head is rotated away from the acupuncturist to make the muscle stand out. It can then be gripped between finger and thumb. A short (15 mm) needle is preferable; take care to avoid the external jugular vein, which crosses the muscle.

Headaches

Headaches, both **migrainous** and **tension-type**, often respond well. Acupuncture is mainly preventive though it sometimes will relieve an acute headache. There may be a reduction in the frequency of headaches, the severity of headaches, or (ideally) both. There are two possible approaches.

Local treatment. Needle **GB20, GB20.5, GB21. GB20** is much the most important of these and the other sites are possibly unnecessary unless there is a lot of neck and shoulder tension. (Figures 2.1,2.2, 2.3)

Central treatment. Needle **LR3** (Figure 10.3)

How to choose?

1. If there is neck tenderness start with the local neck sites, especially **GB20.**
2. If there is a visual or other aura, start with **LR3.**
3. If the headaches are triggered by food or alcohol, start with **LR3**.

Using both at once never seems to work! Generally try each approach at least twice before giving up, so many patients will need 4 treatments before a decision is made. Relief is not usually permanent; most patients will require repeat treatments, perhaps every 3 months or so. It may take about 6 treatments to obtain the maximum relief.

♣ *Acupuncture can mask serious pathology (brain tumours).*

♣ *Aggravations may occur: some people always get a headache on the day they have their treatment. New patients should be warned of this (at the possible risk of suggesting the effect to them) and if they have something important to do that day it is best to delay the start of treatment to another day.*

Resistant headaches

Three types of headache seldom or never respond to acupuncture.

1. Headaches that are associated with menstruation.
2. Cluster headaches.
3. Constant daily headaches.
   Probably the commonest cause of these is over-use of analgesics. If this is the case acupuncture will fail; the patients need to stop using the medication in question.

Trigeminal neuralgia

Figure 2.5 shows the needling site for the *infratemporal foss*a used for **trigeminal neuralgia**. It is often possible to obtain worthwhile relief in this condition, even if the patient still has some pain and cannot stop medical treatment completely. The needle is inserted in the infratemporal fossa, in the angle between the lower border of the zygomatic arch and the anterior border of the ramus of the mandible. The needle is directed slightly upwards and slightly posteriorly. It may strike the maxilla; this does not matter although the treatment is not meant to be periosteal. It is most easily done with the patient lying on their side. It seems to work better if both sides are needled. I have sometimes supplemented the treatment by inserting a line of 15 mm needles along the area of pain. It may take 6 or more treatments to get the maximum relief, which normally lasts for some months.

Pain in the root of the tongue

May be due to TPs near the insertion of sternocleidomastoid (Figure 2.3).

♣ *Pain in the root of the tongue is a potentially worrying symptom (cancer of tongue?).*

Sinus sites

Figure 2.6 illustrates needling sites over the *frontal* and *maxillary sinuses*. These are needled periosteally using 15 mm needles to treat **frequent sneezing**. They occasionally help with true **chronic sinusitis** and are worth trying for **hay fever** (together with **LR3** – Figure 10.3).

♣ *Take care not to enter the orbit when needling the infraorbital region.*

Temporomandibular jaw dysfunction

Not a brilliantly successful treatment but it is worth trying some periosteal needling above and below the *temporomandibular joint*.

Unilateral watering eye

Often responds to needling **GB20**.