
MULTIMODALITY THERAPY OF BRONCHIAL ASTHMA CASES: SU JOK APPROACH

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INTRODUCTION

Asthma is one of the earliest-recorded diseases affecting the human being. The recurrent paroxysms of asphyxia of a characteristic type were described as early as over three millennia ago. The disease is likely to occur in any populated area of the world regardless of age. A distinct growth in the incidence of asthma has been reported in most industrialized countries in the past 10 to 15 years. Therefore the problems concerning the diagnosis and treatment of the disease have acquired international dimensions and prompted consolidated efforts aimed to deal with bronchial asthma. Thus, in the year 1992 the USA National Heart, Lung and Blood Institute organized the issuance of a "Report on the International Consensus regarding the Diagnosis and Treatment of Asthma". The report was prepared by the panel of 18 experts from 11 countries of the world. The position of principle of this International Consensus became its concerted recognition that the first-order factor in the pathogenesis of bronchial asthma is apt to be due to the chronic persistent inflammation of the respiratory tract - which is the ultimate cause of such elements of the asthma pathogenesis as bronchial hyperactivity or obstruction. Bronchial asthma may develop in persons who are predisposed to this type of diseased condition. Genetically determined will be asthma, atopy and bronchial hyperactivity. The most important part in developing bronchial asthma belongs to allergens affecting persons who are exposed to the inhalation of the tick or mite excretions, mixed house dust, pollen of grasses and trees, the hairs of animals, animal danders, mold spores, and so on. The list could be complemented with medical drugs, occupational sensitizers, etc. The inflammatory process would result in four mechanisms of bronchial obstruction being formed, which are: acute bronchospasm, subacute edema, recurrent formation of mucoid impactions, and irreversible restructuring of the bronchial wall (fig. 1).

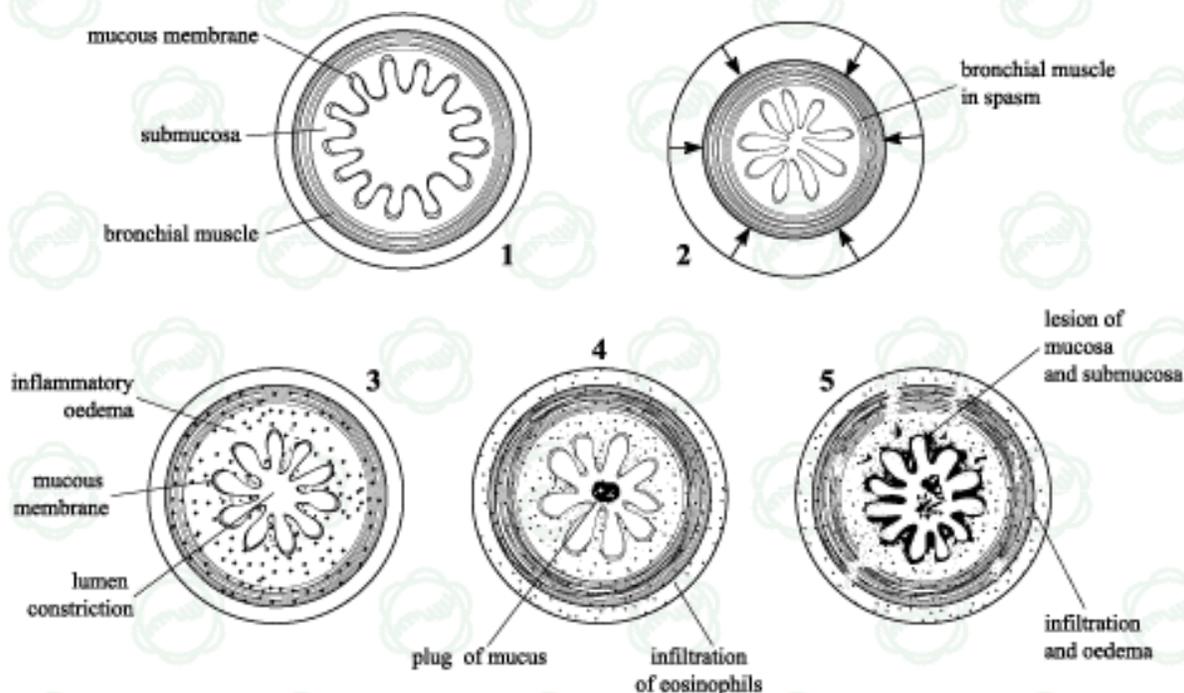


Fig. 1. Histopathology of asthma: 1 - normal bronchial cross section; 2, 3, 4, 5 - mechanisms of the bronchial obstruction

In dealing with the disease, the treatment strategy will be based on the elimination of allergens and irritants, the early order to perform and prolonged anti-inflammatory treatment, using primarily the inhalation glucocorticoid hormones.

The above International panel of experts has pointed out a number of lines of research held as the most pressing ones, yet which remained unsolved in the course of discussions. One of these researches will be aimed at applying and evaluating the effectiveness of nonmedicamentous therapy, including acupuncture, and at establishing the indications for their application.

This paper deals with the working out of multimodality therapy of bronchial asthma patients based on Su Jok technique.

MATERIAL AND METHODS OF RESEARCH

The patients were examined and underwent treatment in the clinic and the hospital treatment department at the St.Petersburg State Medical University named after Academician I.P.Pavlov, as well as at the Medicosanitary unit No.22 of St.Petersburg. There were 56 patients under observation, ranging in age from 16 to 62, noted for diverse clinicopathogenic variations of bronchial asthma (BA) in its aggravated phase. The disease in these subjects lasted from 1 to 20 years. The mild course of the disease was observed in 12% of the patients, moderate one - in 78% of them, and 10% suffered from its severe form.

The parameters to be investigated included: disease pattern, the 11-HKS (11-hydroxyketosteroids) plasma level, sputum cytology, the erythrocytes' membranoreceptor properties, hydrocortisone absorption by lymphocytes, external respiration functions (ERF), the Nakatani computer-assisted diagnosis, and gas-discharge fingers visualization (Kirlian effect). The investigations were carried out before and after the treatment following Su Jok approach, with its complete course amounting to 10 to 15 sessions. The patients were also investigated prior to and after individual procedures.

The five-stage treatment based on the hands-and-feet correspondence system involved the microneedles insertion, moxas-based heating, seeds application, the use of low-energy laser, and massaging with elastic ring.

In the course of treatment the patients were trained in self-massaging the hands and feet, plus magnets-aided therapy carried out along the byol-meridians. In trying to alleviate a paroxysm of asphyxia or a respiration-related discomfort, the efficient outcomes were attained through the magnet application onto the lung and conception byol-meridians, and by activating the pair of Yin-Yang meridians belonging to the lung and large intestines, as well as providing treatment based on Six-Ki principle. Since the patients afflicted by the disease under consideration would be notable for having fear, anxiety, susceptibility to offence, suppressed anger, treatment was provided at the emotional or mental levels.

RESULTS AND DISCUSSIONS

As the BA patients had undergone Su Jok therapy, good and excellent results were attained in 85% of the cases involved in treatment and studies. The remission of the disease was achieved and medicamentous therapy was reduced or eliminated altogether. The course of treatment proved uneventful. The more definite improvement was observed in the atopic form of BA, including extrapulmonary manifestations of allergy. Patients noted for a total aspirin-based triad and hormonal dependence appeared less susceptible of the treatment. A statistically significant increase in bronchial permeability became evident following magnets treatment along byol-meridians and Six-Ki channels, both after their single application and a therapeutic course. It is noteworthy that similar effect was observed even in those cases when there was no response to the berotecum inhalation and in the event of paradoxical response to berotecum.

Along with a relief in the status of the bronchopulmonary system following the SJT approach, there were also corrected so-called concomitant illnesses associated with the same imbalances in the energy system which contributed to the clinical manifestation of BA. Thus, the 11-HKS level was very clearly tending to normalize after therapeutic course. The amount of sputum in the course of treatment lessened, and cytological signs of the inflammation proved to be reduced. The blood and sputum demonstrated a drop in the amount of eosinophils. Furthermore, the hydrocortisone intake by lymph cells showed an increase, whereas the initially low level of this process would be apt to give rise to an aggravated course and progression of BA (table 1).

Indices	Unit of measurement	Before treatment	After treatment
Hydrocortisone intake by lymph cells	microgram per 1000 cells	0,041±0,02	0,1±0,05 **
11-HKS	%	9,6±2,8	10,6±1,5 *
Eosinophiles in blood	%	13,1±6,1%	6,9±2,1% **
Forced expiratory volume per second	%	73,3±19,9%	95,5±5,2% **

$p < 0,5$ *; $p < 0,05$ **

Table 1. Results of Examinations before and after Treatments

As to the gas-discharge finger (Kirlian effect), its imaging makes it possible to assess in real-time environment the impact produced by different treatments. A session (course) of Su Jok therapy resulted in the glow line being normalized, with the pathologic phenomena of the kirlianogram disappearing (fig. 2).

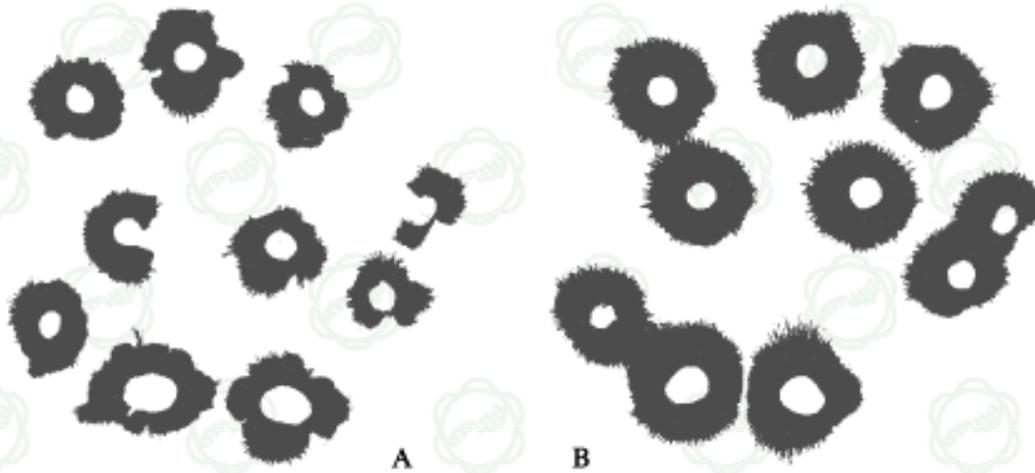


Fig. 2. Gas-discharge finger imaging (Kirlian effect):
 • - before treatment, b - after treatment

Modified computer-assisted diagnosis according to Nakatani would allow the altered energy structures and the right-left/up-down imbalance to be identified following the conductance ratios in the "yuan" points of corporal meridians.

The standard-type interpretation of the findings obtained has it that an increased conductance will be indicative of an excess of energy in a channel, while lowered conductance will be suggestive of energy's deficiency. However, in actual practice this approach would often lead to the situation when the computer-based outcome proves to be out of line with the results of the clinical and application diagnosis. For example, in BA patients noted for an explicit excess in a lung channel the computer would not infrequently indicate "insufficiency". After tonifying the lung byol-meridian the computer-displayed insufficiency will become more manifest. Such a pseudo deficiency of the gall bladder channel is characteristic of the cholelithic patients; of the urinary bladder channel - in patients notable for an obvious predominance of AH-Coldness, and so on. In our opinion, though, the conductance in the "yuan" point would largely reflect the status of an energy structure, or of a meridian, but never the total excess or deficiency of its main energy. Hence an energy structure noted for excessive Heat would lead to vasodilatation, to an increased sweating along the channel run - which results in an increase in conductance. Conversely, the state of a structure with predominant Dryness and Coldness would bring about a decreased skin conductance along the channel. From this viewpoint the said discrepancies look quite comprehensible. In this context, the computer-assisted diagnosis may well be applied as a useful adjunct to an all-round clinical diagnosis and for carrying out a dynamic follow-up (fig. 3).

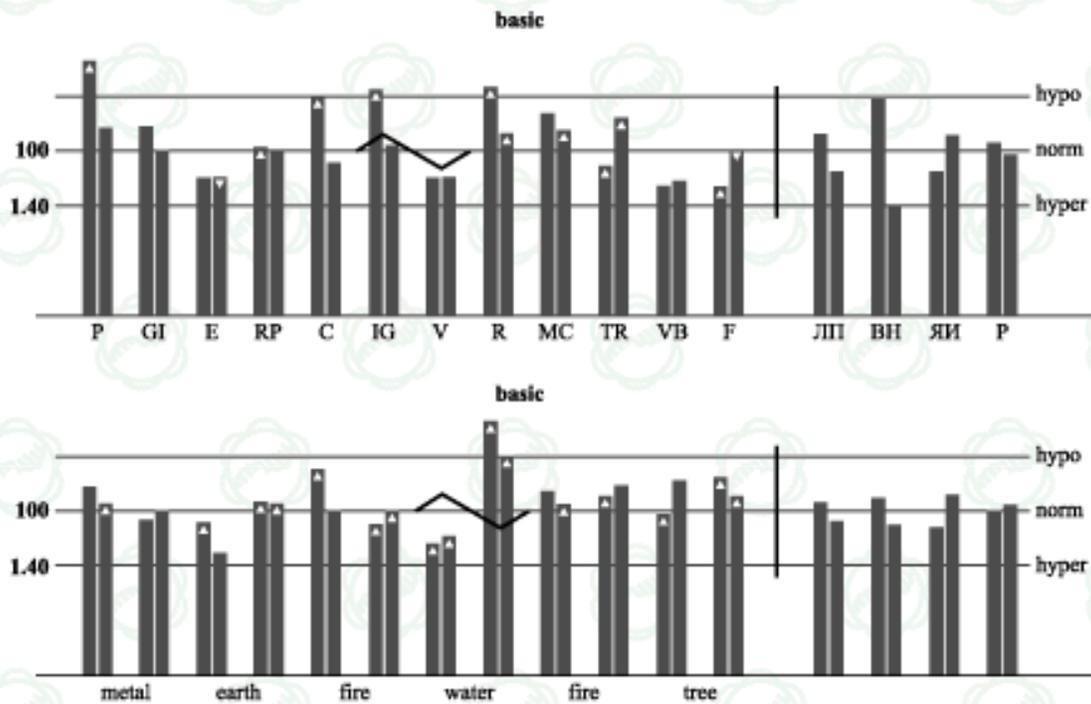


Fig. 3. Computer-assisted diagnosis according to Nakatani. The initial diagram shows Coldness and Dryness in the lung channel structure. The repeat diagram demonstrated how the energy status of the lung channel is normalized. The , imbalances are brought to norm. Coldness and dryness are retained in the kidney meridian structure

It is noteworthy that an excessive energy in the lung meridian would result in a stormy paroxysm associated with sonorous distant rale, largely occurring in the early morning time. In this case the magnets will be placed so that the lung meridian is appropriately sedated. Where a paroxysm appeared to be of "quiet" type and the rales could be only perceived by means of auscultation, with aggravation coming in in the second half of the day - this results from energy deficiency in the lung meridian, which is to be tonified. While conducting the diagnosis of application type, it is advisable that treatment should be started by activating a single byol-meridian. Otherwise an inadequate placement of magnets simultaneously on two (paired) meridians could lead to a rapid development of a paroxysm.

Moreover, a bronchospasm will be arrested by means of a slow, intense and prolonged massage of a point corresponding to the trachea bifurcation (sharply painful in all asthma patients). This can be done with fingers by simultaneously pressing upon the zone corresponding to the prominent vertebra. In providing a correspondence-system-based treatment a moxa should be applied to heat up what is called the asthma point until there emerges a bubble. The point is located between spinous processes of the thoracic spine - in the xiphoid process projection - and known to be the point of tenderness.

The Six-Ki-oriented treatment using byol-chakras and byol-meridians should be provided on a strictly individual basis in each particular case. In order to work out a tactical algorithmization aimed at arresting paroxysms of asphyxia and at providing a differentiated and scheduled treatment strategy, we did the following. The principal pathogenic mechanisms of BA were reviewed in the context of the theory of energy structures and substructures. The classical syndromes of the mainstream Chinese medicine (MCM) practised in the course of millennia in the Orient to deal with BA were also considered from the same standpoint.

As a matter of fact, an attack of asphyxia is likely to illustrate Six-Ki circulation. Prodrome, sensation of impending paroxysm and semicough would be in line with the Wind stage. Immune inflammation, hyperemia, edema of the bronchial mucosa, a discomfort in the chest would correspond to Heat and Hotness stages. Sputum hypersecretion will be related to Humidity. Bronchial spasm and blocking of the respiratory tracts with

thick and tenacious sputum are associated with Dryness energy, while Coldness energy is manifested in a severe spasm, bronchial obstruction, dense vitreous sputum and acute respiratory incompetence. Hence, in order to alleviate a paroxysm of arphyxia it would be highly worthwhile to resort to the lung meridian involving sedation of Coldness and tonification of Hotness (A/VI/III). If an illness proved to be associated with the unified energy, similar treatment will be provided in the large intestine meridian structure.

As it happens, BA would affect the whole bronchial tree, upper respiratory tracts and accessory nasal sinuses. In the energy structure of the bronchi their muscles would reveal the branch Wind; the blood vessels - branch Heat; sympathetic and parasympathetic innervation will be associated with the branch energy of Hotness; the glands secreting the mucus - with the Humidity branch energy. Mucous membrane of the bronchi and the connective-tissue stroma would be related to the branch energy of Dryness, whereas the tracheal cartilage and bronchial serous membrane - to the branch Coldness. Therefore, hyperactivity and predisposition to spasms are likely to be associated with the fact that Coldness and Wind are predominating in the structure AH- or UM-Wind of the bronchi. This is specifically manifest provided BA occurs in conjunction with cholelithiasis (in some patients the condition is caused by the energy imbalance of the liver). Disturbed circulation in the lungs will be brought on by the status of subbranch energies in the branch Heat of the Dryness, notably: the rate of the blood flow would be advanced due to the subbranch Wind; hyperemia is influenced by subbranch Heat and Hotness; perivascular edema - by subbranch Humidity; spasm and shunting are brought about by subbranch Dryness; pronounced diminution of the blood flow will be caused by subbranch Coldness.

Vegetative innervation of the bronchi is conditional on the status of the Hotness branch energy: the sympathetic innervation contributing to the bronchodilatation effect will be controlled by subbranch energies of Wind, Heat and Hotness in the branch Hotness of Dryness. Parasympathetic innervation whose intensified status results in hypersecretion and bronchospasm is controlled by subbranch energies of Humidity, Dryness and Coldness in the branch Hotness of Dryness. For example, to eliminate the vegetative misbalance at the bronchopulmonary system dimension, the sedation of subbranch Dryness and tonification of subbranch Heat in the Hotness of Dryness would be indicated (fig. 4). Of special importance is the energy evaluation of the branch Humidity of the lung, which is helpful in controlling the status of the submucous layer of the bronchi where a persistent immune inflammation is localized and where the hypertrophied mucous glands reside - the focus of hypersecretion and dyscrinism. When the subbranch Wind predominates in the branch Humidity of Dryness, the sputum is either lacking at all or present in negligible quantity. With subbranch Heat, Hotness and Humidity in excess, however, the sputum is abundant, watery, with the submucous layer showing an immune inflammation and edema. Where the subbranch Dryness energy is excessive, the sputum proves to be tenacious, in the form of the bronchial molds, and is noted for having the Curschmann's spirals. If the subbranch Coldness energy demonstrates excessiveness, the sputum appears to be dense, vitreous, notable for a large quantity of calcium crystals (in effect, crystallizing would set on before a paroxysm of asphyxia and tend to intensify during a magnetic storm). In order for these disturbances to be accurately corrected, a comprehensive diagnosis of the AH- and UM-Humidity should be arranged to make sure that a relevant chakra or a rent channel are adequately chosen.

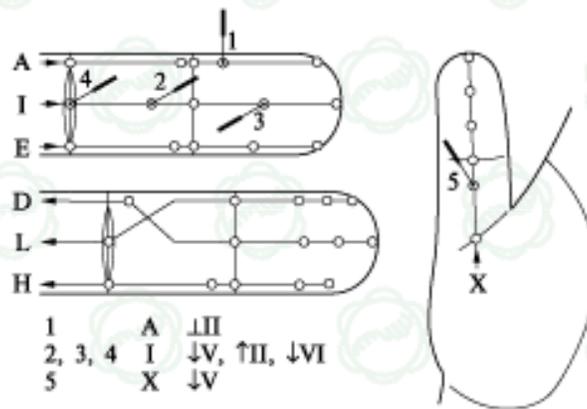


Fig. 4. Sedation of the subbranch Dryness energy in the branch Hotness energy of the main UM-Dryness energy

Of great practical value is the fact that the UM-Dryness framework would concurrently represent the state of the adrenal glands, and it is this very framework where the substructure of the lung branch Dryness will be projected on. In the meantime, the branch Coldness in UM-Dryness with which are associated both the pronounced bronchospasm and crystallization, and the allergic lesion - the mechanism to trigger BA - will become manifest in the renal (urinary bladder) channels in the form of subbranch energies.

Where the asphyxia attacks were related to a specific phase during a menstrual cycle - for instance, if they come in just before or during the monthlies (i.e. at the Dryness or Coldness stage of a monthly cycle) there should be performed sedation of the subbranch Dryness (Coldness) in the branch Hotness of UM-Dryness, as well as sedation of the branch Dryness (Coldness) in UM-Dryness.

This is how we are able to provide treatment at the main, branch, and subbranch energies dimension, and to ensure a unique individual approach to each and every BA patient.

In their efforts to diagnose and treat the BA patients the medical practitioners of Mainstream medicine of China (MMC) will use the following syndromes: Complete asthma (characterized by severe expiratory dyspnea; asphyxia noted for sonorous distant rale; alterations in remission unavailable).

1. Wind and coldness penetrate into the lungs.
2. Hotness and sputum in the lungs.
3. Energy misbalance in the liver.
4. Energy misbalance in the liver, hotness has emerged.

Hollow asthma (severe, but silent dyspnea; asphyxia with mild physical manifestations; dyspnea is keeping up during remission).

1. The lung's energy is running low.
2. The spleen's energy is running low.
3. There is little Yang in the kidney.
4. There is little Yin in the kidney.

The "root" of BA is believed by the MMC to reside in the kidney, with the main pathognomonic process developing in the spleen, while the disease manifestation - or what can be described as its "flower" - is to be referred to the lungs. It is an easy matter to note that the cited energy-related substructures, which would in essence coincide with the syndromes offered by the mainstream medicine of China, are fairly notable for greater accuracy and flexibility in as far as their therapeutic approaches are concerned.

CONCLUSIONS

1. Su Jok therapy stands as a highly efficient method of nonmedicamentous treatment of BA patients.

2. The Su Jok therapy approach has the capacity to remedy health disorders at a variety of levels, including emotional, mental, at the somatic (intersystemic) level, the afflicted system and cellular levels.
3. Su Jok therapy will emerge useful both as a tactical therapeutic modality in order to relieve an exacerbated condition, and as a strategic treatment aimed at dealing with first-order factors of the BA pathogenesis.
4. Su Jok therapy has proved to be in tune with the therapeutic methods advised by the International Consensus; besides, it can be applied as a monotherapy.

CLINICAL EXAMPLE

A male patient, born 1934. In the first year of his life he had episodes of generalized convulsions. According to his medical history he suffered from the right cheek furunculosis, the right elbow joint bursitis, the right knee joint arthritis, erysipelatos inflammation of the right shin, and arthrosis of the left hip joint. The patient has a low, hoarse voice. His complaints included fits of AH-anger provoked by a disturbance in the established life-organization pattern. Investigation into his external respiration functions (ERF) revealed a pronounced, slightly reversible obstruction of the bronchi. The amount of the 11-HKS level showed a 50% drop. The USI findings pointed to a deformity in the gall bladder.

On the strength of these data, a comprehensive diagnosis of this patient's BA was made.

As evidenced by his date of birth, convulsions, the gall-bladder deformity, the left hip-joint arthrosis and his AH-anger, the patient has an excessive AH-Wind where Dryness and Coldness predominate. Given that the right cheek, right elbow and knee joints, including the right shin will represent the Dryness-related regions - the manifestations of AH-Heat, Hotness and Humidity therein would point to a structure of AH-hotness excess in the large intestine channel. At the same time, a low coarse voice of the patient, bronchi obstruction, and an explicit diminished function of the adrenal cortex would be indicative of the phenomena related to Coldness and Dryness in the UM-Dryness framework.

Having corrected the said disorders, it became possible to attain a prolonged clinical remission, improve the patient's ERF, enhance the adrenal cortex functions, and remove pains in the left hip joint. This enabled therapists to avoid having to administer the inhalation steroids.

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