Cases from the London School of Acupuncture Teaching Clinic

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Ms L. was a 46 year-old who first attended the clinic in the summer of 1999. She seemed worn down. She was of medium build, slightly pale, and well presented. She had a good job in marketing, although felt some bitterness at having been passed over for promotion a number of times. She was suffering with headaches and said that she wanted relief from these, and also an improved sense of well being. She had four distinct types of headache:

• The first occurred mostly on Monday mornings, although it could also come on during the day, when she would feel it as a constant background "noise". It concentrated itself around the temples and behind the eyes, but could also express itself as a band around the back of the head from the temples, and sometimes over the top of the head "like a cap". Although this headache felt "like I can hardly lift the weight of my head", Ms L was able to go to work with it. It was worse during stormy weather, and sometimes resolved with eating. It made her want to lie down and close her eyes.

• The second kind of headache was a migraine, and appeared to the patient to be a continuum of the first, but its severity was such that she had to go home if it came on at work. It expressed itself along a posterior-anterior line on the left side of the head, about level with the mid point of the eye (the left Bladder channel), which fell along the line of the patient's hair parting. It was a severe throbbing headache, which cut through her head "like a hot knife through butter". With it she became photophobic and nauseous. She had prodromal symptoms of neuralgia (mostly in her arms and hands as though "the skin were sore to touch") and nausea.

• The third kind of headache appeared on the same line as the migraine: the left Bladder line. It had the sensation of a pressure under the skull, "like a sausage". It was accompanied by dizziness, and made her feel "wobbly". It had appeared 12-18 months previously.

• The fourth kind had appeared in the last 2 or 3 months. It expressed itself as a very intense throbbing around Tongtian BL-7 on the left side. It lasted a few moments, disappeared, and then reappeared about 10 minutes later. She had had this headache several times over the past few weeks, and had found it very frightening.

She had been prescribed painkillers and anxiolytics for these headaches, and when she first appeared at the student clinic she was taking as many as 6 Co-dydramol (paracetamol + codeine) daily - a weekly total of close to 30 tablets. On the whole nothing relieved the headaches other than the use of painkillers, and Ms L had clearly become very dependent upon them. She carried them everywhere with her, and sometimes took some prophylactically if she felt a headache coming on.

The history of the headaches went back to childhood. She remembered her mother taking her to the doctor when she was about 10, and she had been given "some white tablets"; but she was not aware of any preceding precipitating factors. These facts, coupled with the death of an uncle who died unexpectedly of a brain tumour after having suffered from headaches for years had brought her to clinic at this juncture. She had seen her GP, and had an appointment with a neurologist booked, but not for another 8 months.

Ms L's own understanding of her headaches was that they were because of "worries". She said that she found it hard to relax, and it took her a while to wind down after work. She had also been feeling "shattered", with low energy recently. Her background was that she lived alone, which she described as being "effective". She had been married until 1985 when she had had a stressful divorce, about which she still harboured bitterness.

Ms L had had a hysterectomy in 1996 because of fibroids. Her ovaries had been retained. She felt on the whole it had been a "positive experience", although she was sad about her childlessness.

She sometimes had blurred vision, particularly in the mornings, and accompanying her migraines. She sometimes experienced flashing lights in the right hand side of her visual field with her headaches. Her eyes felt dry, as did her mouth, particularly at night. Her appetite was good, although she sometimes got a bad burning sensation from "too much stomach acid". She would then experience constant hunger, although eating just produced more discomfort. Her bowels were variable, sometimes resembling goat's droppings, sometimes more solid. She drank a litre of water a day, and her urination was normal. She had occasional night sweats that had been profuse in 1998. Her sleep was erratic and she suffered from insomnia at times. She suffered from lower back pain, and pain in her hips and knees. Emotionally she felt stable, but sad. She didn't like the cold, and tended to get phlegmy coughs in the winter. She frequently got a blocked nose at night, "with nothing to blow". Her diet typically consisted of fruit for breakfast, a sandwich for lunch and salad with a hot dish in the evening followed by muesli and yoghurt.

Her left pulse was thin, wiry and empty; and her right pulse was weak and empty.

Her tongue was red with a purplish area in the centre and a very slight white coat. The frontal area was swollen and there was a redder tip. There were teethmarks to the sides, and the tongue quivered.

Diagnosis

The diagnoses of her four headaches were:

i. Spleen qi deficiency leading to dampness obstructing the clear orifices leading to the first "morning" headache

ii. Kidney and Liver yin deficiency leading to Liver yang rising along the Bladder channel leading to migraine headaches

iii. Phlegm obstruction in the Bladder channel causing qi stagnation and giving rise to the "sausage" sensation of pressure and dizziness

iv. Phlegm obstruction in the Bladder channel leading to blood stasis and intense, static bursts of pain.

Historically, Ms L. began to develop regular headaches as a child. They had already developed to such an extent by the age of ten that her mother took her to the doctor who prescribed medication. Both parents also had long histories of headache. Maciocia (*1994: 1-2*) holds that "Persistent and recurrent headaches that start in childhood (usually between about 7 and 10) strongly indicate the presence of a constitutional factor of disease". She had amoebic dysentery at 4; and whooping cough as a child, both very debilitating diseases. Both these conditions, and their (presumed) treatment with antibiotics would compromise the Spleen, injuring qi and blood production. With time, and further Spleen depletion, dampness would likely have accumulated, so producing a combined dampness and deficiency type headache. Hence the empty pulse, toothmarked tongue, dull morning headache, and extreme tiredness.

It is difficult to tell at this distance of time whether there was a constitutional deficiency, and if so, which organ(s) might have been affected. The childhood whooping cough implicates perhaps the Lung (*Maciocia, 1994: 2*), but there are no clear signs of Lung deficiency in later life. However when Ms L. first presented at clinic there were signs of Kidney and Liver deficiency, specifically yin deficiency: sore back and knees, sleeplessness, visual disturbances, dry eyes and mouth. Liver and Kidney yin deficiency had led to a Liver yang rising headache, which had manifested along the Bladder channel, perhaps because of Kidney deficiency, and the Bladder being the exteriorly-interiorly related channel.

There were other signs of Liver imbalance. Ms L. was clearly depressed which leads to, and is fed by, Liver qi stagnation. "Goat-like" faeces is a sign of Liver qi stagnation, and the wiry pulse supported this view.

The long-term Spleen deficiency had led to a build up of dampness and phlegm. Turbid phlegm had become lodged in the Bladder channel, perhaps driven there by Liver yang rising along that channel, and the phlegm was causing qi stagnation, which in turn produced a palpable sense of pressure (the "sausage" sensation) as well as sensory disorientation.

The most recent development in this sequence of events was the development of very characteristic blood stasis type headaches in the same position as the phlegm type - around Tongtian BL-7. This was presumably caused by phlegm in the channel blocking the free movement of blood and qi, so leading to blood stasis. Her tongue's purplish hue supported the diagnosis of blood stasis.

A Western medical viewpoint

Within Western medicine the over use of analgesics is a well-documented cause of headaches in and of itself (*Consumers' Association, 1999:41*). The characteristic features of this kind of 'analgesic induced headache' is a "self-sustaining, rhythmic headache medication cycle characterised by daily or near daily headache, and an irresistible and predictable use of pain medication as the only means of relieving headache attacks". (*Mathew, 1993: 82*). Drug-induced headache is dull, and band-like, usually starting in the early morning (*Diener et al, 1989: 9*). Other features of this kind of headache are sleep difficulties, and a gradual increase in the use of analgesics, sometimes using them in anticipation of headache. Drug and Therapeutics Bulletin defines excessive consumption as more than 12 doses, or 3 medication days per week (*Consumers' Association, 1999:42*). Ms L was typically taking around 30 Co-dydramol (500mg paracetamol, dihydrocodeine tartrate 10mg) a week, or 2-6 tablets a day, by the time she came to see us.

The descriptions in the Western literature tellingly echoed Ms L's own descriptions of her headaches, and her relationship to analgesic use. This information was significant to us as practitioners of TCM because Western research into analgesic induced headache states unequivocally that medication misuse "markedly reduces the effectiveness of all forms of headache treatment." (*Consumers' Association, 1999:41*). The Western literature is clear that patients suffering from analgesic induced headache have to withdraw from their medication to break the cycle. Additionally, on withdrawal they are likely to experience withdrawal symptoms that last 3-10 days and include initial worsening of the headache, insomnia, sweating and nausea (*Diener et al, 1989: 11*).

In summary, to manage Ms L's case effectively it was likely that acupuncture alone was not going to be enough and we were going to have to approach the issue of her stopping her painkillers completely. However in so doing she was likely to suffer from withdrawal symptoms which she should be counselled about, and acupuncture could be offered for symptomatic relief.

Management

The picture that emerged from this patient was of a woman who was very deficient in qi and blood, who had dampness and phlegm blocking channels in the head, and whose yin

deficiency was causing Liver yang to rise along the Bladder channel. The treatment plan was to address the *ben* (dampness and phlegm from Spleen qi deficiency, rising Liver yang from Kidney and Liver yin deficiency, blood stasis) and *biao* (headaches) simultaneously using local and constitutional points; to introduce dietary advice gradually to try to regulate the Spleen and to build qi and blood; and to give exercise advice to encourage the movement of qi and blood. However if the analysis of the importance of painkillers in this picture was correct, and the Western research was correct, this TCM approach would not be enough without Ms L coming off her high regime of daily painkillers.

The patient was asked to keep a daily symptom diary as a way of tracking her treatment. The diary was to include the time of any headache, its type (1-4 as in the schema above), and its severity on a 1-10 pain scale. She was also asked to keep a record of how many analgesics she took each day. Meanwhile we would start with acupuncture treatment before the difficult issue of painkiller usage was addressed.

Treatment and response

The treatment was directed at clearing dampness, tonifying qi, nourishing yin and resolving phlegm. Zusanli ST-36 and Sanyinjiao SP-6 were used together to tonify Stomach and Spleen qi, to clear dampness and phlegm and to nourish yin. Tongtian BL-7 was used as a local point. It also is an important point to clear nasal congestion (*Deadman & Al-Khafaji, 1998: 261*), which interestingly was something Ms L complained of as a chronic problem. Shuaigu GB-8 and Taiyang (M-HN-9) were used together as local points for temporal headache (*Maciocia, 1994: 13*). Lieque LU-7 was used because it is the command point of the head. We agreed to treat once a week for ten weeks and then review.

After two treatments the patient said that she was feeling better in herself and was less tired, but that the headaches had not improved. At this point we introduced the idea that the analgesics could be contributing to her headaches, and that there was some evidence that they weren't going to get significantly better until she stopped them. We also pointed out that she could feel a lot worse initially on stopping her pills, and so the timing of withdrawal should be carefully judged to fit with the patient's workload and personal life. We went through the possible side-effects with her and said that the clinic would support her if she wanted to come in more frequently to get help and relief from nausea, sweating and so on. Ms L gave permission for us to contact her doctor to communicate what had been discussed.

At this juncture the Stomach and Spleen pulses were feeling stronger. We added stick moxibustion to Zusanli ST-36 to further tonify qi. We left it that she would think about withdrawal, and think about its timing if she wanted to go ahead with it.

The following week there was no change, although she had not had a headache yet that day. She was thinking about withdrawal, and said that she would give us a decision the following week. A fortnight later Ms L appeared at clinic very cheerful. She had missed the previous week's treatment, but despite this had experienced remarkable recovery: she had not had a headache in five days, which for her was a result that made her "stunned, wondrous and pleased." Analgesic withdrawal had happened by default rather than by design. She had spontaneously stopped having headaches, and had therefore stopped her drugs. Her sleep was better, but she had been having terrible night sweats. This was predicted by the Western research on the side effects of withdrawal. We removed Shuaigu GB-8 and Taiyang (Extra) from the prescription and added Fuliu KID-7 and Yinxi HE-6 for her night sweats.

At her next visit to clinic she presented with prodromal migraine symptoms. She had been having some of the type 1, dampness headaches but she said that they had not been as bad as before treatment, and they now went of their own accord. Up until now, she had had no migraines or no headaches of type 3 or 4. We needled Zusanli ST-36 and Sanyinjiao SP-6 to tonify qi and supplement Stomach and Spleen, Lieque LU-7 because it is the command point of the head, Zulinqi GB-41 on the left and Taichong LIV-3 on the right to spread Liver qi.

At the next treatment (and the last by this student) Ms L reported that the previous treatment had averted her migraine, which nothing previously had been able to do. She had had some headaches, but less frequently, and without the accompanying feelings of sleepiness. Her sleep was still not improved, but her night sweats had diminished and she was no longer "getting drenched". Her energy was better, but still "on and off". We needled Zusanli ST-36 and Sanyinjiao SP-6, Lieque LU-7, Taichong LIV-3, Tongtian BL-7 and Anmian (M-HN-54) to help her sleep.

A summary of the treatment response is shown below in a table. The headache score is the number of daily headaches x severity. The first treatment was August 4th.

Week beginning	Headache score	No. of analgesics
Aug 4	81	33
Aug 11	99	24
Aug 18	67	15
Aug 25	23	5
Sep 1	12	2
Sep 8	33	0
Sep 15	39	0
Sep 22	6	0
Sep 29	13	0
Oct 6	4	0

Follow up

The patient was followed up by telephone one year after treatment had started. She was having "very occasional" headaches which were manageable, and went of their own accord. She had not had any recourse to medication for headaches.

Discussion

There are various aspects of this case that are striking. Firstly it demonstrates that acupuncture can be effective in treating long term headache, even when the patient is

concurrently taking large numbers of analgesics. Of course we cannot be sure that this woman was suffering from analgesic-induced headache. She certainly fitted the profiles published in the Western literature, but she had not received that diagnosis from a Western physician - indeed it was her GP who had been prescribing her Co-dydramol. However she did have a very dependant relationship on large quantities of paracetamol, and acupuncture was effective in alleviating her headaches, so allowing her space to securely reduce her dependence on, and intake of medication.

Secondly, it is very common for patients to suffer withdrawal symptoms after the abrupt cessation of analgesics. This patient was generally free from withdrawal symptoms. She did have some bad night sweats soon after she had stopped medication, but these had been a feature before treatment, and were not necessarily as a result of withdrawal.

Thirdly the patient's daily symptom diary was a crucial component in understanding and tracking her recovery. At the beginning of treatment Ms L was having headaches, and nine weeks later she was still having headaches. There was an eight-week span between these two events. Would it have been easy for her to evaluate the difference in the number of headaches she was having and their quality without some record? The diary was useful for her because she had a clear chart of her progress, and it was useful to the clinic staff who could assess and judge the quality of their care. It is a particularly useful tool when improvement of a chronic condition may take place over the course of several weeks.

References

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