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A Benign Complex Ovarian Cyst Treated with Traditional Chinese Medicine: A Case Study

By **Kandace Cahill**, MSOM, Dipl OM (NCCAOM), LAc

Kandace Cahill, MSOM, Dipl OM (NCCAOM), LAc, owner and director of Essential Being Health in Boulder, CO, is a licensed acupuncturist and women's health specialist providing acupuncture and Chinese medicine for the treatment of both gynecological and reproductive/fertility issues. She serves as a faculty member at Southwest Acupuncture College in Boulder and is currently receiving her Doctorate in Acupuncture and Oriental Medicine (DAOM) from Oregon College of Oriental Medicine in Portland, OR. She is currently compiling research for a practitioner's guide on Chinese medicine and polycystic ovarian syndrome (PCOS). She may be contacted at: info@essentialbeinghealth.com

Abstract

Background: Complex ovarian cysts occur in approximately 10% of women and can have serious consequences. Possible complications include ovarian torsion leading to adnexal necrosis, peritonitis, infertility, leakage of cystic fluid into the abdominal cavity and sepsis or abdominal hemorrhage. While many studies exist that discuss the role of traditional Chinese medicine (TCM) in treating various female pelvic disorders, none were found that pertained to the treatment of complex ovarian cysts.

Objective: To present a case and discuss the potential effect of TCM as a non-surgical option for resolving complex ovarian cysts.

Design, Setting, Patient: A single case report of a 50-year-old perimenopausal female diagnosed with a complex ovarian cyst treated by acupuncture and Chinese herbal medicines in a private acupuncture practice.

Intervention: The patient was treated with a combination of acupuncture, Chinese herbal medicines, and moxibustion over the course of 2 three-month periods.

Results: Complete resolution of the cyst as detected by sonography.

Conclusion: Traditional Chinese medicine, which includes both acupuncture and Chinese herbal medicine, may provide a non-surgical alternative treatment for the resolution of certain types of complex ovarian cysts.

Keywords: Complex ovarian cyst, acupuncture, Chinese herbal medicine, dysmenorrhea, pelvic pain

Introduction

Complex ovarian cysts are an uncommon type of malignant or benign tumor occurring in approximately 10% of women.¹ These include dermoid cysts, which can exceed 10 cm in diameter and, in some instances, cause no symptoms or complications. However, when the mass size exceeds 4 cm there is a 3-16% chance of pedicle torsion with resulting ovarian necrosis as well as cystic rupture, which could lead to peritonitis or sepsis. The rate of spontaneous resolution is 8.3% in pre-menopausal women.² Malignancy can

be assumed to be related to a vegetarian diet. However, no further medical evaluation was performed to rule out other causes, and the patient was instructed to take supplemental iron and increase intake of iron-rich foods. Complete hysterectomy was recommended for removal of the ovarian cyst, which the patient declined. A second opinion and follow-up ultrasound in October, 2008, revealed a decrease in the size of the cyst (see Table 1); salpingo-oophorectomy was then recommended. The patient expressed concern over possible malignancy but was hesitant to receive immediate surgical intervention. She desired an alternative approach that might reduce or eliminate the mass and consented to a trial of several months of acupuncture and herbal therapy.

“Emotional stress is the primary cause of Liver *qi* stagnation, especially when it is longstanding. Over time, stagnant *qi* in the Liver exerts excessive control on the Spleen, impairing its ability to transform and transport food and fluids. ”

be detected with an elevated serum CA-125 when combined with positive ultrasound findings; however, false positives negate the efficacy of this value.³ Similarly, the differentiation of ovarian tumors can be difficult via ultrasound. For these reasons, surgical excision of the mass prior to torsion, either by cystectomy or oophorectomy, is often the recommended treatment.⁴

In traditional Chinese medicine (TCM), abdominal masses are in the category of *zheng jia* (症瘕), or “concretions and conglomerations.”^{5,6,7} In these patterns, blood stasis and *qi* stagnation are the primary categories of pathology.⁸ Other complicating factors include phlegm-damp accumulation and *qi* deficiency, with one or both patterns existing in most cases. Treatment principles, therefore, are to move *qi* and blood and resolve masses by breaking blood and softening hardness. For maximum efficacy, treatment plans combine the use of both acupuncture and Chinese herbal medicine.

Case History

A 50-year-old Caucasian female presented to the clinic in October, 2008, complaining of intermittent right lower quadrant abdominal pain. Initial onset of the pain occurred five years prior, intermittently, with no discernible pattern. The pain was reported to be unrelated to menses, dull, fixed, worse upon palpation, and mild to moderate in intensity (4/10 of the pain scale). Two years prior, her menstrual cycles had become irregular and unpredictable, and she was diagnosed with the onset of perimenopause.

In August, 2008, a pelvic ultrasound was performed, confirming the presence of a right ovarian complex cyst with septation measuring 5.1 cm x 3.5 cm. Lab values were simultaneously drawn, revealing iron deficiency anemia (serum iron 20mcg/dl and Hgb 9.4gm/

dl) assumed to be related to a vegetarian diet. However, no further medical evaluation was performed to rule out other causes, and the patient was instructed to take supplemental iron and increase intake of iron-rich foods. Complete hysterectomy was recommended for removal of the ovarian cyst, which the patient declined. A second opinion and follow-up ultrasound in October, 2008, revealed a decrease in the size of the cyst (see Table 1); salpingo-oophorectomy was then recommended. The patient expressed concern over possible malignancy but was hesitant to receive immediate surgical intervention. She desired an alternative approach that might reduce or eliminate the mass and consented to a trial of several months of acupuncture and herbal therapy.

The patient’s last menstrual period (LMP) was noted as 8/30/08, with a recent history of approximately 60 days between menses. Menstrual flow was 3-4 days long, with moderate to heavy bleeding in the first 2 days and a sudden tapering of flow in the remaining 2 days. Menstrual blood was reported to be bright red with no clotting. Pre-menstrual symptoms included breast tenderness, cravings, and abdominal bloating with occasional mittelschmerz. Additional history included: cold hands and feet, dryness of the skin, hair, and nails, lack of thirst with desire to sip fluids, desire for warm food and drink, and constipation with hard and dry stools. She also reported irregular food and supplement intake, low appetite, insomnia, high stress, and fatigue, all worse with inactivity and stress. Past history included chronic migraine headaches before menses. Medications included Maxalt as needed for migraine pain and an over the counter iron supplement for anemia. No other significant past history was noted. There was a family history of cancer, albeit not reproductive. The patient was married with three living children and has a graduate level education, working for 30 years as an environmental scientist. She reported minimal alcohol intake and did use tobacco 25 years prior.

The patient was overweight (Height: 5’2”; Weight: 165 lbs) with centralized weight distribution, a slightly dark facial complexion with dark circles beneath the eyes, and pale, dry lips. Her middle to lower abdomen was cold on palpation with right lower quadrant tenderness and normal bowel sounds. The tongue was pale purple with a white, sticky, and dry coating; it was swollen and scalloped, with a slightly red tip and slightly distended sublingual veins. Pulses were thin and wiry in the left *cun* and *guan* positions, slippery in the right *cun* and *guan*, and slightly weak in both *chi* positions.

The patient was diagnosed with Liver *qi* stagnation leading to Spleen *qi* deficiency and damp-phlegm accumulation, with concurrent Liver blood stasis, blood deficiency and cold accumulation in the lower *jiao*. The pattern of Liver *qi* stagnation leading to Spleen deficiency was apparent in the left side wiry pulse and right side slippery pulse, as well as the swollen, scalloped tongue. Other symptoms included: history of emotional stress, digestive complaints improved with exercise, irregular stools with hard and dry stools that were difficult to expel, insomnia precipitated by stress and alleviated with exercise, premenstrual breast distention and bloating, mittelschmerz pain⁹ and chronic history of migraines. Damp-phlegm accumulation was apparent in the body type with centralized weight distribution and absence of thirst. Cold accumulation in the lower *jiao* was indicated by a desire for warm food and drink, cold abdomen on palpation, and pale purple tongue body with white coating. Blood deficiency was evident in the history of iron deficiency anemia and dry skin/hair/nails while blood stasis was apparent in the fixed lower abdominal pain aggravated by palpation and abdominal masses.

Emotional stress is the primary cause of Liver *qi* stagnation, especially when it is longstanding.¹⁰ Over time, stagnant *qi* in the Liver exerts excessive control on the Spleen, impairing its ability to transform and transport food and fluids.¹¹ When the digestive function of the Spleen is hampered, fluid accumulates into dampness or phlegm, which further impairs the smooth flow of Liver *qi*. Likewise, longstanding Spleen *qi* deficiency can lead to a weakening of the body's *yang*, causing interior cold accumulation, as well as generalized blood deficiency. *Qi* stagnation and *yang* deficiency coupled with internal cold accumulation can impede the movement of blood, causing it to become static and accumulate into fixed abdominal masses.¹²

The primary treatment principles were to regulate Liver *qi*, tonify Spleen *qi*, warm interior yang, and move static blood to reduce accumulation of masses and decrease pain. Though the patient presented with anemia, blood deficiency was not addressed in the initial treatment plan because of tongue and pulse presentation and the quality/intensity of pain, which revealed that *qi* and blood stagnation were primary. Because iron supplementation and dietary changes were recently implemented, she was advised to have repeat lab work in 2-3 months to reevaluate the anemic condition, with changes made to the treatment protocol if the iron deficiency persisted.

The recommended course of treatment consisted of three months of weekly acupuncture and daily herbal therapy, followed by sonographic reevaluation. Another course of treatment was to be recommended if the mass persisted at that time.

Treatment

Acupuncture treatment was performed with DBC .20 x 30mm or .20 x 40mm sterile needles; needle lengths were chosen according to acupuncture point and physical anatomy of the patient. Distal and abdominal points were needled bilaterally with the exception of the master-couple points of the *Chong* and *Ren Mai*. Needles were inserted and manipulated until *deqi* sensation was obtained, with

either tonification or reducing methods performed when indicated. The needles were retained for 25-30 minutes per session, with manipulation performed midway through the treatment. TDP heat was routinely applied to the abdomen. (see Table 1)

Herbal Formula:

Modified *Gui Zhi Fu Ling Tang* and *Kai Yu Er Chen Tang* (Cinnamon twig and Poria Decoction plus Two Cured Decoction to Remove Painful Obstruction)¹³

- *gui zhi* (Ramulus Cinnamomi Cassiae), 4g
- *fu ling* (Sclerotium Poriae Cocos), 12g
- *ban xia* (Rhizoma Pinelliae Ternatae), 12g
- *xiang fu* (Rhizoma Cyperi Rotundi), 9g
- *mu dan pi* (Cortex Moutan Radicis), 9g
- *bing lang* (Semen Arecae Catechu), 9g
- *chuan xiong* (Radix Ligustici Chuanxiong), 6g
- *e zhu* (Rhizoma Curcumae Ezhu), 9g
- *chen pi* (Pericarpium Citri Reticulatae), 6g
- *qing pi* (Pericarpium Citri Reticulatae Viride), 6g
- *dang shen* (Radix Codonopsis Pilosulae), 12g
- *zao jiao ci* (Spina Gleditsiae Sinensis), 6g

The principal formula, *gui zhi fu ling tang*, is comprised of *gui zhi*, *fu ling*, *chi shao*, *mu dan pi*, and *tao ren*. It was chosen because of its ability to move static blood and resolve cold accumulation in the uterus. A lesser known formula, *kai yu er chen tang*, is comprised of *chen pi*, *ban xia*, *fu ling*, *zhi gan cao*, *cang zhu*, *xiang fu*, *chuan xiong*, *qing pi*, *mu xiang*, *bing lang*, and *e zhu*. While traditionally used to treat amenorrhea due to *qi* stagnation, evaluation of the herbs led this author to believe that it could treat blood stasis with damp-phlegm accumulation.¹⁴ Subtractions were made to the original formulas to reduce the total number of herbs used. *San leng* (Rhizoma Sparganii Stoloniferi) 6g, was added to the formula during the second month to strengthen the blood cracking action.

The above doses were combined into a grinder and ground into a powder, then distributed in equal doses into seven teabags and sealed with a heat sealer. The patient was instructed to steep one teabag in two cups of boiling water in a tightly covered glass jar for a period of 10-12 hours, drinking the infused tea in two divided doses the following day. This was to be repeated daily for the entire initial course of treatment, with modifications made as needed. While this method of administration was chosen because it allows for greater patient compliance due to ease of preparation and lower cost, this patient did not regularly take the herbs due to her work schedule and inconsistent daily routine.

During the 7th week of treatment, menstruation occurred with menorrhagia, marked dysmenorrhea, substantial clotting, and migraine headache. In the week following menses, abdominal pain decreased significantly. However, an intermittent dull headache, fatigue, and pale tongue were present, which suggested an increase in *qi* and blood deficiency. Therefore, during the last four weeks of this treatment period, the point protocol was modified to gently move and nourish the blood, harmonize the Liver and Spleen, and reduce the headache. Due to non-compliance, herbal therapy was discontinued.

Reevaluation at Three Months

After 14 consecutive treatments, the abdominal pain had resolved. Tongue was consistently pale red to pink, and the sublingual veins were no longer distended and purple. There was, however, a persistent, intermittent headache that varied from dull and empty to severe migraine. The pulses continued to be predominantly wiry on the left, slippery on the right, deep and weak in both chi positions. Stress levels had risen sharply, and the patient's workload was expected to increase over the next two months. Repeat blood work showed that the anemia had resolved. Because of work-related time constraints, the patient opted to schedule a follow-up ultrasound in 8 to 12 weeks and to suspend regular acupuncture treatment in the meantime.

Ultrasound was performed in March, 2009, revealing a slight decrease in mass size from the preceding finding (see Table 1). A concurrent blood draw was again negative for anemia. The patient then returned to clinic for acupuncture and herbal treatment with the hope of decreasing the mass to a size that would no longer indicate the need for excision.

Because of the continued presence of the mass, treatment principles were continued as before. However, the presence of a thin pulse, fatigue, and chronic empty headache suggested that previous *qi* and blood deficiency had not improved despite the resolution of anemia. This change was attributed to the significant rise in stress levels and subsequent change in eating habits. Therefore, both the herbal formula and acupuncture protocol were modified, with the importance of consistent herbal compliance stressed to the patient. Modified *Tao Hong Si Wu* and *Gui Zhi Fu Ling Tang* (Four Substance Decoction with Safflower and Peach Pit plus Cinnamon

Twig and Poria Decoction) was prescribed as follows:

- *dang gui* (Radix Angelicae Sinensis), 9g
- *chuan xiong* (Radix Ligustici Chuanxiong), 6g
- *tao ren* (Semen Persicae), 9g
- *hong hua* (Flos Carthami Tinctorii), 6g
- *mu dan pi* (Cortex Moutan Radicis), 9g
- *chi shao* (Radix Paeoniae Rubrae), 9g
- *e zhu* (Rhizoma Curcumae Ezhu), 6g
- *xiang fu* (Rhizoma Cyperi Rotundi), 6g
- *zhi shi* (Citri Aurantii, Fructus Immaturus), 9g
- *fu ling* (Sclerotium Poriae Cocos), 9g
- *wu yao* (Radix Linderae Strychnifoliae), 12g
- *gui zhi* (Ramulus Cinnamomi Cassiae), 6g
- *gan cao* (Radix Glycyrrhizae Uralensis), 6g

This formula was prepared according to the above method. It was taken for two weeks then discontinued due to further non-compliance. No further herbs were administered for the treatment of this condition. Acupuncture treatment continued on a weekly basis until May 29, 2009, with modifications to the point protocol made as needed for migraine pain.

Outcomes

A third obstetrician/gynecologist opinion was obtained in April, 2009, and a final ultrasound was performed. It showed a minor decrease in size as well as the absence of septation within the cyst. CA-125 was assessed and found to be within normal limits. However, because of the persistent nature of the mass, a right

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Table 1: Treatment Description and Timeline (Key to symbols: + Tonify, - Reduce, = Even)

	Oct 2008	Nov 2008	Dec 2008	Jan-Feb 2009	March 2009	April 2009	May 2009
Acupuncture Protocol	-: SP10, ST29 Δ: ST36, CV6, CV12 +: CV4 =: SP4/PC6, LU7/KI6, Zigong, LV3, LV14, HE7	-: SP10, ST29 Δ: ST36, CV6, CV12 +: CV4 =: SP4/PC6, LU7/KI6, Zigong, LV3, LV14, HE7, LV5	+: SP6, LV8, CV4 Δ: ST36, CV6, CV12 =: LV13, LV3, LI4, LV5, HE7, Yintang	-	+: SP6, LV8, CV4 Δ: ST36, CV6, CV12 =: LV13, LV3, LI4, HE7, Yintang, points for headache as needed	+: SP6, LV8, CV4 Δ: ST36, CV6, CV12 =: LV13, LV3, LI4, HE7, Yintang, points for headache as needed	+: SP6, LV8, CV4 Δ: ST36, CV6, CV12 =: LV13, LV3, LI4, HE7, Yintang, points for headache as needed
No. of Acupuncture Treatments	4	4	6	None	5	6	4
Herbal Therapy	Gui Zhi Fu Ling Tang + Kai Yu Er Chen Tang	Gui Zhi Fu Ling Tang + Kai Yu Er Chen Tang	None	None	Tao Hong Si Wu Tang + Gui Zhi Fu Ling Wan	None	None
Herbal Compliance	14 days	7 days	None	None	14 days	None	None
Cyst Measurement	3.4cm x 2.3 cm (prior to TCM)				Unavailable (reported as "slight decrease")	3cm x 2.1 cm	Resolved (detected via CT on 6/30/09)

salpingo-oophorectomy was recommended and surgery scheduled for June, 2009. However, a pre-operative abdominal CT scan revealed spontaneous resolution of the adnexal mass. The surgery was cancelled, and the patient released from surgical care. Stress reduction and strict adherence to meal planning with consumption of regular meals was strongly encouraged to prevent recurrence of the previous TCM pattern.

Discussion

In TCM, acupuncture alone is considered to have a “neutral” and relatively harmonizing effect on the channels of the body compared to herbal medicine. Subsequently, the use of herbs is often chosen when movement or tonification of the body’s substances is required. Due to the complex nature of *zheng jia* patterns, therefore, a combination of acupuncture and Chinese herbal medicine may be the preferred treatment method, with routine and consistent use of herbs offering the principal means of affecting a timely change.¹⁵

Benign complex ovarian cysts rarely undergo spontaneous resolution and can pose significant risk once they become symptomatic. Because of this, large adnexal masses are often surgically removed to decrease the potential for a life-threatening event or malignancy. However, in this case, the patient achieved 100% reduction in the adnexal mass and resolution of all symptoms of associated pain after six months of TCM treatment, the majority of which was acupuncture rather than combined acupuncture and herbal therapy. With an 8.3% chance of occurrence, the resolution of the cyst could have been due to spontaneous resolution. However, there is

also a possibility that, by consistently using acupuncture to move *qi* and blood and resolve accumulation as well as nourish concurrent *qi* and blood deficiency, resolution was attained as a result of TCM treatment. Furthermore, this author speculates that if the patient had consistently complied with herbal therapy, positive results may have been obtained in a shorter period of time.

Conclusion

Few studies exist that explore acupuncture and Chinese herbal medicine in the treatment of complex ovarian cysts. This case illustrates that there is a need for further investigation. Well-designed randomized controlled trials that explore the efficacy of acupuncture, herbs, or combined therapy could provide more conclusive information and guide future treatment of this condition.

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doctoral@fivebranches.edu

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