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A Compendium of Clinical Methods

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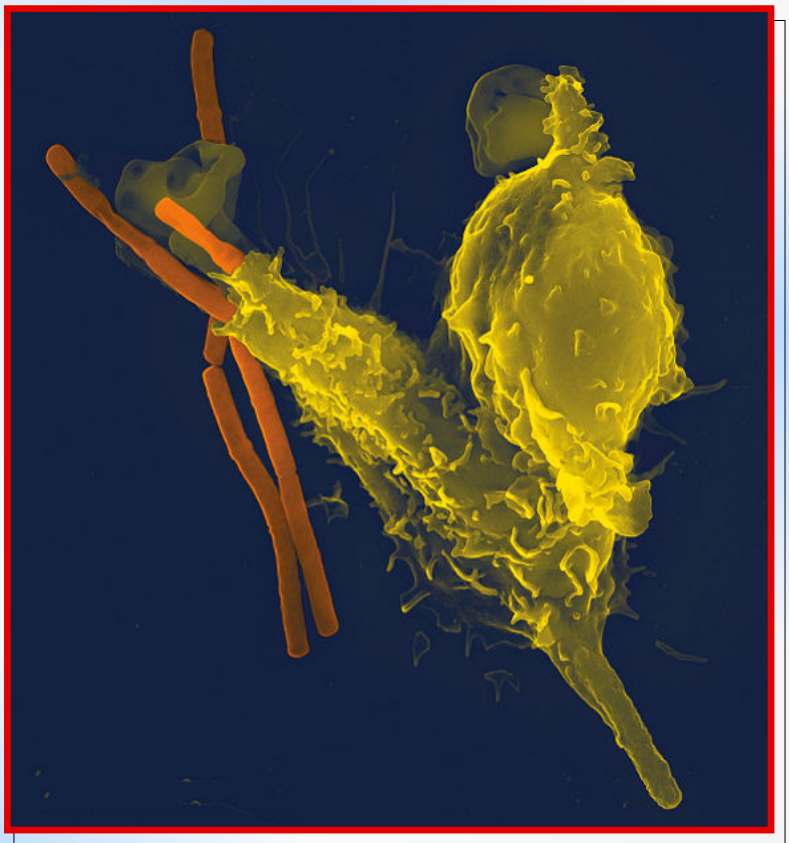
Working with Phlegm Part II



"Neutrophil engulfing Bacillus anthracis" by Volker Brinkmann

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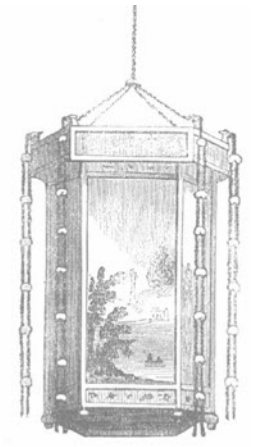

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With best wishes

Dr. Holmes Keikobad
Editor in Chief

Working with Phlegm Part II

Phlegm. Intractable, mysterious, dangerous and of ill intent.

The Ancients called it culpable when nothing else was, and the Contemporaries never faulted it in any chronic illness, unless as an afterthought.

It occurred to the writer that maybe there is a third state, where Phlegm becomes the ultimate Evil, simply because things were never really thought through, wearing, not the weighty Crown of Wisdom, but just the Cap of Can-it-Be?

In this discussion, the attempt will be not to recapitulate what is scribed over centuries, laid out in Tracts and Tomes, but to work things out with homegrown Shen, rooted in sense of the common kind.

As declared previously, these are simply the author's musings, winnowed over years of work, suggesting no more than, that maybe the Song of Phlegm needs to sung by a different tune?

Working with Phlegm
Continued from Part I in Previous Bulletin

Dr. Holmes Keikobad MBBS DPH DIP AC NCCAOM

We had put to vote if we should continue the Series and we got an unmistakable 'yes' and everyone knows that the Reader, may he or she be in Massachusetts or Mongolia, or Vermont or Vancouver, is always right.

In these pages, and in successive Parts, we will try to cover some of the following, adding fresh thoughts as we come upon those.

In a case of suspected Phlegm ...

1. What kind of a Blood Picture is likely to be seen?
2. What can ESR, a common and inexpensive test, tell?
3. What can the state of skin pores tell?
4. What picture will the tongue show?
5. How to check for Heat in a system?
6. How are symptoms of Heat different from those of Fire?
7. What face color diagnosis signs will present?
8. What tongue signs to look for?
9. How to use ST 40, the Universal Phlegm Point to best effect

1. In a case of Phlegm, what kind of a Blood Picture is likely to be seen?

Probably one which shows an infection, viz the White Blood Cell [WBC] Count will be higher than normal.

[Continuing in the Q & A format; many questions reflect actual ones from students]

Q. Does one have to have knowledge of clinical pathology to read the results?
A. No. With the proviso that you follow rules of your licensing body, the tests are simple to order, and results come in as reports rendered by the pathologist. In most cases it mentions normal levels alongside variations making conclusions is easy.

Q. So what test will one order in a case of Phlegm?
A. The test to establish a level of leucocytosis. In the Order form you check 'Blood Picture', and in a sub heading, 'Leucocytes'.

Q. For lesser mortals, Leucocytosis, what exactly is that?

A. Of all blood cells, the white ones, leucocytes, are most involved in fighting infection. When there is palpable infection, these increase, and condition known as leucocytosis has happened.

Q. !!?Where did this infection come in from? Are we talking of Phlegm, or of an invasion by a microorganism?

A. So here is one of the several Bridges for the Unwary we will cross. When Damp was Damp, there was no Dryness. When Dryness was not, there was no tendency to Heat. Hence there was no need to establish an infection.

However, when Dryness has entered Phlegm, there is now a decided tendency to Heat. So one will have to rule out an infection.

Q. Will a simple Heat also show leucocytosis?

A. It should not.

Q. Ask this in a different way. In case of Phlegm which has not transgressed to Heat, will there be a leucocytosis?

A. No.

Q. And even when there is leucocytosis, does this mean, always, an infection?

A. No.

Q. Some explanation is in order perhaps?

A. Yes. A leukocyte count above 25 to 30 x 10^9/L is leucocytosis, the reaction of a healthy bone marrow, to 3 conditions:

- Extreme Stress
- trauma, or
- infection.

Q. Which means in a case of Phlegm a raised leukocyte count can, not necessarily, mean only an infection, it can also be the result of trauma, or even stress?

A. Yes.

Q. Let’s go back to Heat in Phlegm. Does it register as raised temperature?

A. A brilliant question indeed. Not necessarily.

Q. Because?

A. Heat in Traditional Medicine is more of an energetic concept. There may be raised temperature but scanty signs of Heat. Or there maybe a normal temperature with clear signs of Heat.

Q. So what are the Traditional signs of Heat?

A. As many as possible of the following:

- A pulse count of 5 per breath or more
- Skin hot to touch
- A malar flush of the afternoon, a reddish hue on cheek between 1 PM to 5 PM with a definite sensation of heat
- Bloodshot eyes or at least several capillaries in sclera, the white of the eye
- A palpably Dry skin
- A history of scanty or no perspiration even in summer
- Reddish hue on tongue substance and a brownish thick coat
- Desire to drink cold drinks even in winter
- Scanty, yellowish urine with increased frequency
- Constipation with dry stool
- etc

Q. In a case of Phlegm with Heat, then, a blood test for leucocytosis is a waste of time?

A. No, it ought to be taken and in case there is a raised count, further tests should rule out an infection.

Q. And if there was none?

A. We did well by excluding it.

Q. So in a case of Phlegm with Heat, we have ruled out an actual infection. What are we left with?

A. A case of Phlegm with Heat.

Q. So in a case with Phlegm and Heat what is more important, the Traditional signs of Heat, or a raised leukocyte count?

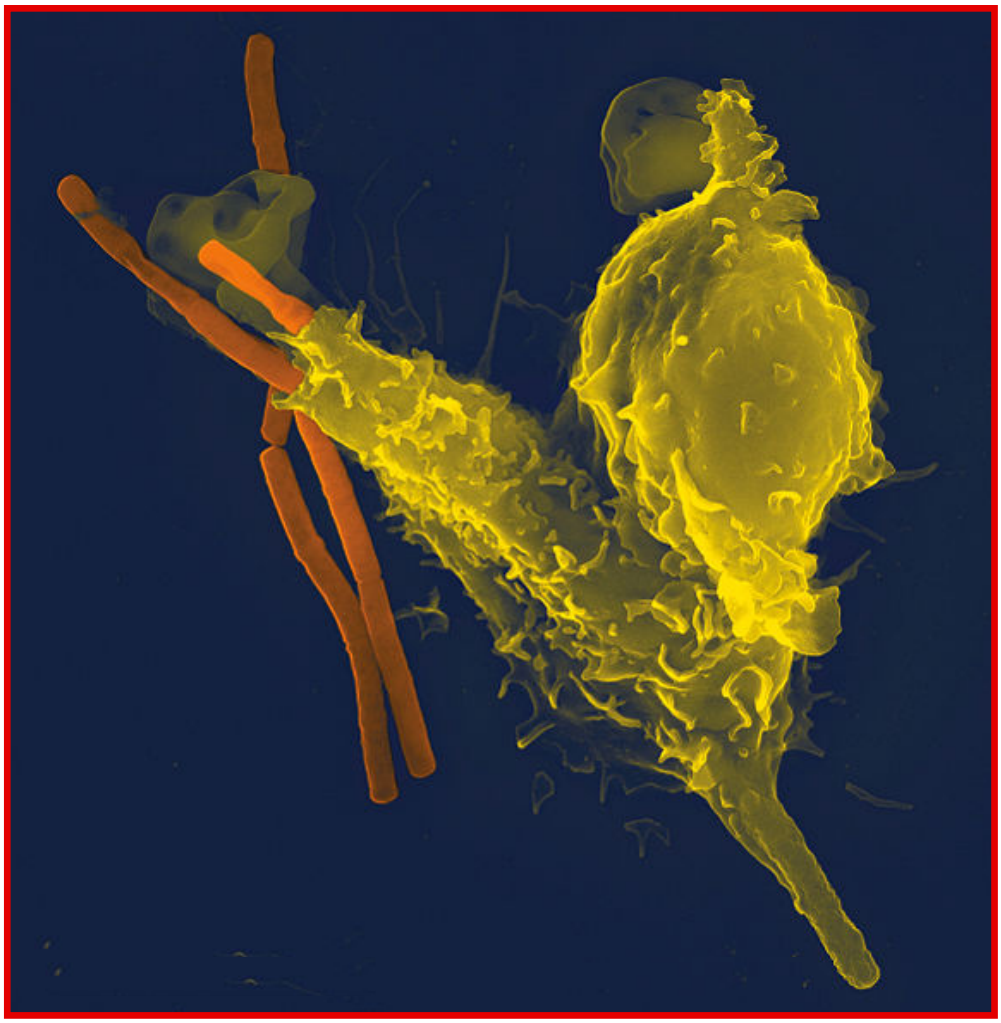
A. Traditional signs of Heat.

Q. Is it possible to have an infection superimpose itself on a case of Phlegm with Heat?

A. By all means, for the overall Resistance is compromised.

Q. There are several kinds of WBC's. Which ones are increased in an infection?
A. The Neutrophils. When the cells are examined these are first stained with a pair of dyes. If the cytoplasm of the cell shows dark blue under the microscope, this is a basophilic cell. If bright red, this is an eosinophilic cell. The Neutrophil does not take either dye and remains a neutral pink, and is therefore called the name it is called.

WBC's are also recognized by the number of nuclei these have. The Neutrophil has 3 lobes and is sometimes called polymorphonulear, poly is many, morpho is morphology and nuclear is the nucleus. Pathologists, like anatomists of old, loved complex Latin names.



Here is a classical photo showing a Neutrophil [golden] in action, engulfing an anthrax bacillus, the reddish rods.

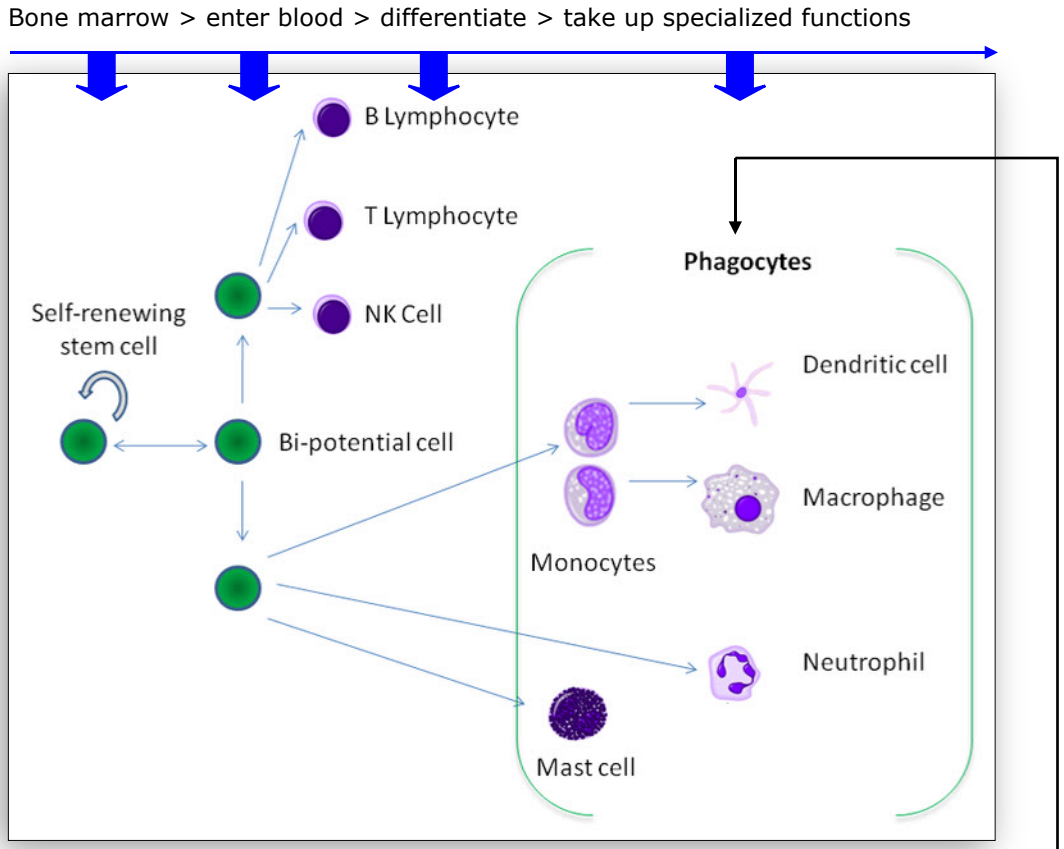
That tens of millions of Neutrophils live inside us, with births, deaths and destinies of their own, unknown to us, in their heroic venture to protect us, is daunting. And we don't know they exist.

I wonder if they know we exist.

"Neutrophil engulfing Bacillus anthracis" by Volker Brinkmann

This was selected as picture of the day on English Wikipedia for January 14, 2008.

Q. Can we see some more white blood cells?
A. The image presents cells as found in blood. A short description follows:



In the study of leucocytes we are mainly dealing with phagocytes:

Monocytes have large, smooth, lobed nuclei and abundant cytoplasm that contains granules; these ingest foreign or dangerous substances and present antigens to other cells of the immune system.

Macrophages stand guard over those areas of the body that are exposed to the outside world. There they act as garbage collectors, antigen presenting cells, or ferocious killers, depending on the signals they receive.

Neutrophils are round cells with a segmented nucleus, the intra-cellular granules are visible in the cytoplasm. Neutrophils are the most abundant type of phagocyte, constituting 50% to 60% of the total circulating white blood cells.

Dendritic cells are almost the shape of a star; are specialized antigen-presenting cells that have long outgrowths called dendrites,[82] which help to engulf microbes and other invaders.

Mast cells have receptors and interact with Dendritic cells, B cells, and T cells to help mediate adaptive immune functions. Mast cells can consume and kill gram-negative bacteria and process their antigens.

Q. To revise, we have a case of Phlegm with signs of Heat, and we should send for a blood picture to rule out infection. Right?

A. Yes.

Q. If the test shows no leucocytosis, there's no infection. But the signs of Heat may still persist?

A. Yes. All you are doing is being alert to any sudden changes in the state of the patient. You are monitoring Heat signs in a Traditional sense, and checking for infection in the conventional sense.

Q. Here is question which begs itself to be asked. If there is infection, and antibiotics are suggested, and you are asked your opinion, what would you say?

A. An absolute yes.

Q. Wow. And are we as Traditionalists not really enamored of antibiotics, considering there is no mention of a microorganism, or an infections, over the centuries, in Traditional literature?

A. All of that is overridden by the concerns for the safety of the patient. If an infection is indicated, antibiotics will deal with it and heal it, and as well prevent a spread.

Any approach which is legitimate and which helps the patient with Phlegm Heat is indicated. Here teamwork is required as well as constant monitoring.

Q. And conventional medicine and acupuncture will coexist?

A. Absolutely. Western Medicine and Traditional Medicine, cannot each alone, deal with Phlegm Heat. The approach must be joint with a team working as a whole.

Q. This Phlegm thing is getting scary by the minute.

A. As I have seen over decades.

Q. Promoting paranoia even?

A. Sure. Phlegm with Heat can get out of hand so fast as will leave one reeling.

Q. The matter of a test for leucocytosis in a case of Phlegm with Heat seems discussed enough. Where to next?

A. To the quest for ESR.

2. What can ESR, a common and inexpensive test, tell?

Q. What test is this ESR?

A. A common one taken in almost any situation where a pathological process has to be established.

Q. What does ESR stand for?

A. The erythrocyte sedimentation rate. It is the rate at which red blood cells sediment in a period of 1 hour.

Q. Purpose?

A. To establish in a non-specific manner that there is an inflammation going on.

Q. Meaning if it came out positive what would that mean?

A. Just that there is an infection, not what kind and where. To perform the test, anticoagulated blood is placed in upright tubes, known as a Westergren tubes, and the rate at which the red blood cells fall is measured and reported in mm/h.

The ESR is governed by the balance between pro-sedimentation factors, mainly fibrinogen, and those factors resisting sedimentation, namely the negative charge of the erythrocytes

When an inflammatory process is present, the high proportion of fibrinogen in the blood causes red blood cells to stick to each other. The red cells form stacks called 'rouleaux,' which settle faster. increasing the ESR Rate. As a result the level of sedimentation in the Westergren tube rises.

In normal circumstance:

Fibrinogen in blood > RBC'S not clumped = ESR in normal bounds

When infection occurs:

Fibrinogen increased > RBC'S clumped = ESR levels rise

Q. The normal ESR?
A. Here is a neat formula you can remember:

HOW TO PREDICT THE NORMAL ESR FROM AGE AND GENDER

Formula:
Maximum normal ESR = A + G divided by 2
[where A is the age and G is a factor which is 0 in men and 10 in women]

Finding ESR in a man:
What is the normal ESR in a man of 40?
ESR in a man of 40 = A + G divided by 2
= 40 + 0 divided by 2
= 40 divided by 2
= 20

Finding ESR in a woman:
What is the normal ESR in a woman of 24?
ESR in a woman of 24 = A + G divided by 2
= 24 + 10 divided by 2
= 34 divided by 2
= 17

Find out what your ESR should be. Use the formulae above.

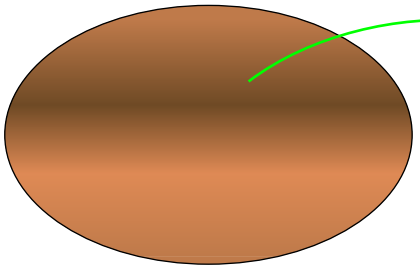
Q. So we have discussed 1 & 2 from the list on p 4. What next?
A. We could consider #3. What can the state of skin pores tell?. Or we could revisit the construct of Phlegm.

Q. On to Phlegm then. One more time, what is it made of?
A. Damp at its matrix.

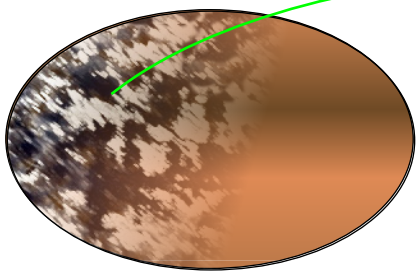
Q. But it is not Damp.
A. No. There is an added component of Dryness.

Q. And in 5 element terms this came from a Deficient LU Yin.
A. Yes.

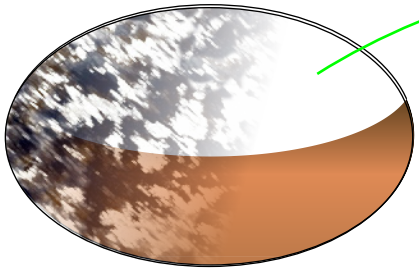
Q. Could we picturize this as we go along?
A. Yes.



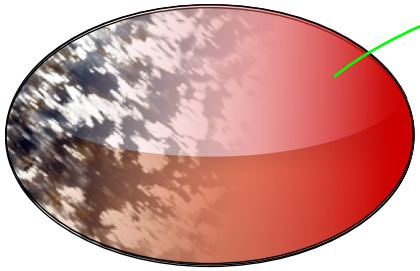
This is Damp. From Spleen.



This is Damp with Dryness. From Lung.
Its right name now is Phlegm.



Phlegm has further had its Fluid depleted. From a Deficient K. Its right name now has become, Phlegm tending to Heat.



If not corrected this may become Phlegm with Heat.

In the making of Phlegm with Heat, of the 5 elements, 3 are involved: Spleen from Earth + Lung from Metal + Kidney from Water.

Q. So what will a Phlegm Heat illness look like?
A. I can give one example and this will fill up 4 Issues of the Bulletin.

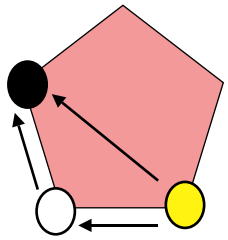
Q. Are we being judiciously sarcastic?
A. No, we are being sarcastically judicious.

Q. Well, what is the example?
A. Psoriasis. Some points we know about it:

- A widely occurring skin condition which is not contagious
- Presents scales which appear on topmost layer of skin
- These are red and white scaly patches
- Supposed to be a chronic immune-mediated disease
- Immune system speeds up the growth cycle of skin

Q. How do we translate this to Phlegm with Heat.
A. Scaly lesion in superior layer of epidermis. Emphasis on Dry and Skin. Both pertain to LU Metal. And the condition is chronic, and difficult to treat.

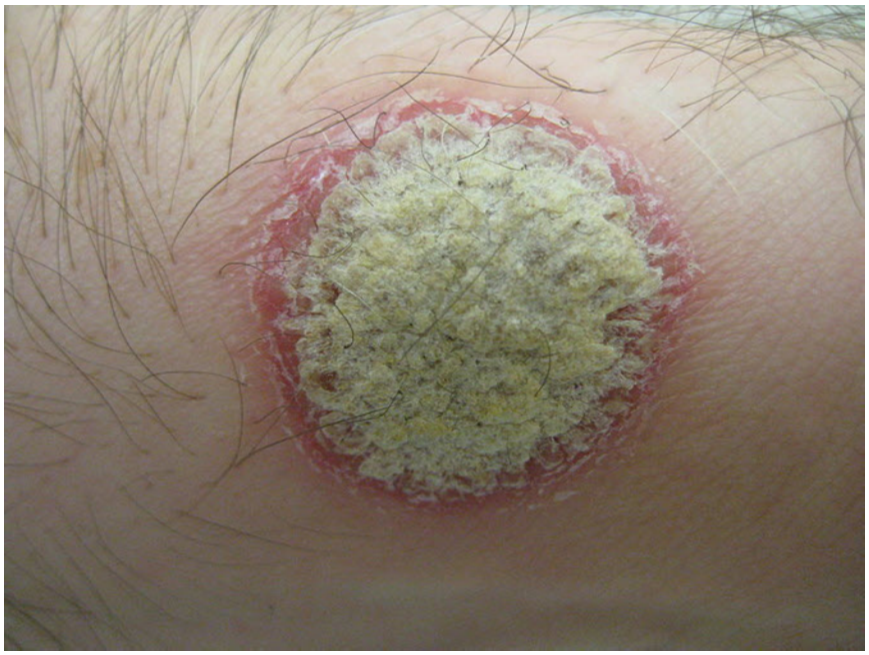
Q. Which is to say LU Metal is involved. What of SP and K?
A. In 5 E work no one element can be Deficient without involving at least 2 more.



LU Metal [white] is Deficient so that Psoriasis has occurred on skin which it rules. LU Metal in turn does not nourish K [black], so there is a Deficiency leading to Sinking of Fluid. It is possible Earth [yellow[did not also nourish Metal. Meanwhile Earth is also Aggressing on K aggravating matters.

Q. Is always such a elemental Pattern seen?
A. Not always. Be prepared for surprises in 5 element work.

Q. Can we have some examples of the Psoriasis lesion?
A. Sure see next page. A warning. If you are sensitive to the blunt and bizarre presentations one finds in clinical situations please go directly to page 15. If not, please proceed to page 14.



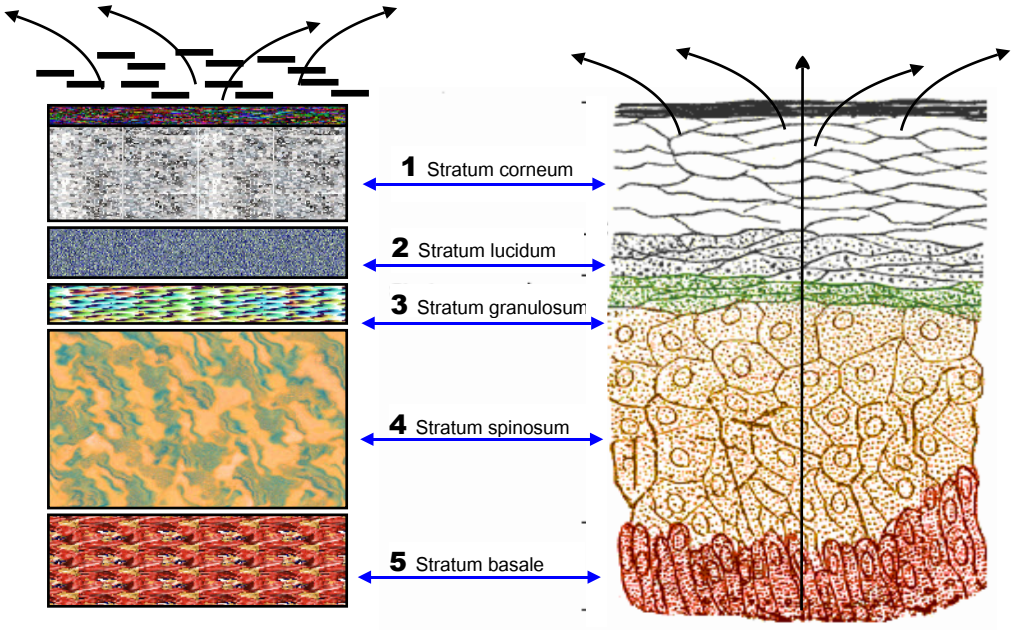
A typical psoriasis lesion:

Image Courtesy of:
James Heilman, MD

Source Wikipedia

Q. Wow. What is that yellow stuff on the lesion?
A. Surplus epidermis. Its nature is that it is scaly and crusts off.

Q. Can we see a section of skin microscopically?
A. Sure. Check the 5 layers of skin. Can you guess the layer involved in Psoriasis?:



Q. The 1st layer, stratum corneum?

A. Near enough. It is everything from stratum basale upwards. The key to Psoriasis and to Phlegm with Heat is this layer.

Q. Which are the elements or organs which influence Fluid Metabolism?

A. Short answer:

- Small Intestine
- Lungs
- Kidney and Urinary Bladder
- San Jiao

Q. What about Spleen?

A. It deals more with Damp rather than Fluid.

Q. So how does this skin condition become a case of Phlegm in Heat?

A. It always has a long drawn out history, involves skin, is typically Dry, [see crusting], one of the main signs of Phlegm, often shows signs of Heat on lesion, see reddish border. There will be a history of Deficient LU Qi and K Qi.

Q. Are all cases of Psoriasis Phlegm Heat presentations?

A. No, you will have to substantiate the Pattern of:

1. A SP Deficient condition which led to Damp derangement
2. A later LU Qi Deficient condition appeared
3. Finally precipitating a K Qi Deficiency

Q. Unless you do, this is not a Phlegm Heat?

A. No.

Q. And once you do, it is?

A. Yes.

Q. Advantage?

A. You know how to treat it. It has a chance of being contained and cured.

Q. Wow. OK. How long have you been studying Phlegm?

A. Not long enough.

Q. We thought you had, over decades.
A. That's not long enough.

Q. Because?
A. What was to be found was not founded.

Q. We'll pretend we understood that.
A. That was not meant for you.

Q. Back to Phlegm then, it must be at the root of many illnesses we thought had other etiologies?
A. Yes.

Q. What if one is dealing with an illness which has had a recognized etiology for ever; does one negate that?
A. One only establishes the Pattern of SP > LU > K > SJ on the accepted picture and validates that. If that is done, you have a way of treating it.

Q. But what if the other picture also had a treatment which was successful?
A. Whatever else is this condition, if there is Phlegm it will resist cure. If there is Phlegm Heat we have an emergency on our hands.

Q. Yet a dilemma. Which approach may work better in such an illness, the known treatment protocol, or an approach for Phlegm Heat?
A. Again, if there is Phlegm involved, however well a protocol works, unless Phlegm is addressed, there will be relapse. In which case one will have to think of addressing Phlegm. And if there is Phlegm Heat, treat this as an emergency.

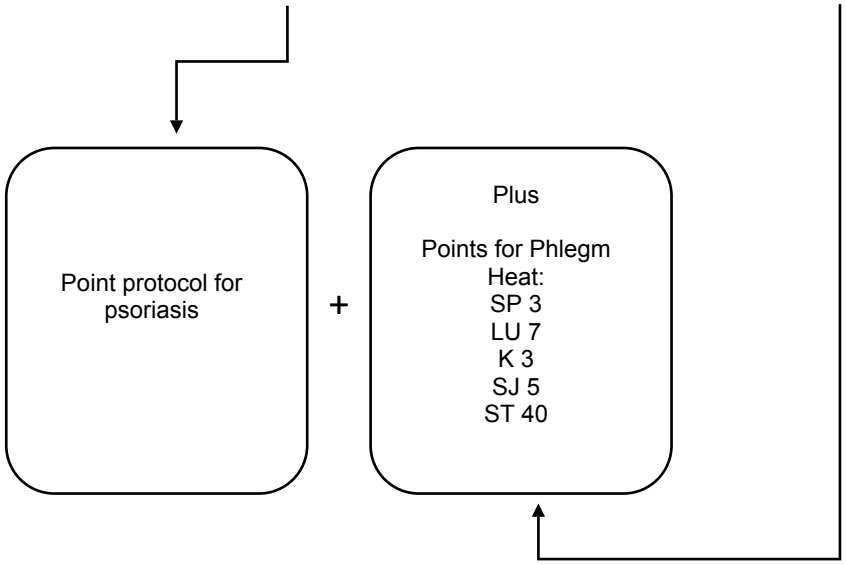
Q. Superimpose one treatment on another?
A. No, quite independent of the other protocol, if there is an established Phlegm Pattern, it will have to be addressed.

Q. Can the one coexist with the other?
A. Yes.

Q. Meaning can Psoriasis coexist with Phlegm Heat?
A. Yes.

Q. What would we call it?
A. Psoriasis with Phlegm Heat.

Q. And treat, how?
A. Use points you choose for Psoriasis, and integrate points for Phlegm Heat:



Q. Did we change the prescription recorded in Part I?
A. Yes, we added a point special to Phlegm, ST 40.

Q. Is this the final point prescription?
A. No, we will evolve it as we go along.

Q. Is there a name for phlegm Heat, other than Phlegm Heat?
A. Possibly. And a dreaded one.

Q. What is it?
A. We must arrive upon it, and not it, upon us.

Q. What have we accomplished in this Issue?
A. Let's see the checklist:

These we have accomplished. If we can complete the list in next 2 Issues that would be satisfactory.

√ 1. What kind of a Blood Picture is likely to be seen?
√ 2. What can ESR, a common and inexpensive test, tell?
√ 3. Constitution of Phlegm & Phlegm Heat
4. What can the state of skin pores tell?
5. What picture will the tongue show?
6. How to check for Heat in a system?
7. How are symptoms of Heat different from those of Fire?
8. What face color diagnosis signs will present?
9. What tongue signs to look for?
10. How to use ST 40, the Universal Phlegm Point to best effect

Q. Have many people have shown interest in this topic?
A. Many, who seem to dedicated to a deeper understanding of it.

Q. We have done 4 stages of transition of Damp, is there a 5th one?
A. Yes.

Q. Which one, what is it called?
A. As yet there is no definite name ascribed to it in Traditional work.

Q. Can it, this illness we are working on, be contained?
A. 'Whatever is ill, was well once'.

Q. Next Part III, when will you publish it?
A. In latter part of July.

'Till then [whole class with a theatrical flourish] Farewell!'

One by one students disperse, soon naught remains,
except perhaps the Teaching.

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