BITTER REALITIES

Applying *Wenbing* Principles in Acute Respiratory Tract Infections

by Charles Chace

A few years ago, I had a really bad winter. At the close of a particularly difficult season of colds and 'flus, I realised that in my 12 winters in clinical practice more of my patients had been forced to resort to antibiotics than ever before. Despite my keen interest in respiratory medicine, I had presided over what for me was an unacceptable number of treatment failures. For a while I consoled myself with the notion that the resistance of viral and bacterial strains was strengthening with every passing year, due at least in part to overuse of antibiotics and antibacterial cleaning products. This resistance and not some shortcoming in my clinical skills was the culprit in this conundrum. The succour of this conclusion, however, was short-lived when I realised that it inevitably lead to a number of therapeutic dead-ends. If indeed, the bugs were getting stronger and I'd thrown the strongest Chinese medicinals I knew of at them to no avail, then I was out of the game just when things were getting interesting. I was faced with the unsavoury possibility that for all its bluster perhaps Chinese medicine really didn't have much to offer in this new age of viral monsters.

Many of my colleagues were talking in terms of the antiviral or antibiotic properties of this or that medicinal and, having read the literature myself, I tried these approaches with due diligence. My clinical experience in this area led me to the conclusion that there is no single medicinal in the Chinese materia medica as strong as Zithromax or even Penicillin. It became evident to me that if we as a profession were going to commit ourselves to the project of trying to equal or surpass pharmaceuticals in sheer germicidal power, it was battle that we were going to lose. Given that the biomedical community is itself beginning to see the folly of such a strategy, an exhaustive search of the Chinese journals for the newest research on the antiviral properties of Chinese medicinals did not strike me as an especially promising area of investigation. In any case, by that time I had literally spent years explaining rather smugly to my patients that Chinese medicine was not fundamentally about the search for, and firing of, magic bullets.

My most rigorous execution of the TCM diagnostic methodology outlined in both English and Chinese language textbooks had proved unsatisfactory, as had my application of the biomedically inspired formulas that were so popular in the Chinese journals. At this point it occurred to me perhaps I should examine the source literature a little more carefully. Since the vast majority of my patients presented in the context of heat patterns I focused my inquiries on the *wenbing* literature pertaining to upper warmer disorders. This has proved to be a fruitful endeavor as evidenced by my improved clinical outcomes. The vast majority of this literature was simply glossed over in my primary Chinese medical training. In retrospect, it is evident that more important than the wealth of information I simply had not been exposed to, there were a number of *wenbing* ideas which, while presented in a general way, were not articulated in a manner that allowed me to use them effectively. Chief among these glossed ideas, at least in terms of the present discussion, are the parameters for diagnosing a disease in the defense aspect (wei fen). Immediately related to this is the issue of when the use of the bitter, cold medicinals that form the bulk of the antiviral agents popular in modern clinical practice is actually indicated.

Diagnostic Criteria for Pathogens Lodged in the Defense Aspect

Textbook criteria for diagnosing external pathogens often look nice on paper, however they can be challenging to apply effectively in the clinic and it is easy to get sloppy. Particularly in the earliest stages of an external contraction, it can even be difficult to say with certainty whether a condition is one of wind cold or wind heat. It has been my experience that the consequences of an incorrect discrimination in this matter can substantially complicate and lengthen the course of treatment. The following informa-

tion is extracted from *Wen Bing Chan Wei* (*A Detailed Explanation of Warm Disease*) by *Xie Lu*. [1]

At the initial stage of contraction, all warm diseases presenting with heat effusion and slight aversion to cold reflect a pathogen in the defense level. If there is no aversion to cold, but aversion to heat, and if the urine is yellow, then [the pathogen] has entered the qi aspect. If the pulse is rapid and the tongue is crimson, the pathogen has entered the constructive (ying) aspect. If the tongue is deep crimson and there is harassing vexation prohibiting sleep or delirious speech at night, then [the pathogen] has entered the blood aspect.

From this passage it is evident that while fever, or more accurately heat effusion (fa re), the subjective experience of heat, is typically a key indicator of any warm disease, a patient my also present with a slight aversion to cold if there is mild damage to the defense yang. Patients with cold damage most often report a definite aversion to cold, yet patients with warm disease may also suffer from a mild aversion to cold and this can complicate a diagnosis. In my experience, the patient with a warm disease pattern however, will report experiencing at least some degree of heat effusion prior to their aversion to cold. This apparently minor distinction can be an important key in making a proper diagnosis. It is not enough to simply ask which is worse, the heat or the chill; one much also determine which symptom came first and if the illness began with a chill, the pathogenesis is wind cold. In my experience, even if a pathogen has completely transformed from wind cold to heat, an effective treatment strategy must reflect the initially cold nature of that pathogen. This may mean that even if the prescription is focused on acrid-cool methods to resolve the heat and out-thrust pathogens, it should also include one or more neutral or even mildly warm surface-resolving medicinals such as Fang Feng (Radix Ledebouriellae Sesloidis) or Jing Jie (Herba seu Flos Schizonepetae Tenuifoliae).

Although a disease in the defense aspect is typically characterised by a light fever, it is important to remember that a patient may present with heat effusion and / or high fever in any of the four stages. Because a fever reaches 40° does not necessarily mean that the disease has penetrated any further than the defense aspect. In general, a high fever and an absence of perspiration is indicative of a constraint of qi in the defense aspect. High fever and an absence of perspiration may also present in diseases involving the constructive aspect where the yin has been damaged, however, this condition will also be accompanied by a crimson tongue lacking a coat.

Another potential indicator of warm disease in the defense aspect is the nature of the headache, if any. Headaches described as tense or tight most often reflect cold damage, while light-headed distending headaches accompanied by dizziness or wooziness reflect warm disease.

Many modern textbooks specify a red tongue and a rapid pulse as discriminating factors in patterns of the defense aspect. In actuality, the tongue body and pulse rate may remain normal and this is often the case in clinical practice. A floating pulse and a tongue with a white coat are much more common indicators of a pathogen in the defense aspect. In my experience if there is heat effusion and the pulse is still floating then the disease is in the defense aspect. This is contrasted with a surging large or slippery-wiry strong pulse with a red tongue with a yellow coat, perspiration, and thirst and reflects a pathogen in the qi aspect.

Even in the presence of a yellow tongue coat, major heat, sweating, and a productive cough with yellow phlegm, it must be assumed that the pathogen has not completely left the defense aspect if the pulse is still floating. Stated more accurately perhaps, in externally contracted conditions, as long as the pulse is still floating, one must resolve the exterior prior to endeavoring to clear the qi aspect. The clinical implications of this are profound.

In the sixth item of his *Wen Bing Tiao Bian*,Wu Jutong describes the symptom presentation and treatment strategy for wind warmth in the defense aspect as follows.

> Tai yin wind warmth, with cough and generalised heat [effusion] that isn't severe, is controlled by acrid cool light prescriptions such as Sang Ju Yin (Mulberry Leaf and Chrysanthemum Decoction). [2]

Acrid, cool, and "light" (*qing*) medicinals that "float" up to the Lung comprise the primary ingredients for prescriptions for warm disease pathogens in the defense aspect. Bitter and cold medicinals to clear heat are included strictly as an adjunct to the acrid, cool and light ingredients.

For example the modern master physician Qin Bowei, rationalised Wu Jutong's de facto designation of Jin Yin Hua (Flos Lonicerae Japonicae) and Lian Qiao (Fructus Forsythiae Suspensae) as the primary ingredients in *Yin Qiao San* (Honeysuckle and Forsythia Powder) as primarily symbolic. Qin believed that Wu was simply trying to make the point that it was necessary to use cold medicinals as opposed to warm ones to treat warm diseases.

According to Wu Jutong, one of the indicators of a warm pathogen in the qi aspect is a floating and surging pulse (*fu hong mai*) and such a pattern requires the administration of acrid, cool and heavy prescriptions such as *Bai Hu Tang* (White Tiger Decoction).

Warm disease in the hand tai yin Lung channel will present with the following symptoms. The pulse image will be floating and surging, the tongue coat will be yellow and dry, there will be pronounced thirst and copious perspiration, the face will be red and there will be an aversion to heat. [These symptoms] mean that the pathogen has entered into the qi aspect of the Lung and Stomach and that the effulgent heat has begun to damage the fluids. One must use acrid cool and heavy prescriptions such as *Bai Hu Tang* to treat this condition.[3]

This passage would seem to contradict the premise that the presence of a floating pulse demands the resolution of the defense aspect, and prohibits the administration of bitter cold medicinals. Its acrid, cool, and heavy appellation

notwithstanding, *Bai Hu Tang* is nothing if not cold and somewhat bitter, and exerts little or no influence on the wei aspect. *Bai Hu Tang* has a long history of use prior to its adoption by the *wenbing* schools, and the parameters for its administration are well defined. *Bai Hu Tang* originally appears in *On Cold Damage* (*Shang Han Lun*) where in line 176 it is indicated for heat in both the interior and exterior. In this case the pulse is floating and slippery. It may indeed reflect qi hastening toward the exterior to resist an externally contracted pathogen, or it may be an outward manifestation of exuberant internal heat. *Bai Hu Tang* is indeed indicated for heat in both the interior and the exterior, however as it states in line 170, it cannot be administered without first having ensured that the exterior has been resolved.

> When in cold damage the pulse is floating [and there is] heat effusion [and] sweating is absent, the exterior has not resolved, one cannot give White Tiger Decoction.[4]

The general consensus among wenbing scholars and researchers is that *Bai Hu Tang* appears in *Wenbing Tiao Bian* in much the same context it does in *On Cold Damage* (*Shang Han Lun*), that is primarily as a remedy to a previously inappropriate treatment. It is certainly not considered an optimal prescription to begin treatment with, however it could conceivably be indicated as a second prescription once the exterior had been resolved either with acrid warm medicinals in the case of wind cold, or acrid cool medicinals in the case of wind heat. The key lesson of *Bai Hu Tang* germane to this discussion is that the pulse may remain floating even if the pathogen has penetrated to the qi aspect, however this situation still requires the resolution of the exterior prior to treating more deeply with bitter cold medicinals.

Case Histories

When all is said and done, it must be admitted that the nicely circumscribed parameters described above are largely theoretical, and as such, may or may not reflect how competent physicians actually use *wenbing* ideas, if they use them at all. Case histories provide a much more realistic picture of clinical practice if one takes the time to analyse carefully what the attending physician is actually doing. The following case represents a fairly rigorous application of *wenbing* principles in the context of a symptom presentation many of us see in the clinic every day. It is excerpted from *Wen Bing Ming Zhe Qing Hua Xuan Xi, A Selective Analysis of the Essential Writings of Famous Warm Disease Authors.*[5]

Zhang, a 2 year old male presented with a fever of 3 days. Neutrophils were 76% and lymphocytes were 24%. Body temperature was 39.9c. Auscultation revealed bubbling lung sounds. The biomedical diagnosis was pneumonia.[6]

Over the course of treatment he had received a variety of antibiotics. Despite his high fever he had not perspired. His spirit was clouded; he was somnolent, and thirsty. He had a cough and slight panting, Young Zhang's tongue was red with a slight yellow coat. These symptoms, and a floating and rapid pulse indicated a contraction of wind heat in the upper warmer with a constraint of Lung qi. An acrid, cool, light prescription was indicated to diffuse the Lung and out-thrust the defense so *Sang Ju Yin* was administered.

Sang Ye (Folium Mori Albae) 3g
Ju Hua (Flos Chrysanthemi Morifolii) 6g
Lian Qiao (Fructus Forsythiae Suspensae) 5g
Xing Ren (Semen Pruni Armeniacae) 5g
Jie Geng (Radix Platycodi Grandiflori) 1.5g
Gan Cao (Radix Glycyrrhizae Uralensis) 1.5g
Niu Bang Zi (Fructus Arctii Lappae) 5g
Bo He (Herba Menthae) 3g
Wei Gen (Rhizoma Phragmitidis) 15g
Zhu Ye (Herba Lophatheri Gracilis) 6g
Cong Bai (Bulbus Allii Fistulosi) 3g
Two packets

Following administration of the medicinals the patient perspired slightly and the fever abated slightly as well. The cough became productive. The tongue was normal red and with a slightly yellow coat. His pulse had become slippery and rapid. This presentation indicated an opening of the exterior obstruction, however the heat had not been completely eliminated. A prescription to clear, course, and disinhibit phlegm was indicated.

Zi Su Ye (Folium Perillae Frutescentis) 3g
Qian Hu (Radix Peucedani) 3g
Jie Geng (Radix Platycodi Grandiflori) 3g
Huang Qin (Radix Scutellariae Baicalensis) 3g
Sang Ye (Folium Mori Albae) 3g
Tian Hua Fen (Radix Trichosanthis) 6g
Dan Zhu Ye (Herba Lopthatheri Gracili) 6g
Pi Pa Ye (Folium Eriobotryae Japonicae) 6g
One packet

There was another episode of slight diaphoresis and the generalised fever abated, his spirit had cleared and he was no longed somnolent, and the cough was now minimal. However, the patient had not moved his bowels for 2 days. The redness in his tongue had abated slightly and the coat was slightly greasy. His pulse was deep and rapid. These symptoms indicated that although the exterior had been resolved, the interior was not yet harmonised. Zi Su Ye was omitted from the above prescription and Zhi Shi (Fructus Citri seu Ponciri Immaturus) 3g, Lai Fu Zi (Semen Raphani Sativi) 3g, and Mai Ya (Fructus Hordei Vulgaris Germinantus) 6g were added.

With administration of the above medicinals the patient's body temperature normalised completely, and the cough was arrested, although he still had not had a bowel movement. The slimy coat in the center of his tongue had still not abated and the pulse was slippery and rapid. This presentation indicated that the Lung and Stomach were not harmonised, requiring a prescription to harmonise the Lung and Stomach, disinhibit dampness and disperse stasis.

Dong Gua Ren (Semen Benincasae Hispidae) 12g
Xing Ren (Semen Pruni Armeniacae) 6g

Yi Yi Ren (Semen Coicis Lachryma-jobi) 12g
Wei Gen (Rhizoma Phragmitidis) 15g
Chao Zhi Shi (fried Fructus Citri Immaturis) 3g
Lai Fu Zi (Radix Aconiti Carmichaeli Praeparatae) 3g
Mai Ya (Fructus Hordei Vulgaris Germinantus) 6g
Shen Qu (Massa Fermentata) 6g

After 2 packets of the above prescription the patient was cured.

In this case we see the utility of a rigorous approach to the clinical application of *wenbing* ideas. The overall severity of the symptoms including the presence of a high fever with a red tongue and a yellow coat did not over-rule the presence of a floating pulse in guiding the treatment strategy toward the use of acrid and light medicinals. The fact that this is a paediatric case only reinforces the necessity for avoiding over-treatment. Many physicians prescribe for children using the same doses they would for adults and simply reduce the amount of the decocted liquid they consume. The doses in these prescriptions are not only consistent with the tender age of the patient but also remind us that principle of administering light *(qing)* prescriptions extends to dosing as well. Even when treating a strong pathogen, moderation in dosing of the correct medicinals may yield a superior result to a more heavy handed approach. In this case it is also evident that the attending physician did not ignore the obvious phlegm-heat that was present. However, it was first necessary to resolve the exterior obstruction prior to tackling the phlegm and heat. Having cleared the heat while still mildly resolving the exterior in the second prescription, the physician then turned her attention to the residual phlegm and its attendant Lung-Stomach disharmony.

The overall treatment strategy is obviously dictated to a large degree by the presenting symptoms, however this physician is clearly in control of this case and is making proactive decisions regarding what facet of the disease she will tackle and when. In the final analysis, a fairly severe respiratory tract infection was resolved without resort to bitter cold medicinals.

The following case illustrates the fact that the administration of acrid, cool, surface resolving medicinals may be administered to help out-thrust a pathogen that has become lodged more deeply than the defense aspect.

Zhang, a four year-old female, had suffered from a cold for one week. At its onset, she had experienced heat effusion, slight aversion to cold, cough, and a temperature of 39°C. Her original physician had prescribed a modification of *Ma Xing Shi Gan Tang* (Ephedra, Apricot Kernel, Gypsum and Licorice Decoction*)* following the administration of which the high fever abated. However, the cough persisted, as did an afternoon fever that hovered around 37.5-38°C. She was then given a modification of *Qing Hao Bie Jia Tang* (Artemisia Annuaand Soft-shelled Turtle Shell Decoction) which was ineffective. Zhang presented to her subsequent attending physician with a red tongue with raised papillae, and a white slimy and dry tongue coat. Digital examination revealed a purple vein. She was agitated and restless at night.

Her attending physician's diagnosis was that cold-cool enriching and cloying medicinals had damaged the qi dynamic. Pathogenic heat had become constrained in the interior and the Lung qi had lost its capacity of diffusion. The treatment strategy was to diffuse depression, transform dampness and clear heat, and promote depurative down-bearing to stop cough.

Dan Dou Chi (Semen Sojae Praeparatum) 6g
Chao Shan Zhi (fried Fructus Gardeniae Jasminoidis) 3g
Qian Hu (Radix Peucedani) 3g
Xing Ren (Semen Pruni Armeniacae) 6g
Zi Su Ye (Folium Perillae Frutescentis) 6g
Huo Xiang (Herba Agastaches seu Pogostemi) 6g
Chan Tui (Periostracum Cicadae) 6g
Gou Teng (Ramulus Uncariae Cum Uncis) 6g
Bai Mao Gen (Rhizoma Imperata Cylindricae) 10g
Wei Gen (Rhizoma Phragmitidis) 10g
Jiao Shan Zha (burnt Fructus Crataegus) 6g
Shen Qu (Massa Fermentata) 6g
Mai Ya (Fructus Hordei Vulgaris Germinantus) 6g
Sang Ye (Folium Mori Albae) 6g
Three packets

The cough diminished after two packets and the fever abated after taking the third.

This illness began with heat effusion and a mild aversion to cold, a symptom presentation suggesting a warm disease etiology. The original physician prescribed *Ma Xing Shi Gan Tang*, which is indicated for heat lodged in the Lung due to wind heat, or wind cold transforming to heat. Strictly speaking, this formula fit the presenting pattern at its onset, but since we are not given the specific constituents of the prescription that was used it is difficult to say why it did not work. *Ma Xing Shi Gan Tang* is a versatile formula and is a personal favorite of mine, however in using this formula I have on occasion seen the resolution of a pathogen "stall" in just the same manner that happened here. Although Shi Gao (Gypsum) is not bitter, it is very cold and its dose must be carefully monitored relative to the dose of Ma Huang (Herba Ephedrae). *Ma Xing Shi Gan Tang* first appears in *On Cold Damage* (*Shang Han Lun*) where it is indicated for panting subsequent to precipitation (purgation) and sweating. The pulse image is slippery, rapid and not floating, reflecting the fact that the pathogen has already penetrated to the Lung. Strictly speaking, Ma Huang appears in the formula to dissipate depressive fire, not to resolve the exterior. Although some physicians administer *Ma Xing Shi Gan Tang* in instances of external wind cold complicated by Lung heat, it is likely that it was administered prematurely in this case. Furthermore, the presence of the Shi Gao in the prescription actually caused the pathogen to become lodged in the Lung, producing an abatement of the exterior symptom of fever but further impairing Lung diffusion such that the cough persisted.

At this juncture, the original physician administered *Qing*

Hao Bie Jia Tang probably on the assumption that the pathogen had penetrated to the constructive-blood blood aspects as evidenced by the afternoon fever, restlessness and agitation. This too, proved ineffective and it is interesting to note that *Qing Hao Bie Jia Tang* is actually contraindicated in conditions where the pathogen is still in the defense and qi aspects because its cool and cloying ingredients damage the qi dynamic. While afternoon fevers are often due to yin vacuity they may also result from a damage to the qi. This is likely the dynamic at play in this case, although it was not addressed in the prescription. Admittedly, at this point in the case it is difficult to say with certainty exactly where the disease is. The attending physician clearly had the benefit of the experience of his predecessor. The fact that *Qing Hao Bie Jia Tang* was ineffective suggested that the disease was not in fact, in the constructive- blood aspects. In any case, when the patient finally received a much milder exterior resolving prescription the condition resolved.

The first ingredients, Dan Dou Chi and Chao Shan Zhi constitute *Zhi Dou Tang,* which first appears in *On Cold Damage* (*Shang Han Lun*) as a formula to clear and diffuse depressed heat. The lowly Dan Dou Chi is actually valued by many *wenbing* authors for its capacity to out-thrust pathogens from all the aspects. Zhi Zi, of course, clears heat from all of the thee burners. It is interesting to note that one of the key indications for this prescription is tossing and turning (*fan fu dian dao*), an inability to fall asleep with repeated tossing and turning in bed. Again although some of the symptoms in this case suggested a deeper penetration of the pathogen, the disease actually remained lodged relatively superficially.

The formula also contained Zi Su Ye and Huo Xiang, both acrid, slightly aromatic medicinals that diffuse the Lung and transform dampness. It included medicinals that further cleared and out-thrust depressive heat in the Lung such as Chan Tui and Sang Ye. Finally this prescription contained diffusing and down-bearing medicinals to stop cough including Qian Hu and Xing Ren.

This case illustrated some common errors in diagnosing and prescribing for respiratory tract infections. In the administration of both *Ma Xing Shi Gan Tang* and *Qing Hao Bie Jia Tang* the physician prescribed more deeply than the actual location of the pathogen and probably compounded the condition. The cold Shi Gao, probably in concert with an inadequate dose of Ma Huang to out-thrust the pathogens and diffuse the heat, locked the pathogen into the Lung, and the cloying yin-nourishing medicinals further obstructed the qi dynamic. Although the disease was located in the qi aspect and the use of some bitter cold medicinals was indicated, its complete resolution required that the pathogen be out-thrust thrust through the defense aspect. For this reason Dan Dou Chi, Sang Ye and Chan Tui were included.

Both of the above case histories were in the back of my mind last year when I saw a patient who complained of a lingering cold.

Robyn, a 47-year-old female, had caught a cold 5 days prior to seeing me. It had begun with head congestion, a severely sore throat, and chills, and progressed to a raw nose with clear runny mucus, alternating chills and heat effusion, and a craving for warm drinks. Based on the severity of the sore throat, another acupuncturist had prescribed a favorite self-composed formula that was a combination of medicinals with known antiviral properties. Including Ma Bo (Frucificatio Lasiosphaerae) and Ban Lan Gen (Radix Isatidis seu Baphicacanthi). Unfortunately, this prescription had no effect in this case and may have compounded the situation. Her condition worsened and when she visited my clinic, her chief complaint was severe head congestion and the feeling of grogginess that accompanies it. She still craved warm fluids, however she no longer had chills or heat effusion. Her pulse was floating and her tongue had a white coat.

This was a case of exterior wind cold lodged in the head. I believe that the early administration of bitter cold medicinals had congealed the pathogen in the exterior. A mild, neutral prescription was indicated to resolve the exterior, out-thrust the pathogen and open the orifices.

Fang Feng (Radix Ledebouriellae Sesloidis) 9g
Jing Jie (Herba seu Flos Schizonepetae Tenuifoliae) 9g
Bo He (Herba Menthae) 9g
Zi Su Ye (Folium Perillae Frutescentis) 9g
Sang Ye (Folium Mori Albae) 9g
Ban Xia (Rhizoma Pinelliae Ternatae) 6g
Xing Ren (Semen Pruni Armeniacae) 12g
Bai Zhi (Radix Angelicae) 4g
Xin Yi Hua (Flos Magnoliae Liliflorae) 9g
Cang Er Zi (Fructus Xanthii) 9g

She was given one packet of the above prescription in decoction, three quarters of a cup 3 times per day.

Two days later she reported that she was much improved, although she was still somewhat congested and her nasal discharge was slightly yellow. She was given the same prescription with the addition of Bei Mu Bulbus Fritillariae) 3g, and the dose of Bai Zhi was reduced to 3g. This resolved the condition completely.

This case illustrates the risk of administering cold "anitvirals" too early in the disease process and in contradiction to the overall pattern. As we have seen, although cold and cool medicinals are effective in clearing the qi, they do not resolve the qi restraint that typically accompanies it; excessive administration of cold and cool medicinals may actually obstruct the qi dynamic, locking the pathogen in and driving it deeper into the body. While it may seem wise to administer bitter cold medicinals prophylactically in an effort to prevent a warm pathogen from penetrating further, such a strategy can easily backfire and compound the condition. This pitfall extends to nasal problems as well. According to ENT specialist Hua Liang-cai: "If one uses cool and cold medicinals excessively or too early, this may cause cold to become deep-lying ice in the nasal orifice causing the blood to become static and the phlegm snivel to congeal locally."[7]

The first two cases we have discussed make it clear that the severity of the presenting symptoms alone is not a reliable indicator of the depth of the pathogen. Our patients may look and feel quite ill; they may come to our clinics after having suffered for days with whatever particularly nasty virus is circulating that season and yet the pathogen may still be in the defense aspect. Still, the impulse to hit hard with bitter cold "aniti-virals" is understandable and it is a clinical reality that such a strategy sometimes works. Recent Chinese studies touting the potent anti-viral properties of medicinals such as Da Qing Ye (Folium Daqingye) may lead us to the conclusion that such biomedical prescribing is the answer to our prayers. Be that as it may, it has been my experience that these strategies frequently fail altogether, or produce an initial improvement in the symptoms, which then linger because the pathogen has become lodged in the interior, ultimately requiring antibiotic intervention. Any understanding of the antiviral properties of Da Qing Ye must be placed in the context of its functions as an anti-toxic (*jie du*) medicinal that primarily influences the blood aspect. Building a prescription around a bitter, cold, anti-toxic medicinal with the intention of addressing the defense aspect is like using a jackhammer to drive a finishing nail.

Busy clinicians concerned with more pressing matters than a seasonal onslaught of patients with colds and 'flus may elect to "play the odds," and dispense their favorite cold prescriptions formulae such as *Gan Mao Ling, Chuan Xin Lian, Zhong Gan Ling,* or more recent formulations such as Health Concerns' *Cold Away*. These preparations undeniably benefit a portion of the patient population, but for the reasons discussed above, such a shotgun approach will not only miss the mark with some patients, but is bound to produce complications in some as well.

It is not that the administration of cold and even bitter medicinals is completely contraindicated when a disease is still in the defense aspect. However, when these medicinals are used they must be administered judiciously with an understanding that the treatment should still be focused on resolving the exterior with acrid cool medicinals. In many instances, it may seem expeditious to go straight for the qi aspect when the symptoms are severe, and the tongue is red with a thick yellow coat, even though the pulse is still floating. Nevertheless, taking the time to first ensure that the qi dynamic in the defense aspect is unobstructed will ultimately facilitate a more rapid conclusion to the illness.

Chinese medicine is evolving along many fronts, not the least of which is the fascinating pharmacological research occurring in *materia medica*. The purpose of this paper is not to impugn the value of biomedical research while advocating an exclusively backward-looking approach to solving the problems presented by modern diseases. Rather I hope I have illustrated that pharmacological information must be incorporated in a judicious manner and should not be adopted *ad hoc*. In-vitro studies and even clinical trials can be compelling influences that encourage one to adopt a mode of practice that more closely resembles naturopathy than Chinese medicine. This is not intrinsically a bad thing, however in so doing we risk forfeiting many of the aspects of the Chinese medical paradigm that make it so powerful. We gloss over and trivialise two millennia of clinical insights into the treatment of respiratory tract infections, reducing the pattern specificity that is a cornerstone of Chinese herbal practice almost to the point of meaninglessness.

It has been my experience that precise pattern discrimination in the context of either the TCM or *Kanpo Yaku* styles is essential for effective prescribing for colds, 'flus, and their sequelae. The basic discriminations between cold and heat, and between the defense and qi aspects, are not always easy to identify in clinical practice. However elementary they may seem, they nevertheless, provide the basis for proven treatment strategies. It is all too easy to say the old tricks no longer work for the new diseases, when in fact, we may simply have executed those tricks in an ignorant or sloppy manner.

Notes

1 *Xie Lu,, Wenbing Chan Wei,* (*A Detailed Explanation of Warm Disease*), China Medical Science Publishers, 1988 pg.29.

2 Shen Yannan, en Bing Ming Zhe Qing Hua Xuan Xi, *A Selective Analysis of the Essential Writings of Famous Warm Disease Authors,* Guandong Science and Technology Press, 1988: 38.40.

3 ibid: 40.

4 Zhang Ji, *Shang Han Lun , On Cold Damage,* translated by Craig Mitchell, Feng Ye and Nigel Wiseman, Paradigm Publications, 1999: 318.

5 Shen Yanan: 40.

6 Reference ranges for neutrophils in male children are 38.5-71.5%, and reference ranges for lymphocytes in male children are 19.4-51.4%. Elevated neutrophils and lymphocytes suggest an infectious process, although this child's lab values are inconclusive. The bubbling sounds with auscultation reflect the presence of mucus in the bronchi or the lungs themselves. However, it is currently believed that the only definitive means of diagnosing pneumonia is a chest X-ray so the diagnosis of pneumonia is rather tentative. Be that as it may, the patient is clearly quite ill.

7 Gan Zuwan et al. The Treatment of Chronic Rhinitis, *Zhongyi Zazhi*, #11, 1986: 9-15.

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