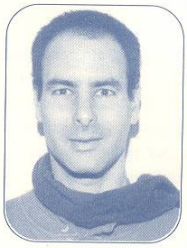
Treatment of Low Back Pain with Kiiko Matsumoto Style Acupuncture

By Avi Magidoff, LAc



Avi Magidoff, LAc

One of the most common problems acupuncturists see is low back pain. Often we see people who have tried a variety of other modalities with little or no success, and their condition is chronic, highly painful and destructive to their lives. In this article I attempt to demonstrate the approaches used by Kiiko Matsumoto for the treatment of low back pain. Kiiko Matsumoto is one of the foremost acupuncturists practicing today. She has earned a tremendous reputation even in Japan. This is a great achievement, especially for a woman, and a clear testament to the effectiveness of her treatment style.

One tenet of the Matsumoto style is that one should always treat the person's underlying and internal conditions prior to treating the current problem. The idea is that the body keeps an energetic record (stagnation) of previous injuries/assaults/illnesses, even if they appear to have been cured. Any new injury/assault that is not healing properly is likely to be lingering because the body's energies are caught up in the past (past medical history) and are not available to deal with the present, current situation. What we attempt to do is to address the first trauma the body has sustained with the expectation that this will facilitate the clearing of more recent ones. The word "injury" here refers to any medical condition. Thus when a person comes in with a shoulder pain that they say was a result of a skiing accident three months previously, we ask ourselves why it is that the shoulder is not healing. What prevents the body from dealing with the skiing accident in a timely manner? Usually the answer is an incident from the past. Often, first we start to treat the person's allergies, or thyroid condition, or the fact that parents and/or grandparents suffered from heart conditions. The person often expresses surprise claiming that their allergies, or thyroid condition, or whatever is no longer bothering them due to medication or lifestyle changes, yet once we needle points that clear the abdominal findings, which reflect the former supposedly "handled" condition, the shoulder improves. The person is happily surprised.

We treat the abdomen as the site reflecting the potential of life, and the back as a reflection of the movement of life, and thus, we always treat both sides.

We consider this approach to be "holistic" in the sense that we look at the whole history of the person, considering all possibilities, rather than treating the actual complaint first. If we were to just apply some known "trick" for shoulder pain, we would have a lower chance of success, and the success may not last because the body is still carrying old baggage (stagnation) that can still trap the shoulder pain. We believe that we are freeing the body from the hold the past has on it, so it can be fully present in the here and now. This only takes a few minutes. I am not suggesting that one must treat the person holistically for three months prior to treating their shoulder – we do this all within the same treatment – but first addressing the underlying/constitutional issues. This tends to release the current problem, sometimes fully, sometimes partially. Once these needles are placed, we can go on to address more recent problems, and ultimately the "official complaint," the one which brought the person in, all in one treatment.

The Matsumoto system of treating the whole body, heavily based on the work of Master Kiyoshi Nagano, is a comprehensive system and cannot be explained in one or two articles. In this article I only discuss palpatory findings and point selections that are specific to the condition at hand – low back pain. However, prior to doing so, two other tenets of this style must be mentioned.

We never needle into the injured site. TCM practitioners talk in terms of remote and local, as well as adjacent, points. We, on the other hand, always choose to needle remote points, not local ones. We first determine where the current problem reflects on the body in terms of pressure pain around the navel. We then choose remote points that release that pressure-pain with the assumption that if the reflex pressure-pain improves, so does the original problem.

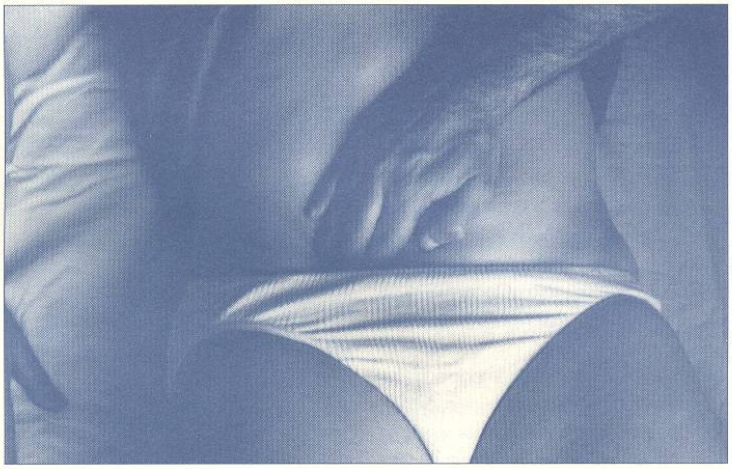
In the case of back pain, it is often the site of pain that can be used as the reflex by which we judge our success. However, there are times when the pain at the site is too elusive or too great to be used as a reliable reflex, and in such cases it is important to find some other reflex to be used. (I shall discuss areas on the front which reflect back problems.)

It is important that you always press a reflex area with the same amount of pressure. Your goal is to find a remote

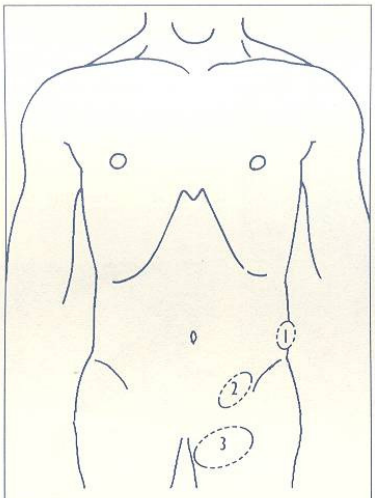
point that alleviates the reflex area. Patients often claim "you are not pressing as hard" when the reflex area is released, so you must develop the skill of controlling the pressure as well as being able to feel changes in the tissue under the skin.

The remote points, which will then become treatment points, must affect the reflex or the actual problem. We do not choose points based on a theoretical understanding, and consider that to be a wasted needle. To check if a point is relevant, press on the reflex area, let go of the pressure and remember the location, the angle, the amount of pressure and the texture. Then press on the remote point you wish to examine and with your other hand re-press the reflex area. There should be an improvement in the reflex area. Ideally the patient says "Wow, gone!" However, an improvement of 50% or higher is significant and merits needling the remote point. Our points are not fixed locations, and one often has to explore to find the exact location and angle that releases the reflex. Once the remote point is needled, we recheck that the reflex was indeed released. If not, subtle up-and-down manipulation, or re-angling of the needle will probably do the job.

Almost always, we start treating the front of the body, even if the complaint is back pain. This allows us to ascertain which historical illnesses still reflect on the abdomen (not discussed here). My own understanding is that we treat the abdomen as the site reflecting the potential of life, and the back as a reflection of the movement of life, and thus we always treat both sides, with the front treatment almost always first. Many people who come for back pain automatically lie down-face down and are a bit surprised when I ask them to turn face-up. As in the case of treating their underlying issues first, they may be resistant to the idea at first, but inevitably this strategy proves itself to be extremely useful. Almost universally, when I ask the person to turn over they exclaim, "wow, my back pain is so much better!" Often they say there is no longer any pain, though I still treat the back.



Inguinal Ligament: Palpating the Inguinal Ligament. Pressure pain here reflects pelvic shifts. Note the angle toward the leg. The Inguinal Ligament is released via St13, GB26 and Inner Yin 5 fingers above K10



Areas on the front of the body reflecting low back problems:

1. **GB26** reflects sacral twists. Look for the ropy area, not exact point location. This point is needled directly. If it is very ropy, it should be released first via K7.

2. **Inguinal Ligament,** the area between GB28 and St30, reflects sacral tilt. Release this area via St13, GB26, and Inner Yin (5 fingers above K10).

3. **Inguinal Groove,** Liv12 area - We also call this Inner Thigh, reflects sacral tilt. Release this area via Lv4.

Aside from comprehensive abdominal diagnosis, the three most important areas to check on the front in cases of low back pain are:

- **GB26** (taken as the area level with the navel all the way to the side, and can be extended down to the iliac crest bone)
- **The inguinal ligament (GB28 to ST 30 area)**
- **The inguinal groove (Lv 12 area)**

When twisting is involved, the area that serves as the axis for twisting is GB26, which will feel tight or ropy with the person showing signs of pain. Some people do not like to say that your pressing is painful, but their reaction will be clear. We press to the depth of one knuckle – that is, no further than the distal interphalangeal joint. In a healthy tissue, the person would feel your fingers but no pain, no tightness, no "weird" feeling. We use three fingers (index, middle, and ring) together so that the area pressed is not too narrow, making such pressing uncomfortable, but we place our attention primarily on one finger, which marks our target. Make sure that pressure on GB26 does indeed alleviate the back pain. If it does you will want to needle it. However, if GB26 is very painful or ropy, it is important to release it first.

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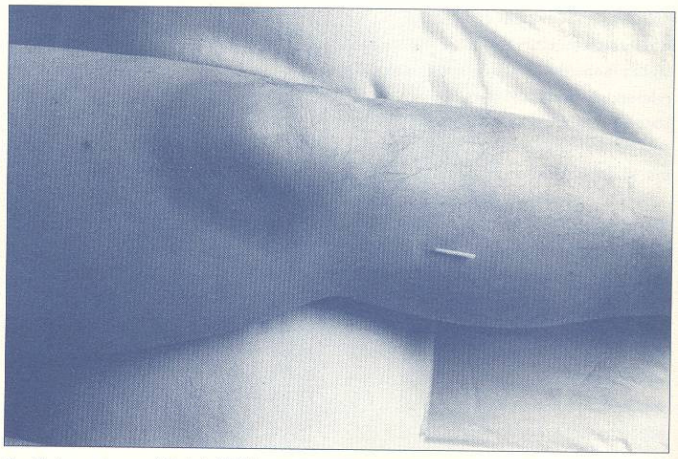
Usually K7 will release GB26 (same side) – we see GB26 as lying in the kidney domain, level with kidney shu, mu, etc. Press on K7, and ensure that this releases GB26. Needle K7 at a 30-degree angle upwards, with the channel flow. Make sure you have the K7 that best releases GB26 area. If the back pain is GB26-involving, you will find that the back is greatly improved also. Once GB26 is released, you can also needle it directly.

Using GB26 is extremely important also for shoulder pain, especially pain on lifting the arm or along the large intestine line and for eye-of-the-knee pain. In fact, because of its importance as a twisting reflex, it should be checked for all structural issues.

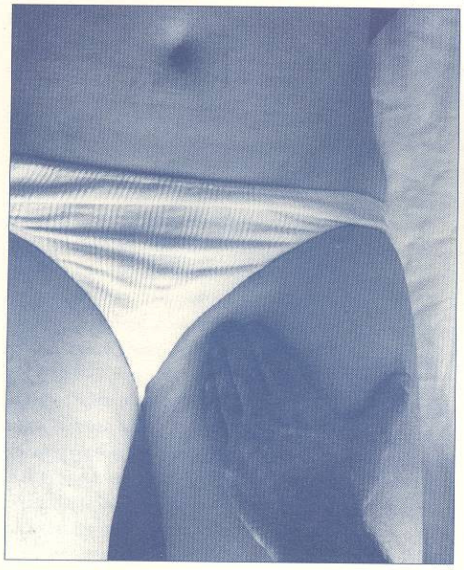


Sp 9 to release L3-L4-L5 The needle angle is superficially upwards, toward Inner Eye-of-the-Knee. About 35mm of the needle was used here. (Seirin 0.18 x 40)

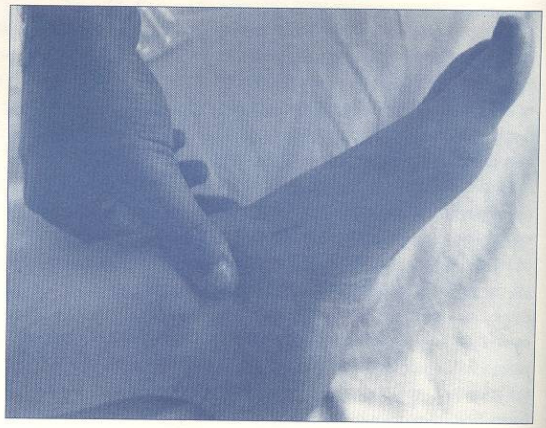
When the low back is misaligned, that misalignment will show on the front on either the inguinal groove, or the inguinal ligament, or both. This is because the pressure of the misalignment will collapse at the bottom of the torso (inguinal ligament), or displace the alignment of the torso on the thighs, showing on the inguinal groove and below. It is extremely important to release these two areas.

When pressing on the inguinal ligament, *(see page 17)* we press towards the leg – that is, laterally and distally from the torso – checking the whole length of the ligament, from GB 27/ GB28 to St 30. Again, you may feel tightness or a rope-like feeling, or the person will tell you it is painful. We call the inguinal ligament pressure-pain *viscero-ptosis reflex.*

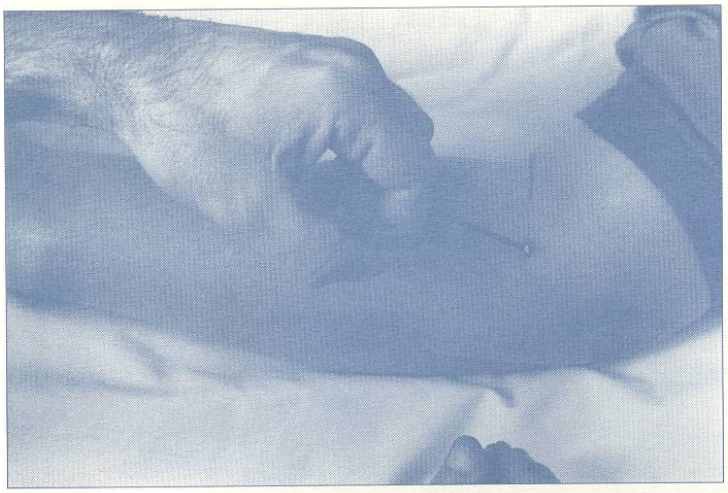
To release the inguinal ligament, we use St13 needled superficially outwards and slightly upwards, following the edge of



Inguinal Groove – Palpating the Inguinal Groove. Note the location is below the actual groove, and the angle is toward the pubic bone. The Inguinal Groove also reflects pelvic shifts and can be released via Lv4



Lv4 is located 1 thumb-width below the ankle bone, needled upwards to release the Inguinal Groove. (Seirin 0.18 x 40)



Immune Point - Needle with direct moxa applied, to release the posterior iliac crest. The location is close to the San Jiao channel on the edge of the bone. (Seirin 0.18 x 40)

the bone, toward Lu2, with the idea of "lifting" the torso from the other end. This point is especially useful on large-breasted women (this treatment is also important for shoulder pain due to heavy breasts) or large individuals who have a "greater interaction" with gravity.

We also use GB26 to release the inguinal ligament. If GB26 is too painful, use K7 to release the GB26. This in turn will release the inguinal ligament. Inner Yin, a point on the kidney channel that is level with Lv 9, about 5 fingers above K10, is also an excellent point to release the trapezius muscle.

There is no need to press on the inguinal groove proper; this is a ticklish area that many people consider taboo. *(see page 18)* You can press about one inch below the groove, as the adductor muscles will also show the tightness. We press three areas: the kidney channel, the liver channel, and the spleen channel, all upwards toward the pubic bone/torso. To release the inguinal groove, or inner thigh, the actual area pressed below the groove, use Lv4. We find Lv4 the width of a thumb below the internal malleolous, on the medial side of the tibialis anterior very close to Sp5, and needle it superficially upwards with the flow. Press on Lv4, up toward the ankle crease, and recheck the inner thigh. Sometimes Lv4 is not enough to release the inner thigh. To release the kidney line, use K7, and to release the spleen line use Sp9. We needle Sp9 superficially upwards.

Lumbar spine pain of the Du Mai or Hua Tuo area often responds to Sp9. *(see page 18)* This is especially true if there is more than one vertebra involved. We believe that once more than one vertebra is involved, the problem cannot be purely structural, and has an internal component. You can check Sp9 directly against L4-L5-S1 (Du, Hua Tuo, or even paraspinals). Palpate these areas with one hand reaching under the person, and the other hand, pressing on Sp9 up towards Inner-Knee-Eye. You may need to move your location of Sp9. Once you find the exact Sp9 which releases the lumbar pain, needle it superficially at a 10-degree angle upwards with the flow, toward the inner Inner-Knee-Eye point, above the bone, breaking down the "gummy" adhesions where the muscle is attached to the bone.

We use a 40mm needle on Sp9, using at least 30millimeters of the needle. I normally use #2 Seirin needles. This is a highly sensitive area and other type needles might be painful, especially on thin patients.

Pain along the posterior edge of the iliac crest is considered to be immune relat-

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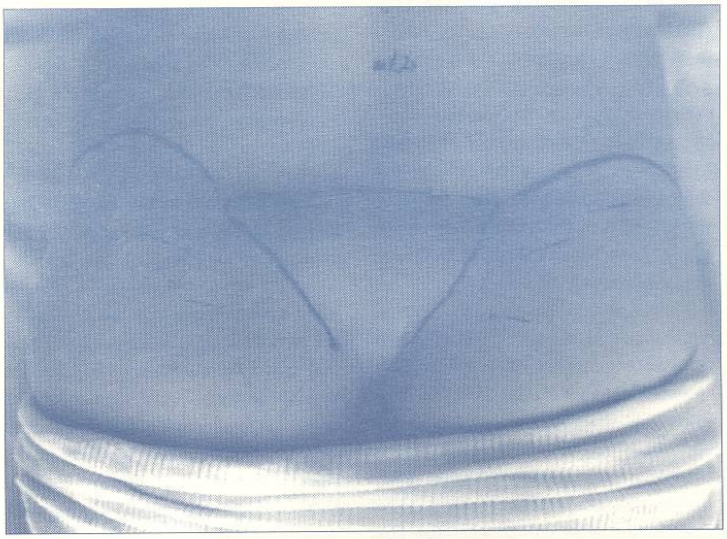

Sacroiliac ligaments - Needling into these releases L5-S1 (area #5) as well as L3-L4-L5 (#6). It is often ropy and tender. Needle into the gummy/ropy area. If the patients's main complaint is here, use Lv8.

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ed. This type of person complains of pain that is not in the center of the back, but that spreads sideways along the iliac crest just below the crest line. They may have a history of immune-related disorders, including tonsillectomy, mononucleosis, lung infections, etc. The main reflex for immune issues is SJ16 and below: this is the area behind the sternocleidomastoid muscle (SCM) and reflects glands, or wind area by TCM terminology.

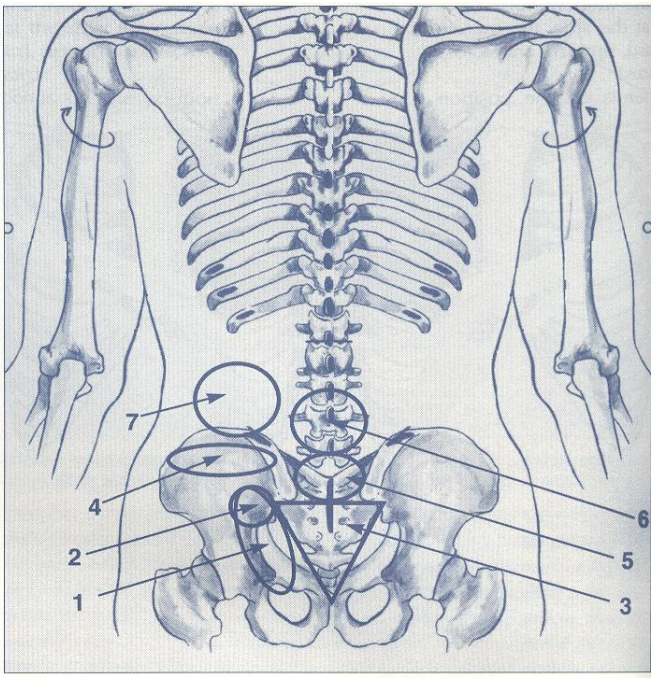
The treatment point is the Immune Point, *(see page 19)* which is located somewhere between LI 10 and LI 11 on the edge of the bone, closer to the San Jiao channel. It is the adhesion of the muscle to the bone that creates a "gummy" feeling here, similar to the muscle attachment on the iliac crest. This point is needled at a 60-degree angle toward the bone (i.e., toward the SI channel) with the addition of direct moxa. The exact point will release both the gland reflex (SJ16) and the iliac crest. The Immune Point can also release the inguinal ligament, as weak immunity can be the cause of weak ligaments, thus it can be added to St13, GB26, Inner Yin combination to release the inguinal ligament.

After treating the front, have the person turn over to lie face down. I often have people walk or move a little so as to test their back pain and ascertain the effectiveness of the front treatment. Now you are ready to address the exact pain location more specifically.

For injuries at the L4 L5-S1 level, the most common injury, we needle into the sacroiliac ligaments. Tight sacro-iliac ligaments will cause tight paraspinal muscles and therefore vertebreal shifts. Palpate the lower lumbar vertebra on the center with straight-down pressure, and on each side of the spine at the Hua Tuo line, press toward the spine at 45 degrees.

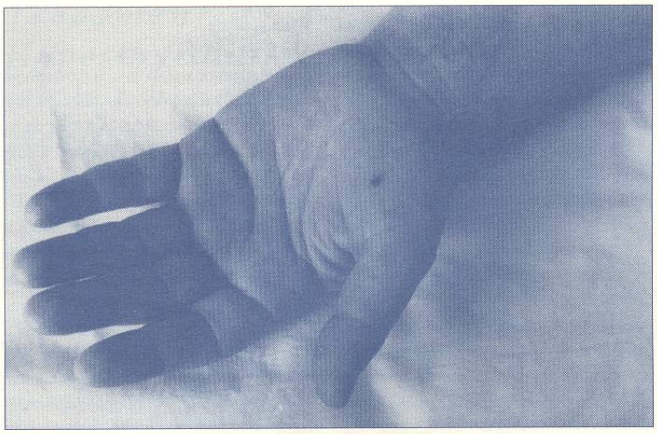
For one-sided pain of the spine (not center, and one side only), we call this SI channel pain. Women who sit on one hip, as they often do traditionally in Japan, can develop one hip higher than the other, affecting a shoulder pain along the SI channel, as well as back pain showing on one side of the spine. Ht 3, same side and needled superficially and down with the flow, does an excellent job for this pattern. We also use Ht 3 for other SI channel pain. To Ht 3 we often add GB26, as well as UB 27 (SI shu). We define UB 27 as the gummy/ropy area at the lateral-superior edge of the sacrum: this is one part of the sacroiliac ligament, and is always further than 1.5 cun out from the spine.

For bilateral spine pain (Hua Tuo line) and/or pain on the Du line, needle into the sacroiliac ligaments on both sides with up to 4 needles on each side. You must find the gummy/ropy section of the ligament, and break it down with the needle. Aim the needle so that it is angled



Differentiating pain areas in the lower back:

1. Sacroiliac ligaments. Needling into these releases L5-S1 (area #5) as well as L3-L4-L5 (#6). It is often ropy and tender. Needle into the gummy/ropy area. If the patients's main complaint is here, use Lv8.
2. UB27. This is the top part of the sacroiliac ligament and releases the same side L4-L5-S1 (area #5 and 6).
3. Sacrum. Sacral pain is release via K6 and UB62 combination.
4. Posterior Iliac crest. This area is related to immune issues and is released via the Immune Points.
5. L5-S1. This area, the most common injury site, includes the Du and the Hua Tuo lines and is released via the sacroiliac points, at least one on each side.
6. L3-L4-L5. This area, including the Du and Hua Tuo areas, is released via Sp9 and sacroiliac.
7. Quadratus Lumborum. Pain on this muscle is released via moxa on Lu10 (Huakaya).



Lu10 (Huakaya) - Direct moxa, to release the quadratus lumborum muscle. Note the location is different than the TCM Lu10. This is a moxa point only, not a needle point.

under the bone toward the opposite GB26, but because of the tightness, the angle often reverts to almost 90 degrees. If the sacroiliac ligaments are too painful to needle into, try to release them by using Lv 8. If the whole sacrum is painful, use K 6 and UB 62 bilaterally.

The sacroiliac treatment is an excellent treatment for L4-L5-S1 problems, whether it is a bulging disc, degenerative disc, or even spondolythesis. It is an excellent treatment to relax the paraspinals all along the spine, not just at the lumbar level. For true L4-L5-S1 pain, this treatment is almost always successful. If you fail using this treatment, it is likely that you have not found the right gummy spots to release along the sacroiliac ligament, or that you have not properly addressed other previous issues that the body is still carrying, or that there is a tailbone or sacrum injury.

It is important to treat **tailbone injuries** prior to the rest of the back. This is equivalent to the notion of fixing the basement before fixing the roof. Tail bone shifts may show on the front on right St 27 which can be released by Lu 8. Needle superficially toward Lu 9. We locate Lu 8 somewhat closer to the pericardium channel than most TCM practitioners. You need to find the exact location that releases right St 27, and either side Lu 8 might do the job. However, be aware that, aside from tailbone shifts, right St 27 can also reflect lung, immunity, or digestive issues.

When the person lies face-down, you can palpate the tailbone directly. I do it over their underwear. Many people do not remember childhood tailbone injuries until they feel the pain when their tailbone is pressed. Many people have tailbones that are curved at an almost 90-degree angle to the front which is a "collapsed" Du 1. The best points to release the tailbone are Lu 8 (as per above, but in this case you can check it directly against the tailbone), UB 66, and Hua Tuo of C6-C7-T1. You may need to use one or more of these three points to release the tailbone.

Sacrum pain is best resolved by use of K 6 and UB 62. Those are needled, each superficially in the direction of their respective channels; that is, K 6 toward the back of the heel and UB 62 toward the little toe.

Lumbar, sacrum, and tailbone shifts can all also result in a lower cervical or upper thoracic shift. It is often the case that people with low back problems display pressure pain on the Hua Tuo line of C6 to T1. If these are not too painful, they can also be needled so as to affect the lower back, or they can be used as a reflection of the back pain when choosing points, especially Ht 3. In other words, when choosing a remote point, that point should alleviate both the cervical and the lumbar pain for it to be considered the "best" point, otherwise we might look around that point for a slightly better result. Remember, sometimes a change of a few millimeters in location can change the results drastically.

Quadratus lumborum is considered to be the kidney muscle. Pain along this muscle, from UB21 down to UB24 and the corresponding outer bladder line, can be treated using Lu10 *(see photo left)*, based on the understanding that the lung is the mother of, and therefore tonifies, the kidney. Our Lu10 is located not at the border of the red and white skin, but on the fleshy part of the thenar eminence. This is a direct-moxa point, not a needling point.

In general, when treating pain, we take into consideration the tissue of the pain. For muscle pain we use "Sp 3.2". We call this point "Sp 3.2" because it is further along the channel, towards Sp 4, than the point located at the edge of the bone. For joint pain, we check for pressure pain on Sp2. If Sp2 is painful, we treat Sp5 and Sp9. This is based on the principle that if the fire point is painful upon 3kg pressure, it can be treated through the metal and water points, as water counters fire and metal is the mother of water and thus enhances water's ability to counter fire.

Ligament pain is treated with Lv8, which is the water point of wood, wood being responsible for ligaments, as well as the immune points, because weak immunity can cause weak ligaments. Bone pain is treated with K7, the tonification point of the kidney. This is regardless of the actu-

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al location of the pain, and based purely on the tissue type.

We tend to treat once a week for chronic conditions, and more for acute or if the pain recurs after a couple of days. We retain needles for 15-20 minutes with no electrical stimulation. We normally do not stimulate or manipulate needles unless the reflex area is not released, in which case, we do tiny up-and-down manipulations to "break down" the gummy adhesions in the connective tissue. Generally, needling is done on the same side of the pain or reflex area.

Treatments usually take 1 hour 10 minutes. For most garden-variety back pain, it takes 4 sessions or less, even for chronic conditions, and disc problems can take up to 10 treatments. In cases of spondylolisthesis, where L5 is cracked and shifted forward, the person will get relief, but stabilization will not occur until about 10 treatments. Treatment of laminectomies requires treating the scars also. After repeated operations, the nervous system can be affected, similar to reflex sympathetic distrophy (RSD). This involves addressing not only the low back, but the RSD or the nervous system, via the pericardium.

This style can be difficult to practice as it does not support "intellectual" decisions. Every needle we put in must release a palpatory finding. This makes us more vulnerable to patients, as the patient is fully able to monitor progress. Kiiko calls herself a "blue collar" worker: we work with our hands - palpating, poking, retesting - not just with our brains. Thus, not every practitioner resonates with this style. However, in this article, I have concentrated on "tricks" that are easily verifiable and do not require a lot of Hara diagnosis, and so it is my hope that every practitioner can implement these treatment ideas into their practice.

The Matsumoto style calls for treatment of original or previous assaults on the body system, a subject that needs to be learned thoroughly and cannot be fully addressed here. Nonetheless, it is still possible to obtain tremendously beneficial results using the above treatments. It is my hope that these treatment ideas will facilitate better results for practitioners of all styles, levels, and skills.

Avi Magidoff has studied extensively with Kiiko Matsumoto and teaches classes in the US and Europe on the Nagano-Matsumoto style. He is writing a book, Meditations on the Meridians: Philosophical Statements of Energy Pathways.