POINTS ON THE NECK AND SHOULDERS

ST-9 *(jin-gei / rén yíng)* ★

(SYSTEMATIC): "The great pulse on the neck. [It is] where a pulsation can be palpated. It is on either side of the laryngeal prominence. [It is] used to examine the qi in the five yin organs."

(ILLUSTRATED): "On the anterior aspect of the neck one-and-a-half units lateral to the laryngeal prominence. It is over the pulsation of the common carotid artery."

LOCATION: Where the pulsation of the common carotid artery is strongest (Fig. 2-21).

PALPATION: Place the tip of your middle finger on the point where you feel the strongest pulsation, and move it back and forth to find a tiny groove, which is the bifurcation of the carotid artery. If it is difficult to locate, pinch the skin in the area above the artery, and insert the needle in the point where the skin is thickest. I use this method of locating ST-9 when I retain an intradermal needle.

INSERTION: Use a vertical, shallow insertion up to the wall of the carotid artery. This is a very sensitive point, so simple insertion and gentle manipulation with a thin needle works best.

INDICATION: Sore throat, hoarseness, or sensation of something stuck in the throat. An intradermal needle can be used on one side for pain or discomfort in the throat.

DISCUSSION: ST-9 lies directly over the common carotid artery and close to the carotid sinus, which has baroreceptors related to changes in blood pressure. Shirota Bunshi, a student of Sawada Ken, developed a direct insertion technique for the treatment of high blood pressure, asthma, and chronic pain conditions such as

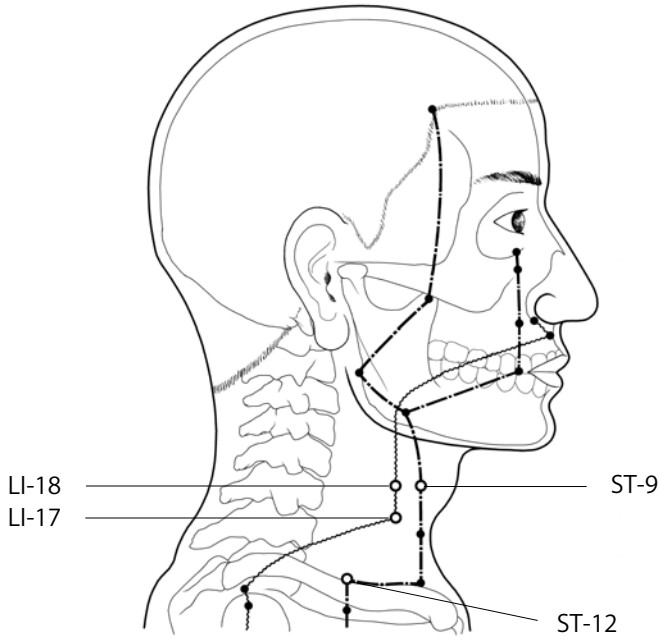

Fig. 2-21

arthritis. In this technique, a needle is inserted until it runs into the wall of the carotid artery. The needle is retained, and the head of the needle moves back and forth with the pulsation of the artery. I do not use ST-9 in this way and do not retain the needle.

ST-9 is known as *jingei/rén yíng*, and taking the pulse here at the carotid artery seems to predate the pulse diagnosis at the radial artery, which is the common practice today. The term *jingei*—pulse diagnosis—refers to a comparison of the carotid pulse with the radial one, and is mentioned in both *Basic Questions* and *Vital Axis*. In Japan, Dōkei Ogura revived this method in the 1950s and has been successfully applying *jingei* pulse diagnosis in his practice. Ogura palpates the pulses with the patient seated. He uses the thumb and index finger of one hand to palpate the carotid artery on both sides, and palpates the radial artery with the index, middle, and ring fingers of his other hand. I have never used this technique in my practice, but it shows that there are a number of different approaches to pulse diagnosis that can be applied successfully in acupuncture.

LI-17 *(ten-tei / tiān dǐng)* ★★★

(SYSTEMATIC): "Above ST-12 in line with LI-18. One-and-a-half units posterior to ST-11."

(ILLUSTRATED): "The artery on either side of the laryngeal prominence is ST-9, and just lateral to this point is LI-18. [From this point] go down over the sternocleidomastoid muscle; it is one unit inferior on the posterior aspect of the sternocleidomastoid muscle."

LOCATION: I locate this point about three finger-widths above ST-12. It is just above the posterior margin of the sternocleidomastoid muscle (Fig. 2-21).

PALPATION: Bend your thumb at the first joint to form a hook, then press the point with the tip of your thumb. Press and work your way down from LI-18 until you feel a projection of the spine. This point is where the tenderness is greatest and where pressing causes a radiating sensation in the shoulder and arm.

INSERTION: Needle with the patient in the seated position. Carefully insert a 30mm, No. 01 or 02 needle, angled posteriorly. Insert slowly as you rotate the needle. When the tip of the needle reaches the surface of the induration, there is a pleasant needle sensation that extends to the GB-20 area, the upper arm, the interscapualr area, the pectoral region, the ear, or the throat. Be sure to avoid deep insertion and the use of thick needles at this point.

Ask the patient about the needle sensation, and feel the hardness of the tissue around the point with your fingers as you slowly insert the needle. Then it is up to you whether you insert the needle a little deeper into the center of the induration, or stop on the surface of the induration. As long as you do not intend to force the needle in, you will make the right choice. If it is the first treatment, play it safe and retain the needle with the tip right on the surface of the induration. In time, the point will soften up so that the needle will go in deeper by itself.

INDICATION: The point is good for *katakori* (see discussion under ST-12 and GB-21), especially when it is related to ear or throat problems. It is also good for tension in the interscapular area, thoracic outlet syndrome, and numbness in the hand, as well as for a feeling of obstruction in the throat.

ST-12 *(ketsu-bon / quē pén)* ★★★

(SYSTEMATIC): "In the depression behind the clavicle."

(ILLUSTRATED): "On the midclavicular line in the supraclavicular fossa. Probing in this area, one finds string-like tender tissue."

LOCATION: On the pulsation in the supraclavicular fossa (Fig. 2-21).

PALPATION: Moving a fingertip lightly back and forth in the supraclavicular fossa, you will find muscle fibers running vertically. The point is close to where a pulsation can be felt with light pressure. Look for the hardest point. Exerting pressure that is too strong can cause numbness or discomfort in the arm.

INSERTION: As with LI-17, needle this point carefully with the thinnest needle. Once there is a mild and pleasant sensation in the upper arm or interscapular area, the right depth has been reached. I usually treat points in the supraclavicular fossa with the patient in a seated position, but one has to be careful about pneumothorax and needle shock. Just remember to avoid thick needles, deep insertion, and strong manipulation. These points are not for those practitioners who believe that the deeper the insertion and the stronger the stimulation, the better.

INDICATION: *Katakori*, numbness in the arms, pain in the upper back, abnormalities in the viscera.

DISCUSSION: *Katakori* (neck and shoulder stiffness) is a troublesome symptom. When I had pleuritis in my youth, and again recently, I experienced strong *katakori*. It is well known that the adhesions that result from pleuritis can cause terrible *katakori*. I remember receiving acupuncture at points like BL-17 and BL-43, SI-11, PC-4, GB-21, GB-34, and GB-41, and will also never forget how painful it was to receive moxibustion at GB-21. As for the more recent episode of *katakori*, I am not sure what caused it. I attempted some symptomatic points on myself, looking for the focal point of tension, but I couldn't seem to get at it. So I had about ten young acupuncturists from my study group try their hands. None of them were able to hit the bull's eye. The more they missed, the worse the *katakori* seemed to get, and I became more and more irritated.

The stiffness seemed to be concentrated under GB-21, and I decided to needle myself once more. After attempting various points, I finally discovered how to get the needle tip on just the right point. It moved around, but was somewhere between ST-12 and LI-17, on the side of the neck. I felt the needle sensation under GB-21,

between the scapulae, and even in the center of my head. My *katakori* must have been caused by some abnormality in the cervical vertebrae or the scalene muscles. Anyway, the secret to needling such points is to locate the tightest or hardest point, and get the needle tip right on it.

For the final step in treating patients with *katakori*, I have them sit on the side of the table and stand behind them. I place my hands on their shoulders, with the four fingers in front and the thumbs on the back. Then I palpate both sides at once with a scraping motion from ST-12 to GB-21. It is easy to find the most indurated points this way. It is said that the Japanese are especially prone to *katakori*, and I find that people with rounded shoulders or hunched backs tend to have it. Active points also tend to show up in the supraclavicular fossa in such patients.

GB-21 *(ken-sei / jiān jǐng)* ★★★

(SYSTEMATIC): "In the depression on the shoulder, above ST-12, in front of the big bone."

(ILLUSTRATED): "On the anterior margin of the trapezius and in line with the midclavicular line. In other words, it is directly above ST-12. Strong pressure here causes pain. It has been said from the olden days that when the second, third, and fourth fingers are placed on top of the shoulder, GB-21 is under the third finger."

(ACUPUNCTURE): "In the midpoint between the spinous process of the seventh cervical vertebra and the tip of the acromion. Locate this point where pressing on the trapezius causes a sensation to radiate to the anterior neck."

LOCATION: On the anterior margin of the trapezius, slightly anterior to the midpoint between the spinous process of the seventh cervical vertebra and the tip of the acromion. It is where the strap of a backpack comes across the shoulder, and it is under the middle finger when three fingers are placed over this area (Fig. 2-22).

PALPATION: Start from LI-16 on the lateral end of the shoulder and lightly press toward the neck with the middle finger. You will find an induration at approximately the midclavicular line. Actually, the location varies between patients and over time. Often it appears in a more anterior direction, closer to ST-12. Pinch the point with your thumb and three fingers and the patient will say "That's it!" This is, however, not quite the same location as when you press. Use the point that is the most reactive.

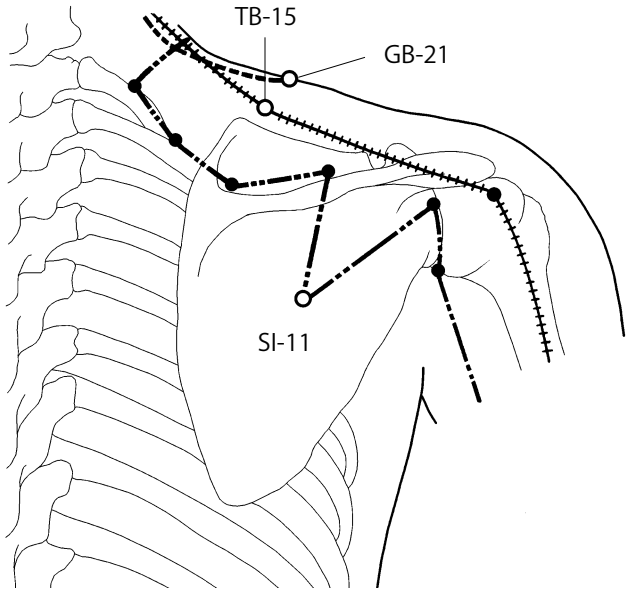

Fig. 2-22

INSERTION: Stand on the left side of the patient, who is lying face down, and insert the needle vertically. In this position, the needle can go quite deeply. When a 40mm needle goes in about halfway, the needle should come up against an induration and you should feel a gummy resistance at the needletip. It is not good when the needle goes in and out without any resistance. Should that happen, reinsert the needle or change the direction of the needle after withdrawing it to just under the skin. Imagine that you are trying to pinpoint an acupuncture point that is floating in midair. Withdraw, reinsert, and apply some rotation, and eventually you will hit the mark. When you do, the needle sensation goes to the occipital area, ear, eye, throat, and temples, and otherwise down to the interscapular area, the pectoral area, and even to the abdomen. Basically, the sensation travels to wherever the patient feels the tension.

When the patient is in a seated position, I insert the needle vertically and superficially. In this position, shallow needling is enough to produce a needle sensation. This is a technique I use at the end of a treatment. Another good technique for this position comes from Yanagiya's text, *Guide to Secret One-Needle Technique*, that is, the trapezius is pinched up between the thumb and four fingers, and the needle is threaded horizontally from front to back.

INDICATION: *Katakori*, headaches and toothaches, diseases above the shoulder, high blood pressure, arteriosclerosis, prevention of senility. Apply multiple cones of direct moxibustion on the affected side for toothaches or trigeminal neuralgia. When GB-21 is used for internal and gynecological problems, it relieves distention of the stomach.

DISCUSSION: When a patient has *katakori*, the sensation of stiffness will quickly subside as soon as the needle tip reaches the palpable source of the stiffness. Patients tend to experience *katakori* around the base of their neck no matter where the problem originates. Often, patients feel the stiffness around GB-21. Yet, when you palpate around the point, you find no special reaction. In this case, of course, needling the point will not do the trick. If, however, you needle points around GB-20 instead (such as Yanagiya's GB-20), sometimes a needle sensation is felt strongly in the affected area (GB-21). This is why treating *katakori* is no simple matter. Other points that work to relieve *katakori* around GB-21 include BL-15, BL-17, BL-41, BL-42, BL-43, TB-15, SI-12, and ST-12. Points like GB-20 and GB-21 are important in the treatment when a person tends toward mental stress and overuse of their arms and hands.

Classical texts emphasize the dangers of needle shock caused by needling GB-21. In *Concise Discourse on Acupuncture and Moxibustion,* Ishizaka Sōtetsu describes this phenomenon:

> It seems that unless the symptoms are severe, this point should not be needled. If the gathering vessels *(sōmyaku/zōng mài)*[3] are pierced by accident, some patients will faint. (Sōtetsu, 1812)

It is true that needle shock is very unpleasant, both for the patient and the practitioner. Ishizaka Sōkei, the son-in-law of Ishizaka Sōtetsu, explains this in more detail:

> Needle shock happens when needling causes light-headedness. Some even faint. This can happen even if an experienced acupuncturist does the needling. It is caused by severe contact with the gathering vessels. Beginners become frightened and lose their composure, and they are at a loss for what to do. (Sōkei, 1860)

This reflects my own experience. It can even make the practitioner break out in a cold sweat! Meanwhile, the patient turns white and sometimes vomits or even becomes incontinent. It is enough to make you become faint yourself. In extreme cases, one might start to think about calling an ambulance. Ishizaka Sōkei instructs as follows:

> Do not become flustered. Quickly get a small towel or cloth and cover the nose and mouth of the person. Then firmly press the area about one unit below CV-15 with three fingers of your left hand. The patient will be revived. (Sōkei, 1860)

Once a patient of one of my teachers started feeling nauseous after being needled at ST-12, and did not seem to get better. My teacher called on a doctor in his neighborhood to help him. The doctor massaged the patient's lower abdomen for a while and the patient got better. I have adopted this method, and it has worked for me. Ishizaka Sōkei further instructs:

> It is also good to needle LI-10. If the needle shock comes from needling a point on the right side, treat LI-10 on the left side. When they come around, it is also good to give them Drain the Epigastrium Decoction *(sha shin tō/xiè xīn tāng)*.[4] (Sōkei, 1860)

It is well known that needling LI-10 or ST-36 on the opposite side helps revive a patient. It is also good to have the patient drink a strong cup of tea.

TB-15 *(ten-ryō / tiān liáo)* ★★

(ZHANG, 1624): "One unit directly posterior to GB-21."

(ILLUSTRATED): "Above the superior angle of the scapula and one unit posterior to GB-21. Pressing [this point] the flesh is depressed, but in its center or to the right or left, there is a hard spot which is not bone. The point is [located right] on this spot."

LOCATION: Just above and medial to the superior angle of the scapula (Fig. 2-22).

PALPATION: Probing two finger-widths above and medial to the superior angle of the scapula, you will find a hard nodule.

INSERTION: Use a vertical, superficial insertion.

INDICATION: *Katakori* (see discussion under ST-12 and GB-21).

SI-11 *(ten-sō / tiān zōng)* ★★★

(SYSTEMATIC): "Posterior to SI-12, below the big bone in the depression."

(ILLUSTRATED): "Inferior to the midpoint of the spine of the scapula; close to the center of the infraspinous fossa. Pressing [here] there is a tender point in some muscle fibers." (Fig. 2-22)

LOCATION: Three finger-widths below the midpoint of the spine of the scapula.

PALPATION: Probing the area below the spine of the scapula, you will find muscle fibers that run vertically and diagonally in an inferior and medial direction. Press with your fingertip and move back and forth over these fibers horizontally to find a point that, when pressed, causes a penetrating pain. The patient may be seated or prone, but use light pressure because this is a sensitive point. The reaction appears within a broad area, so probe the entire infraspinous area. Sometimes, unexpectedly, it appears far below the standard location.

INSERTION: Insert diagonally in either a medial direction or superior laterally. When the needle penetrates into the fibers of the muscle, fasciculation (twitch) can cause the needle to bend if it is thin (less than No. 2). Even so, thick needles can result in too much stimulation and cause discomfort. I often use direct moxibustion instead.

INDICATION: Pain and numbness in the arm: Those who strain their arms at work often show reactions at SI-11. Other indications are problems in the shoulder joint, pectoral region and breasts, chest pain, coughing, and fever from colds.

SI-9 *(ken-tei / jiān zhēn)* ★★

(SYSTEMATIC): "Below the acromion, posterior to LI-15 in the middle of the depression."

(ILLUSTRATED): "On the back, approximately one unit above the axillary crease. One can feel the lower margin of the glenohumoral joint by pressing with the fingers."

(ACUPUNCTURE): "Put the finger on the posterior end of the axillary crease, and move it superiorly along the muscle fibers on either side. Locate [the point] 2cm from the end of the crease." (Fig. 2-23).

LOCATION: In the midpoint between the end of the axillary crease and SI-10 (lower margin of the acromion).

PALPATION: There is a muscle that runs diagonally at the midpoint between the axillary crease and the lateral margin of the acromion (posterior fibers of the deltoid). Press with the middle finger, and move across the muscle fibers horizontally to locate the hardest point. If the reaction is found on the upper end (of the muscle), it is SI-10.

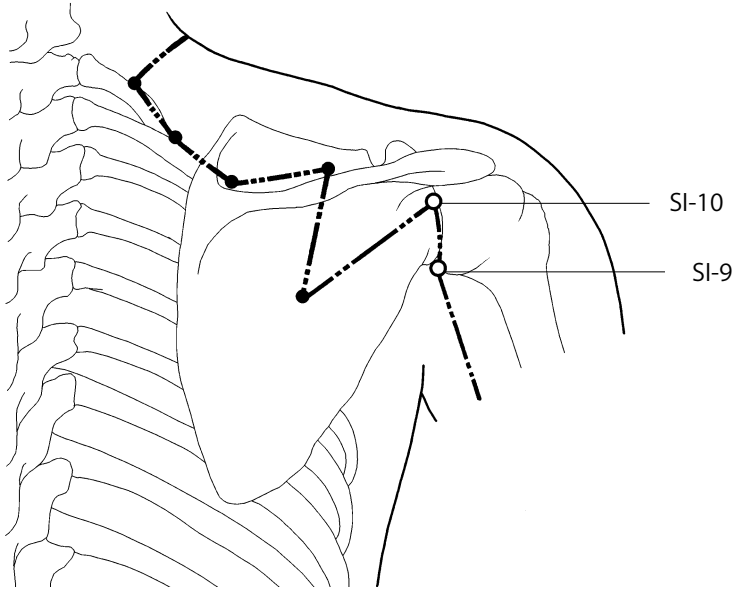

Fig. 2-23

INSERTION: Use a perpendicular insertion. The depth varies from superficial to one-third of a unit. I usually needle this point with the patient in a side-lying position, with the arm resting on the side of the body. Retain the needle in this point for patients with frozen shoulder.

INDICATION: Frozen shoulder and other shoulder joint problems.

LI-15 *(ken-gū / jiān yú)* ★★

(SYSTEMATIC): "On the end of the shoulder, between both bones."

(ILLUSTRATED): "Two depressions form over the shoulder joint when the arm is raised. Locate [this point] in the anterior depression."

LOCATION: Between the acromion and the head of the humerus (Fig. 2-24).

PALPATION: Move the finger anteriorly from the end of the acromion and probe for tense muscle fibers. If there is any tenderness, locate the point right there; if not, locate it in the depression.

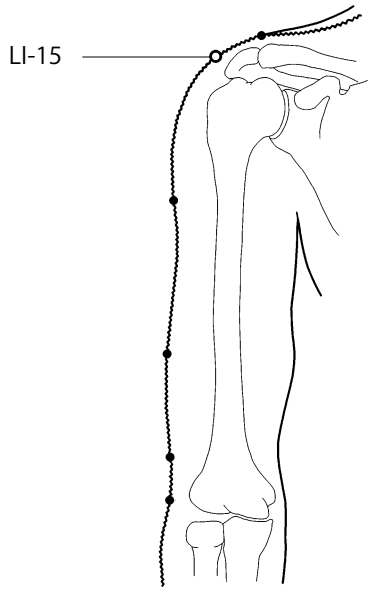

Fig. 2-24

INSERTION: When there is inflammation in the rotator cuff or the tendon of the supraspinatus muscle, insert a needle horizontally into the depression (parallel to the floor), with the patient in a seated position. The needle is thus inserted medially, up to one unit, toward the joint. When the space between the bones is small, it is hard to insert the needle very deeply. In this case, have the patient abduct the arm 90 degrees and insert the needle into the joint. When treating the patient in a side-lying position, seek a tender point close to the head of the humerus. Use a superficial insertion and retain the needle.

INDICATION: Shoulder joint problems.

GV-14 *(dai-tsui / dà zhuī)* ★★

(SYSTEMATIC): "Above the first vertebra, in the depression."

(ILLUSTRATED): "In the space between the spinous process of the seventh cervical and first thoracic vertebrae."

LOCATION: Between the spinous process of the seventh cervical and first thoracic vertebrae (Fig. 2-25).

PALPATION: Press and move a finger back and forth between the spinous processes to find the point. GV-14 is between the biggest protrusion at the base of the neck (C7) and the vertebra under it (T1). With the patient bending their head forward, mark the top of the seventh cervical vertebra. When the patient rights their head, the mark moves down between the vertebrae to GV-14. (If you are not sure which one is the seventh cervical vertebra, have the patient turn their head from side to side. The lowest vertebra that moves is the seventh cervical vertebra.)

INSERTION & INDICATION: Apply direct moxibustion for the early stages of a cold and upper respiratory tract infections. Multiple cones, from 15 to 50, are most effective. This method is also effective for rhinitis. For colds, contact needling, instead of moxibustion, can be applied around GV-14. When there is pathology in the cervical vertebrae and there is tenderness or pain with percussion, retain a needle superficially at GV-14 or on the lateral margin of the vertebra, wherever the tenderness or pain is clearest.