

*“Oh, East is East and West is West, and never the twain shall meet,
Till Earth and Sky stand presently at God’s great Judgement seat,
But there is neither East nor West, Border, nor breed, nor Birth,
When two strong men stand face to face, tno’ they come from the ends of the
earth!”¹*

- Rudyard Kipling

CHAPTER FIFTEEN

WEST MEETS EAST: PART I

This chapter will show that the western symptoms of Parkinson’s described in the previous chapter are the same as the symptoms of Rebellious Qi in the Stomach Channel From Unhealed Injury at ST-42. In addition to showing a Stomach channel relationship to the recognized symptoms of Parkinson’s disease, I will show that the auxiliary symptoms of Parkinson’s also fit the model of Rebellious Qi in the Stomach channel.

I can note the specific locations and natures of the western and auxiliary symptoms and place them as dots on a map of the human body. The line formed by connecting the dots is the same line that is classically described in Asian medicine as Stomach channel. By the end of this chapter, I will demonstrate this match-up: I will show this channel alongside a head-to-toe list of the symptoms. But first I’ll need to write a chapter’s worth of more explanations and another spot of Asian medical theory.

DEFINING “AUXILIARY SYMPTOMS”

Auxiliary symptoms are those symptoms that are somewhat common in PDers and somewhat uncommon in the general population. These symptoms are usually ignored in western writing about PD; they don’t necessarily fit the dopamine theory; they weren’t mentioned by James Parkinson in his book, *The Shaking Palsy*. Still, when listed together with the locations of

¹ Rudyard Kipling, “The Ballad of East and West,” *Ballad, Poems and Other Verses*, Fenno & Company, New York City, 1899, p.11.

This famous stanza, so often quoted out of context, means that although the continents of east and west will of course never physically touch until such time as the earth itself dissolves, yet when great souls of any race, social standing or nationality come together, all barriers disappear. I hope that both Asian and western medical researchers and practitioners can be “great souls” and throw aside their prejudices enough to consider learning broader ways of thinking.

I should not be surprised if someday we learn that what we now call the Asian medical model was used throughout the world in ancient times, just as the recent discovery of the frozen prehistoric man in Switzerland showed knowledge of acupuncture points existed in Europe; his back had been tattooed with acupuncture points known to be effective for the arthritis from which he suffered, as shown in X-rays.

In the same vein, I had two patients who were reluctant to receive treatment because they were not certain that Asian medicine was appropriate for Christians. One nun began treatment after praying for guidance on a Catholic retreat. The other began treatment after his Baptist minister approved it. The minister told him that all healing comes from God, and that he should not be put off by the vocabulary nor the country of origin of a medical process.

the more classic symptoms, they give a fuller picture of the forces at work in Parkinson's disease.¹

Collecting the auxiliary symptoms

I did exhaustive intakes on all my PD patients. Some of my intakes lasted for hours. Some continued week after week as I was doing foot treatment on the patients. I wanted full medical histories and any information that might or might not be of obvious import: anything the patient thought was unique or different about himself. Most of the auxiliary symptoms were told to me on the basis of location. For example: "I get a pain in my lower back molar on the right side; it comes and goes. X-rays say there's nothing wrong." These location-specific symptoms got added to my "Locations of auxiliary symptoms" list. Some patients also described body-wide symptoms and what they felt were unique personality traits. These symptoms got put on two other lists, the "Body-wide auxiliary symptoms" and "Attitudinal symptoms" lists.

I did not include every symptom of every PDer on the lists – only the symptoms that occurred in several patients and which occurred more often in PD patients than might be expected in the general public of about the same age range. These symptoms ranged from always being careful to exhale while chewing in order to prevent choking (often for years prior to diagnosis) to skin problems. The skin problems ranged from mere seborrhea alongside the nose to a history of (removed) cancers, melanomas, and large, worrisome moles.

Actually, the cancer and melanoma symptoms seemed unrelated to PD at first, but *many* PDers had this history. When doing physical exams, I realized that the PDers' scars from the removals of their cancers, melanomas, and moles were always located smack on their Stomach channels, or once in a while on the Large Intestine channels, on the same side of the body where PD symptoms first appeared. I added the cancer histories to the list.

When the highly uncommon childhood symptom of purposely and repeatedly ripping off the entire nail of the small toe came up in two of the first twenty patients, that symptom almost made the list. They both explained that they had ripped off the 5th (smallest toe) toenail on what

¹ Many MDs are utterly unaware of even the most common auxiliary symptoms of PD. For example, a PDer told me that when he called a Santa Cruz MD on her weekly radio talk show to ask about his toe pain and toe spasm symptoms, she assured the PDer that his toe curling was not related to Parkinson's disease.

More than half of my PD patients have had painful problems from toe curling and toe spasming.

Curious, I ran a cursory webscan of the literature. I immediately found four articles relating to this issue:

"The frequency and significance of 'striatal toe' in parkinsonism," King's College Hospital and Guy's, King's and St Thomas' Medical School, London, UK. *Parkinsonism Related Disorders*, 2002, Dec;9(2):97-101. This article stated that 7 of 38 patients with PD patients had striatal (extensor planar response) toes in the absence of any other signs suggesting dysfunction of the cortico-spinal tract.

"Do Parkinsonian symptoms and levodopa-induced dyskinesias start in the foot?" Vidailhet, M., Bonnet, A.M., Marconi, R, et al, *Neurology*, Sep;44(9): 1616-6. This article explained that symptoms of parkinsonism started in the foot in six out of 20 PDers.

The other two articles described cases of rheumatoid-like and psuedorheumatiod deformities of the feet associated with Parkinsonism.

I merely mention these articles because the MD on the radio had been so quick to dismiss a not uncommon auxiliary symptom of Parkinson's disease – toe deformities, toes curling under and toe spasming – simply because this "poverty of vitality and movement in the foot" symptom is not one of the frequently mentioned Big Four symptoms.

eventually became the PD side because the gentle sensation of throbbing in the foot was somehow soothing.¹

Some of these symptoms that were seemingly unrelated to movement and dopamine, such as insomnia or a tendency towards constipation (of a type that is not helped by laxatives), were recognized among western researchers as being symptoms frequently seen in PD.

However, there had never been any attempt to connect these symptoms and events with the Parkinson's itself. The main reason they are not considered important may be that they do not support the 1950's theory of Parkinson's disease being caused by dopamine depletion. Yet these "recognized, but unrelated" symptoms consistently added more weight to my growing hypothesis.

As an aside, while discussing their various foot symptoms, many PDers volunteered that they had intuitively felt that their mobility problems somehow stemmed from their feet. They had been assured by their MDs that such a notion was purely wrong.

DEFINING WESTERN SYMPTOMS IN TERMS OF LOCATION

To create a location list for the "known symptoms" of Parkinson's, I replaced the Big Four's generalized symptom descriptions such as "poverty of movement" and "rigidity" with the exact locations of the symptoms. To do this, I used symptoms of my early- and mid-stage PDers, before their slowness, rigidity or tremor became body-wide.

I replaced the general term "poverty of movement" with the exact *locations* of poverty of movement symptoms in my early-stage PD patients: the lips, the eyelids, cheeks, the index finger, the second and third toes, etc.

I replaced the term "rigidity" with a list of the specific *locations* where rigidity most often appeared: anteriolateral muscles of the neck, the torso muscles along the mammary line, etc.

For tremor, though it may eventually become system-wide, I used the most common *locations* of early-stage PD tremor.

And so I made a list of the specific locations of well-known symptoms from the Big Four. I combined this list with the location list of auxiliary symptoms.

Putting the symptoms together on a map

For many months I had no theory at all as to why my simple foot holding was reversing symptoms of what looked like Parkinson's. But I was acquiring a pretty extensive list of location-specific symptoms, symptoms that might or might not actually be related to Parkinson's disease.

I still don't know why, one morning, I decided to mentally rearrange my growing locations list into head-to-toe order. I realized, to my amazement, that my list was drawing a picture of the Stomach channel; nearly all the symptoms of Parkinson's disease, the classic western and the common auxiliary symptoms, were located at various areas along the Stomach channel – always on the side of the body where the Parkinson's first appeared. If the symptoms was bilateral, the other side of the body's symptoms were much milder, almost an echo of what was happening on the side where symptoms first appeared. When I added in the arm symptoms,

¹ Those two people told me (I will paraphrase): "I've never told anyone about this, it's embarrassing. It didn't hurt, but I knew it wasn't normal. But it felt so good, in a strange way, to have feeling throbbing away down in my feet." That seemed almost bizarre enough to include, but it was too small a number, percentage-wise.

they were all located on the Large Intestine channel – the channel that feeds into the Stomach channel – also on the same side of the body where symptoms first appeared.

Considering that there are two each of the dozen primary channels and eight extra channels – thirty two channels all together – I had to wonder, what are the odds of all the symptoms of an illness appearing on only two channels? If Parkinson's was actually a disorder stemming from neurotransmitter insufficiency, shouldn't the symptoms be spread throughout the body, or at least distributed over many channels?

If Parkinson's disease was actually caused by a dopamine deficiency in the brain, the decrease in dopamine should affect all motor function. But in PDers, the specific movement problems were due to the fact that some muscles worked and other didn't. For example, the legs of PDers had anteriolateral muscles that didn't work and medial and posterior muscles that *did* work. This is why even PDers who have trouble taking steps forward or turning to the side can often walk backwards somewhat easily – sometimes even going backwards without meaning to.

Then again, because the muscles of the Stomach channel are the ones used in a majority of motor functions – walking forward or turning, getting up from a chair or rolling over in bed – a problem in the Stomach channel can look like serious overall movement inhibition, but closer observation will show that the “overall” problem is actually due to the problems in specific muscle groups, not all muscle groups.

For example, the hunched posture of Parkinson's is caused by rigid, shortened muscles in the anteriolateral (front and towards the sides) muscles of the neck and torso and a relative weakness in the muscles along the back of the neck and spine. The overall look thus created is one of body-wide hunching, but the actual muscles causing the hunching are a very specific group.

Of course, over time, as Parkinson's progresses, the conglomeration of worsening symptoms may snowball. And the ever-increasing anxiety and depression can add yet another level of inhibition to neurotransmitter release. The increasing motor problems and the mental/emotional factors can combine and multiply until a person becomes completely immobilized (although he may be able to move somewhat normally if given a convincing placebo (positive thought) or a convincing emergency (negative thought)). But in the earlier stages of Parkinson's disease, most of the symptoms are highly location-specific – not body-wide.

It seemed logical that a midbrain neurotransmitter deficiency should create body-wide symptoms, affecting all muscles similarly. But an *electrical* illness (a channel problem) would affect primarily the specific muscles, blood flow, skin and nerves along the path of the channel. The other muscles, areas of blood flow, skin and nerves would be relatively unaffected.

Based on what I was seeing, Parkinson's appeared to be, in its early stages, an electrical disorder, a channel disorder!

Next, I noted on my imaginary map which of the symptoms were problems of rigidity and which were problems of limpness.

In my mind's eye I could suddenly see that the symptoms of rigidity occurred in the portion of the Stomach channel that ran from the back of the jaw to the center of the foot. Symptoms of limp muscles and weakness were in the portions of the Stomach channel that traverse the face and the portion of the foot between ST-42 and the toes. Rigidity in the arm extended in a narrow line from the front of the shoulder down to the wrist, following exactly the path of the Large Intestine channel. Weakness in the arm most often began at the wrist and extended to the tip of the index finger.

Rigidity versus weakness

An introduction to Asian theory of Excess and Deficiency

In Asian medicine, one always notes whether a symptom is due to too much Qi or too little. These plus or minus quantities of energy are referred to as Excess and Deficient conditions.¹

In muscles, Excess Qi can cause conditions of pain, rigidity, spasms, tightness, and/or heat. A condition of insufficient, "Deficient," Qi can cause numbness, flaccidity, weakness, paleness, and/or cold.

Whether or not unhealthy body tissues are either flaccid or rigid is a point usually ignored by MDs with regard to Parkinson's, but these two opposite conditions can signify very different underlying problems.

In either condition, Deficiency or Excess, when Qi is not running correctly, cell growth veers off from correct to incorrect. The effected area might respond in many ways ranging from atrophy to growing in an uncontrolled manner (cancer, tumors). In either case, whether Excess or Deficient, the tissues in the zone of influence of the incorrect Qi fail to grow correctly. In the term "tissues," I include skin, muscles, bones, blood vessels, and nerves.

In Asian theory, there are many Qi conditions that fit under the heading of Excess, ranging from fever to a nail through the foot. Rebellious Qi (backwards flowing Qi) is considered one of the many forms of Excess Qi.

Examples of muscles with Deficient or Excess Qi

A saggy eyelid: Deficiency

Consider the flaccidity in the lower eyelid of advancing Parkinson's disease, usually worse on the SSFA (Side on which Symptoms First Appeared). This weakness, with the lower eyelid sagging down a bit, can be so severe as to create the illusion that the eyeball on the SSFA

¹ A majority of people using our books and treatment plans are not acupuncturists. My first book was directed to acupuncturists, *not* because they have experience treating energetic blockages or doing Tui Na – they usually do not have such experience – but because they could most easily understand the theories involved.

However, it has turned out that most of the health practitioners treating PD with these theories are not acupuncturists. Therefore, this book includes an extremely rudimentary explanation of channel theory and the theory of Excessive and Deficient Qi. These theories are crucial in allowing anyone to make sense of the symptoms of Parkinson's disease, symptoms that present uniquely in each PDer. Without the theory, this book is only a one size fits all, formulaic cookbook. By understanding the principles, one can understand how to apply the same thinking even if any given PDer turns out to be slightly different from the norm. And since no two PDers are alike, the theory is more important than any specific examples or case studies.

To those acupuncturists who have written helpful letters telling me that my theory chapters are incomplete, I offer thanks and freely admit that I am giving a very simplified version of Asian medical theory.

is larger. There is no pain, no tension, no rigidity in the sagging eyelid. The eyelid hangs lifeless, drooping. The PDer may not be aware of the extent to which the eyelid is sagging because he can't really feel the eyelid tissue.

A rigid neck: Excess

Compare the limp eyelid with the situation in the neck muscles: the muscles of the front of the neck become very rigid and contracted in Parkinson's. This in turn causes the following symptoms: the head is pulled forward and downward by the tightening of the front of the neck. This creates the neck portion of the hunched posture characteristic of Parkinson's.

At night, in bed, the tightness in the neck muscles pulls the head forward, preventing the head from relaxing down onto the pillow. Sometimes three pillows must be used to bring the pillow level high enough to provide support for the head. Without the pillows, the extreme tightness in the neck is very painful, as gravity pulls the head backwards towards the bed but the tension in the neck pulls the head forward.

Painful coughing and choking can occur due to the pressure on the front of the neck from the muscles that are sometimes stiff and rigid, sometimes even spasming.

The differences between the limp, flaccid muscles of the eyelids and the painful, tight, rigid or spasming muscles of the neck are differences between Deficient and Excess muscle conditions, respectively.

These same principles can be applied to a problem in any part of the body. These principles can help a health practitioner understand whether or not he is dealing with a condition of Deficient Qi or Rebellious Qi. This distinction is extremely important when choosing a treatment plan.¹

Rigidity is not a sign of strength

In Parkinson's, body tissues in certain areas become unresponsive to brain command, shrink up a bit and sometimes even become hard and tough, like dried beef jerky. These areas are found on a line that runs from the corner of the jaw down to the center of the foot. The line varies in width: it ranges from a quarter of an inch along the front edge of the neck muscles to an inch

¹ Even first semester acupuncture students should know the classic warning that forbids strengthening (tonifying) a situation that is Rebellious. I get queries from acupuncturists, who should know better, asking me why they shouldn't just needle the Rebellious Qi to "straighten it out." If they considered the Rebellious Qi in terms of the ancient admonitions to never tonify an Excess condition, they would not need to have written to me. The western reader, possibly scratching his head over this jargon, may be able to relate it to the popular injunction, "Don't feed a fever." Fever is an Excess condition.

As for the specious argument that some types of needling can reduce or drain excess Qi, acupuncturists need to remember that this argument only applies in certain conditions, such as bleeding a point to remove hot blood, dispersing a knot of Qi by spreading it out, or draining one element into another element. When it comes to an actual excess of Qi in the channel, and *especially* if Qi running backwards, a needle inserted into the Excess area will usually serve to amplify the ongoing condition. Although an experienced practitioner may be able to temporarily redirect the Qi with a cleverly placed needle, the condition will revert to its old pathology when the needle is removed – and may be worse than before. Many PDers intuitively know that needles placed nearly anywhere in their body (except the Du or Ren channels) make them worse: they tell me that, while they can tolerate pain easily, they've felt deeply uneasy when receiving acupuncture. Many PDers who were needled at the most common points on the Stomach channel prior to learning of our program have told us that the needling caused a horrible, even terrifying sensation, like a body-wide electrical shock, or even needle shock (passing out). Many PDers have a severe aversion to needles, both Asian and western needles.

and a half in the area just below the knee. This toughness and hardness are especially palpable on the front-outer portion of the thigh.¹

I refer to this hardness as “rigor mortis-like” rigidity to suggest that it is a bad thing. I need to do this because too many Americans, unfamiliar with the Asian theory, assume that a rigid muscle is a good muscle. They are thinking in terms of rigid meaning strong as steel: a good thing. In PD, the rigidity feels, to a health practitioner doing some prodding, like cement or a piece of lumber. This type of muscle tightness suggests not only an Excess Qi condition, but a specific type of Excess: decades of Rebellious channel Qi: *not* a good thing.

The nature of the symptoms of Parkinson’s

As noted in chapter five, in Parkinson’s disease, the Stomach and Large Intestine channels have been shunted away from the face. This dearth of channel Qi on the face is the reason that the symptoms along the facial portion of the Stomach channel, starting at the eyes and going down to the back of the jaw, are symptoms of Deficiency. However, where Qi runs backwards, from the jaw down to the center of the foot, the symptoms are symptoms of rigidity, excess tightening and hardness in the muscles. From the center of the foot to the toes, where the Stomach channel Qi cannot flow, the symptoms are once again symptoms of Deficiency.

On the arm, the symptoms are primarily symptoms of Excess, except for the area from the tip of the index finger up to the point where the thumb meets the index finger: this area is deficient, even atrophied.

This brief introduction to the ideas of excess and deficient symptoms will have to suffice. Now we get to apply this theory to the symptoms of Parkinson’s disease.

Remember, Rebellious Qi is considered a type of Excess.

AN “AH HA!” MOMENT

It was while working with my fourth PD patient that I realized, much to my amazement, that the Qi in his legs was running wrong. At the time, I was still extremely dubious about Asian medicine. I had digested my course material in Asian medical school by interpreting its precepts through a protective screen of western science and biology. No one could have been more startled than I to discover that backwards-running Qi, Rebellious Qi, was just that: electricity-like currents that were running in the reverse direction.

I am blessed with extremely poor eyesight; an overdeveloped sense of touch is my compensation. Always keenly sensitive to electric charge or static in people’s skin, I could easily feel with my hands an electrical flow in my patients’ skin, but I had always dismissed it as mere static electricity.²

It was only when I realized that this PD patient’s leg electricity was moving in a reversed direction from my non-PD patients that I suspected that this electrical feeling might be related to that Qi that I had spent four years reading about in school.

In a moment, channel Qi went from being a theoretical concept to a tangible, measurable quality. There is no name for this discernable energy flow in western medicine or even in the

¹ Many of my PD patients have pointed these unyielding muscles on the anteriolateral side of the thigh and told me, “I’m really in good shape despite the Parkinson’s; look how strong these leg muscles are.”

² Actually, anyone can feel it. It just takes realizing what one is feeling. My advantage was that I didn’t need to try to feel for it; it jumped out at me.

entire field of biology. However, based on how it moves, short circuits, and is effected by nearby currents, it recalls to mind the principles of electricity and magnetism I learned almost forty years ago, in high school physics class.

Qi is real. Who knew?

As soon as I realized that the palpable sensations I felt flowing in the limbs of my patients was “Qi,” I could stop thinking of channel Qi as a principle, and start thinking of it as a physical reality. Channel Qi wasn’t some mysterious arcane and theoretical force. It was some energy that felt like static electricity sometimes, and at other times felt like a stream of electricity.

Suddenly, the concept of “Rebellious Qi” that I had learned in school took on a new meaning. I could easily feel that the currents running in this PDer’s Stomach channel was not going in the direction I had learned in school. Nor was it running in the direction that seemed familiar to me. (I had learned about the correct directions of channel Qi flow in Asian medical school, but I had never made the connection between this book learning and the sensations that I was accustomed to notice in patients’ skin.) Doubting myself, I checked his other channels. They were running in the usual directions: the directions that I had learned in school!

Back to the location map

By the time I constructed the location map of my PD patients’ symptoms, I had already seen that all my PD patients had backwards flowing Qi in some parts of the Stomach channel on the side that first exhibited symptoms of Parkinson’s. Other parts of the Stomach channel, the face portion and the portion downstream from ST-42, had no amount of palpable Qi.

Having noticed this already, I felt a giddy chill as I realized that the symptoms of Parkinson’s that featured rigidity were located on the portion of channel that was running backwards. The symptoms of Parkinson’s that featured weakness were on the portions of the Stomach channel that had no Qi at all. Suddenly, the combination of Deficient and Excess symptoms in Parkinson’s made perfect sense. The *nature* of the Parkinson’s symptoms in any given location depended on whether or not Qi was running Rebelliously or was not running at all, in the body part in question. This was glaringly logical.

This combination of Excess and Deficiency corresponding to areas of Rebellious and insufficient channel Qi suggested something new to me: Asian medical theory might be far more practical and objective than I had ever imagined. Also, whatever was happening with my Parkinson’s patients’ symptoms in response to my foot holding at ST-42 *might* have a tangible, logical explanation far beyond my earliest thought that “the Yin Tui Na at the foot allows the foot injury to start healing.”

As mentioned earlier, the classroom lectures on Rebellious Qi back in my school days had addressed superficial, fleeting issues of Rebellious Qi, such as coughing or burping. Rebellious *channel* Qi had never been discussed. (Remember, the very existence of channels had been disavowed by the Chinese government.) But now, for the first time, I understood that the pathologies of rigidity that I was feeling were the results of palpable Rebellious channel Qi on the tissues directly under its influence. Evidently, backwards flowing Qi, over time, caused muscle tissues to become wooden, distorted, or even cancerous. An absence of Qi, somewhat predictably, caused numbness, weakness, lack of muscle function.

I had to wonder if the picture of Rebellious Qi and absent Qi in the Stomach channel could lead me to an explanation of the symptoms of Parkinson's that *weren't* location specific. After all, I still needed a theory that would allow me to account for the few symptoms of Parkinson's that didn't fit on any channel. The dormancy of substantia nigra cells was at the top of my list of puzzling non-channel symptoms. But other body-wide symptoms such as poor temperature regulation and personality-based symptoms such as heightened wariness were also puzzling. The question then became, could Rebellious Qi in the Stomach channel also cause these symptoms? Could Rebellious Qi cause a dormancy in substantia nigra cells? If so, how?

Slowly I was able to put together a logical explanation of the channel routing changes that would occur in response to a long-term condition of Rebellious Qi flow. These Qi routing changes *did* explain the dopamine dormancy and most other body-wide symptoms. That explanation was given in chapter five.

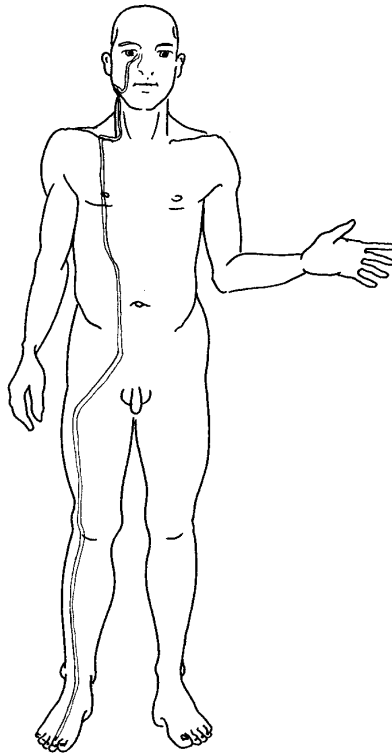
In this chapter, I will show the list of western-recognized and auxiliary symptoms of Parkinson's alongside of a drawing of the Stomach channel – a sort of West meets East presentation.

The list of all symptoms, by location

Key to the list:

- *The PD symptoms recognized by western medicine are marked on this list with a hollow circle.*
 - *The auxiliary symptoms are marked with a filled-in circle.*
-
- no or slow lower eyelid blinking; sagging lower eyelid.
The symptom is worse on the Side of the body where Symptoms First Appeared (SSFA).
 - sinusitis, problems with the sinuses, especially on the SSFA, including severe snoring and even sleep apnea
 - seborrheal skin on the cheeks or along side the nose, especially on the SSFA
While seborrheal skin may appear prior to the diagnosis of Parkinson's, it more commonly appears in the years following diagnosis.
 - loss of sense of taste or smell
 - a feeling as if the roof of one's mouth is sinking down into the mouth at the back of the mouth, as if the sinus bones are collapsing downward inside the face
 - inability to smile, worse on the SSFA
 - inability to realize that facial muscles are not actually moving when PDer thinks that he is smiling
 - feeling of deep cold inside the cheek, especially on the SSFA
 - pain that comes and goes in the back lower molars on the SSFA
 - excess salivation
 - poor swallow reflex
 - spontaneous spasming in the throat for no apparent reason, choking or coughing from "nothing," choking or coughing from saliva, choking easily when eating, spasms in the throat
This choking symptom may start decades before the diagnosis of Parkinson's.
 - aspiration pneumonia from food going down the wrong way
 - teaching oneself to always exhale before putting food in the mouth and not breathing once food is in the mouth to avoid a tendency for food to slide down the airpipe when chewing
This symptom may start decades before the diagnosis of Parkinson's.
 - hunched posture, head pulled forward
 - choked off voice, soft voice
 - difficulty turning the head from side to side
 - orthostatic hypertension (low blood pressure, insufficient blood supply to the head when standing up from a sitting position)
This is probably due to the pressure on the carotid sinus in the neck. The rigid tissues of the neck press on the carotid sinus, sending a false "high pressure" signal to the

sinus. The body correspondingly lowers the blood pressure.¹ This symptom, orthostatic hypotension, is commonly associated with adrenaline insufficiency as well.



The Stomach Channel

(The branch that skirts the lips is not shown.)

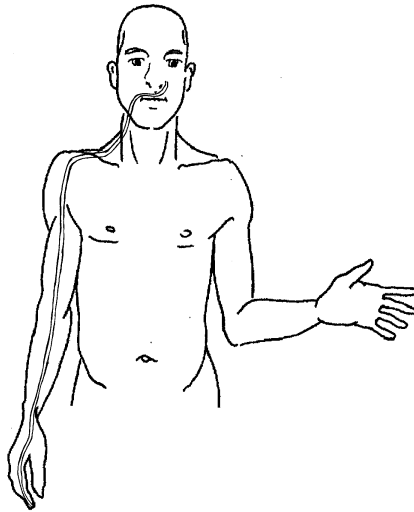
- discomfort, almost a feeling of suffocation or panic, if doing an activity with the arms raised, even briefly, over the head: taking down a shower curtain, getting plates down from a high shelf. This discomfort is due to the rigidity over the collar bone and chest; raising the arms causes the rigid chest muscles to push in on the lungs.
- pain or tingling between the shoulder blade and the spine when trying to sit up very straight with the shoulders back for any length of time, especially on the SSFA
- either a “cast-iron” stomach or a hypersensitive one
- difficulty turning over in bed at night, or turning from the waist
- in women, extremely deep, pathological abdominal stretch marks that formed during pregnancy from an utter failure of the skin to stretch

In one case, a pre-PDer experienced failure of the uterus to expand during her second pregnancy, necessitating a Caesarean section for a baby of low birth weight. Her first child had been carried to term in a fully expanded uterus.

¹ Many people with Parkinson’s are proud of their low blood pressure, never realizing that it is a part of their Parkinson’s pathology.

- either the ability to hold the bladder for an alarming number of hours, sometimes urinating only once or twice a day, if that, or else the opposite: chronically frequent, scanty urination
- chronic constipation – a type of constipation that does not respond to laxatives
 - Some people have the opposite: a long-time tendency to very loose, poorly controlled stools, even prior to the diagnosis of Parkinson's.
- pain in the groin, especially on the SSFA
- lack of hair on the legs along the Stomach channel, especially on the SSFA, even if the other leg or the rest of the leg has a normal hair pattern,
- extreme hardness in the anteriolateral muscles of the upper and lower leg
 - Many PDers point with pride to this steely bit of flesh, and imagine that it is supremely toned muscle. The energy movement and tone in these muscle groups, however, suggests the woodenness of rigor mortis rather than the tone of healthy tissues.
- difficulty in moving to the side, turning to the side while walking
- more difficulty in turning to the SSFA than in turning to the other side
- a sensation described as “woodenness,” “weirdness,” “buzzing,” “something irritating under the skin,” or “something not right” referring to the feeling in the anteriolateral portion of the legs
 - These feelings can be constant, but they especially might be felt at the end of a long day of standing.
- a rare feeling of momentary tingling or buzzing that comes and goes in the medial ankle, especially prior to the diagnosis of Parkinson's
 - This ankle feeling can be significant enough that one is prompted to pull down the sock and stare at the ankle, looking for the source of the irritation. But nothing visible is going on. However, severe vascular irregularities, varicosities, and skin staining may occur on the medial ankle, especially on the SSFA.
- cogwheeling in the ankles
 - The “cog” is at the Stomach channel point of the ankle, worse on the SSFA.
- foot drop, worse on the SSFA
- festinating gait due to shuffling steps, foot drop
- misshapen feet or toes, worse on the SSFA
- grey or purplish cold feet or toes, worse on the SSFA
- veins on the dorsum of the foot on the SSFA that do not run down to the toes
 - Instead, the veins often form a loop just distal to ST-42 (at the center of the foot), worse on the SSFA.
- tendency for cramping in the sole of the foot due to no muscle function in the opposing muscles on the dorsum of the foot, worse on the SSFA
- toes curling under the sole of the foot due to no muscle function in the opposing muscles on the dorsum of the toes, worse on the SSFA
- severe bunions and other displaced bones, worse on the SSFA
- smaller foot on the SSFA
 - The foot on the SSFA might be from one half to two full shoe sizes smaller than the other foot.
- toenail fungus, especially in the three medial toes, worse on the SSFA

- distinct toenail ridges that run parallel to the moon of the toenails
(Interestingly, unusually large ridges that run the *length* of the toenail may, in my limited experience, indicate a blockage in the foot portion of the Spleen channel. This can cause a floppy foot, an inability to lift the feet, and an overall look that is very different from Parkinson's disease.)
- inability to separate the 2nd and 3rd toe on the SSFA
- numbness on the medial side of the big toe (acupoint SP-3), or poor response when a needle is inserted at SP-3, especially on the SSFA
Needling this point should be breathtakingly painful in a healthy person.
- lack of proprioception in the feet and toes, inability to know where the toes are if shoes or slippers are on



The Large Intestine Channel

- lack of proprioception in the hands and arms, inability to know where the hand is and in which direction it is supposed to move when putting on sleeves that hide the hand from view
- atrophy of the muscle that pulls the thumb over to the 2nd metacarpal bone
- atrophy of the bicep
- pain or weakness in the bicep
- poor small motor skills: cutting food, picking up small things, doing buttons
- micrographia
- If micrographia is present, upper arm soreness during extended periods of handwriting

The PDer is using the upper arm to make the lettering instead of just using the very small muscles in the hand and wrist. This may be due to the lack of small motor function and proprioception in the fingers, particularly the index finger.

Inappropriately performing this small motor task with the large motor muscles causes the bicep area to tighten up quickly. And since the actual bicep itself may be somewhat or highly atrophied, other upper arm muscles will struggle to control writing movements that *should* be done with the fingers and wrist.

- cogwheeling at the wrist

- cogwheeling at the wrist most pronounced at the intersection of the wrist with the Large Intestine channel
- lack of arm swing
- prior to diagnosis, when arm swinging is/was still possible, a tendency to swing the arms in a peculiar manner, maybe unnaturally forceful, or with a side to side motion instead of the more normal front to back pattern, or with the hands rotated away from the normal position
- tendency for the arms to be crooked at the elbow when the arms are at rest, with the hands resting on or near the waistline
- pill-rolling tremor
- history of cancer, melanoma, lipoma, or tumor along the Stomach channel or Large Intestine channel

Summary of the location of symptoms:

As seen by the above list, the Stomach and Large Intestine channels are, with few exceptions, the locations of the symptoms of Parkinson's disease.¹

Looking at it the opposite way, the locations of symptoms of PD form a picture of the Stomach channel and Large Intestine channel. At first glance, this map of symptoms fit my budding hypothesis that a Stomach channel disorder was involved in the development of Parkinson's disease. At second, third, fourth and fifth glances, I started putting together the hypothesis of channel aberrations and rerouting that can explain the Excess and Deficient location-specific symptoms of Parkinson's disease.

Happily, this hypothesis also explained the *body-wide* symptoms such as dopamine-cell dormancy (see chapter five xxx), movement inhibition, and other body-wide symptoms that can be sequelae of an unhealed injury that's in a critical location. Those body-wide symptoms can still be related to channel aberrations. The next chapter will further discuss those findings.



¹ The primary exception is the medial ankle pain, varicosities, and discoloration. These medial ankle symptoms are located in an area where the Stomach channel can short circuit into the Kidney channel. This short circuit on the ankle often occurs in the vicinity of acupoints KI-2 and KI-3. In chapter 5, fig 5.1, page 62, a diagram shows how Stomach channel Qi on the foot can sometimes short circuit into the Kidney channel at KI-2.