

Abstract 15: ME86 Symptom or complaint of a body part (SCBP), analysis in 213 patients, Chiren Therapy Centre, Limerick, Ireland, (September 2017 - September 2023).

Objectives:

1. To conduct a causal stratified assessment by sex and age groups using data from 213 patients, focusing solely on information gathered during their first visit.
2. To perform a trend analysis of treatment outcomes after completing five treatments in a subset of 62 patients with SCBP.

Background:

Symptoms or complaints of a body part encompass any physical or sensory discomfort, pain, or dysfunction. Evaluation involves medical history, examination, and tests to identify causes. Financially, it incurs expenses for consultations, diagnostics, treatments, and may lead to productivity loss. Causes include injuries, nerve issues, inflammation, infections, tumours, and psychosocial factors. Effective management requires accurate diagnosis and tailored interventions. The role of psychosocial factors either trauma stress exposure in contributing to Symptom or complaint of a body part remains uncertain. Addressing the complexity of SCBP is requiring the establishment of a standardized methodology for assessment. To meet this need, we introduced two novel indicators: the 'Patient Energy Scale' (PE) and the 'Stress Anxiety Spectrum' (SAS). While the PE was designed to quantify common complaints such as lack of energy, tiredness, or fatigue among patients, the SAS aims to measure the spectrum of symptoms commonly associated with stress and anxiety. Through the observation of the graphic evolution of hundreds of patients in our Trauma Stress Relief (TSR) software, we noticed a trend crossover between the declining SAS line and the increasing PE line after one or more treatments. This crossover, termed the LINQI indicator, blends the Chinese concept of "LI" for restoration, "N" for neurophysio-pathological, and "QI" representing ancestral Chinese energy.

All patients received treatment based on the "Chiren" protocols, with the primary protocol known as the "Ramirez Key," which involves a three-point combination. This combination includes points located on each hand in an area identified by Master Tung as Chong zi 22.01, and Yintang (EX-HN 3), known for its mentally stabilizing effect in Traditional Chinese Medicine (TCM). The selection of these points was based on observed outcomes following needle insertion, where patients frequently reported sensations of clarity, relaxation, and reduced pain levels, sometimes experiencing immediate relief. An immediate treatment response register was created as a result. Subsequently, the Ramirez Key protocol has become the standard protocol used in 100% of patients, regardless of their chief complaint. Additional specific protocols may be incorporated based on individual chief complaints. It is essential to note that we do not offer localized treatment for specific body part pain.

Guided by the principle of the Neurophysio-pathological theory, our treatment aims to stimulate a complex parasympathetic reaction to restore the imbalance in the hypothalamic-pituitary-adrenal axis expressed by the SAS.

Furthermore, this novel acupuncture model diverges from the Traditional Chinese Medicine concept of energy or Qi regulation, focusing instead on harnessing the neurophysiological power to induce relaxation and pain relief.

This study aims to comprehensively explore SCBP assessment, treatment, and outcomes, employing various methods. This includes conducting a causal stratified assessment by sex and age groups using data from 213 patients, followed by a trend analysis after completing five treatments with a subset of 62 patients. The goal is to provide insights into SCBP management and its demographic variations.

Methods:

Data for this study were collected from the Chiren Therapy Centre in Limerick, Ireland, spanning from September 2019 to September 2023. Two distinct population groups were selected. The first group comprised 213 patients suffering from SCBP at their first visit; their chief complaints were recorded and classified based on the International Classification of Diseases version 11 (ICD-11). Exposure to trauma stress was determined by asking each patient if they recalled any physical or emotional trauma or stressful situations preceding or during symptom onset. Stress-Anxiety Spectrum (SAS) scores, derived from a list of 41 symptoms rated on a scale of 0 to 10, categorized patients as experiencing functional stress (≤ 40) or dysfunctional stress (> 40). Stratified analyses were conducted by gender and age groups. The second population group consisted of 62 SCBP patients who completed six visits, with the first visit serving as the baseline assessment and subsequent visits occurring after each of five treatments. Patients recalling any physical or emotional trauma were categorized into four recall groups (No recall, ≤ 10 years, > 10 to 20 years, > 20 years). Pain intensity was assessed using the Visual Analogue Scale (VAS), adjusted for graphical comparability. Symptom intensity was compared between baseline and the sixth visit assessment. Patients also self-reported their experiences using the Patient Perceived Energy Scale (PE), ranging from 0 to 100. Additionally, patients completed the Hospital Anxiety and Depression Scale (HADS), adjusted to a scale of 0 to 100. Trends analysis of SAS, PE and VAS by gender, age group, re call groups, trauma, criterion A, and ongoing trauma stress. The LINQI indicator was observed at each stratification. Data analysis was performed using Oracle Analytics, Excel, and statistical tests, including the Kruskal–Wallis test in SPSS version 28, with writing support from ChatGPT.

Findings:

The distribution of SCBP is notable, with a predominant presence of patients reporting symptoms in the neck (45), shoulder (40), chronic back pain (26), and knee (21), among others, as shown in Table 1. Significant associations were identified between exposure to traumatic stress events and SAS score (Chi-square = 32.532, $p < 0.0000$), age group (Chi-square = 38.419, $p = 0.0000$), and gender (Chi-square = 38.023, $p = 0.0000$), with detailed data summarized in Table 2. After five treatments, significant variations were observed across all recall trauma groups, with an average reduction of 62% in SAS, 57% in VAS, and a 27% increase in PE (p -value 0.0000). Specifically, the group with recall periods of 10 to 20 years exhibited a 70% reduction in SAS, while those with recall periods exceeding 20 years showed a 71% reduction in VAS. Conversely, the latter group exhibited a 40% increase in PE, as depicted in Table 3. The intensity of symptoms chart highlighted stress, racing thoughts, poor concentration, and decreased libido as the most severe symptoms, all rated at an intensity level of 10 (Figure 2). In the trend analysis (Figure 1, Graph 1), notable reductions in SAS and VAS trends were observed alongside an increase in PE. The LINQI indicator was observed only after the first treatment in the recall group > 20 , in the age group ≤ 40 , for those with ongoing "yes" trauma, and for Criterion A "yes." SAS indicators were consistently reported below 75 across all stratifications.

Interpretation:

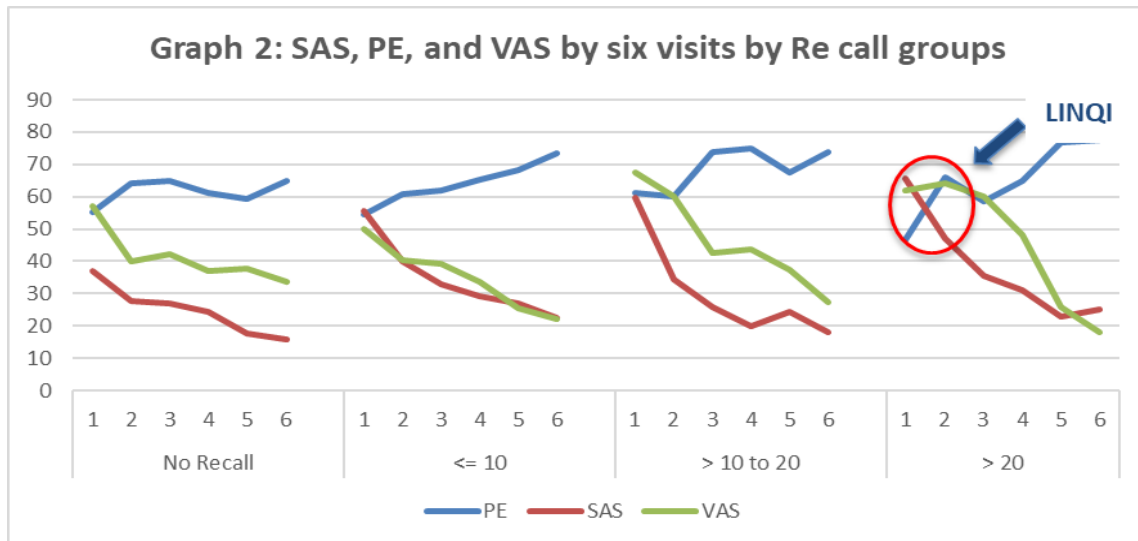
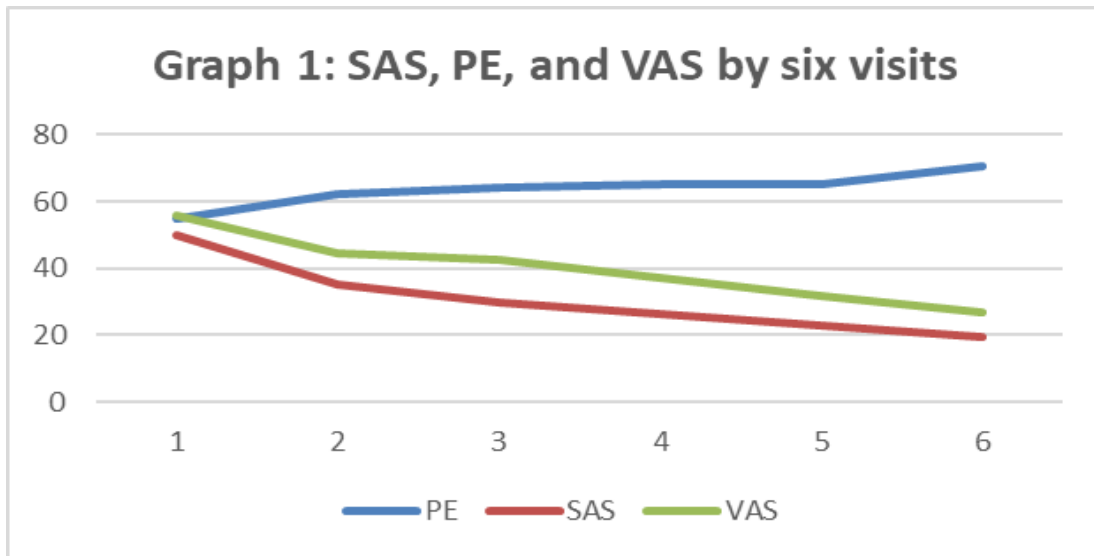
Based on these findings, our study introduces innovative metrics, SAS, and PE, which offer profound insights into the nuanced landscape of SCBP symptoms exacerbated by trauma. The robust causal association observed between exposure to traumatic stress events and SAS score, age group, and gender underscore the intricate interplay of trauma across diverse demographic strata within SCBP patients. Notably, after five treatments, there was a marked reduction in SAS and VAS scores, coupled with a notable increase in PE, indicating favourable treatment outcomes. The early emergence of the LINQI indicator after just one treatment could suggest that the hypothalamic-pituitary-adrenal (HPA) axis imbalance may not be firmly established, presenting a window for early intervention to prevent long-standing imbalances. This underscores the potential effectiveness of the treatment approach in addressing both recent and longstanding trauma-related symptoms associated with SCBP. Additionally, the intensity of symptoms chart highlights common complaints such as stress, and racing thoughts, and poor concentration further emphasizing the multifaceted nature of SCBP symptoms. These findings offer valuable insights into the understanding of nociplastic pain, shedding light on the complex interplay between psychosocial stressors and neurophysiological mechanisms underlying SCBP. Moreover, by elucidating the response patterns to treatment, this study contributes to the burden of SCBP, both in terms of healthcare costs and individual well-being. Further research is warranted to delve deeper into the mechanisms behind these findings and to refine treatment strategies for individuals affected by SCBP. In conclusion, while our study offers promising evidence of the therapy's efficacy in alleviating trauma-related symptoms in SCBP patients, addressing limitations through biomarker analysis, longitudinal assessments, and comparative effectiveness research is paramount. By surmounting these challenges and embarking on further studies, we can deepen our understanding of the therapy's mechanisms, refine treatment protocols, and ultimately augment outcomes for individuals grappling with SCBP exacerbated by trauma stress.

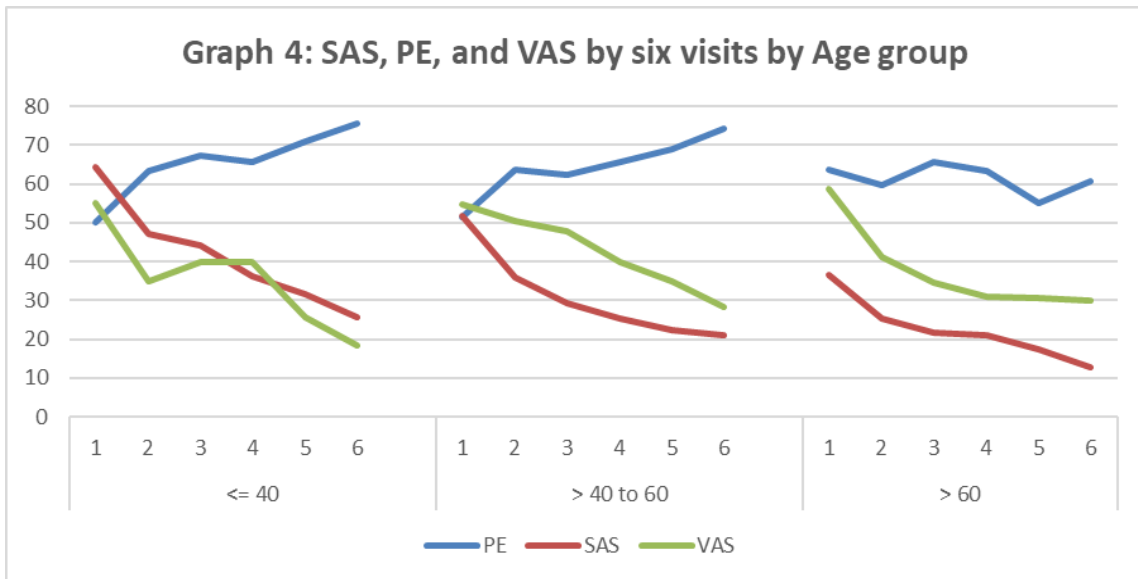
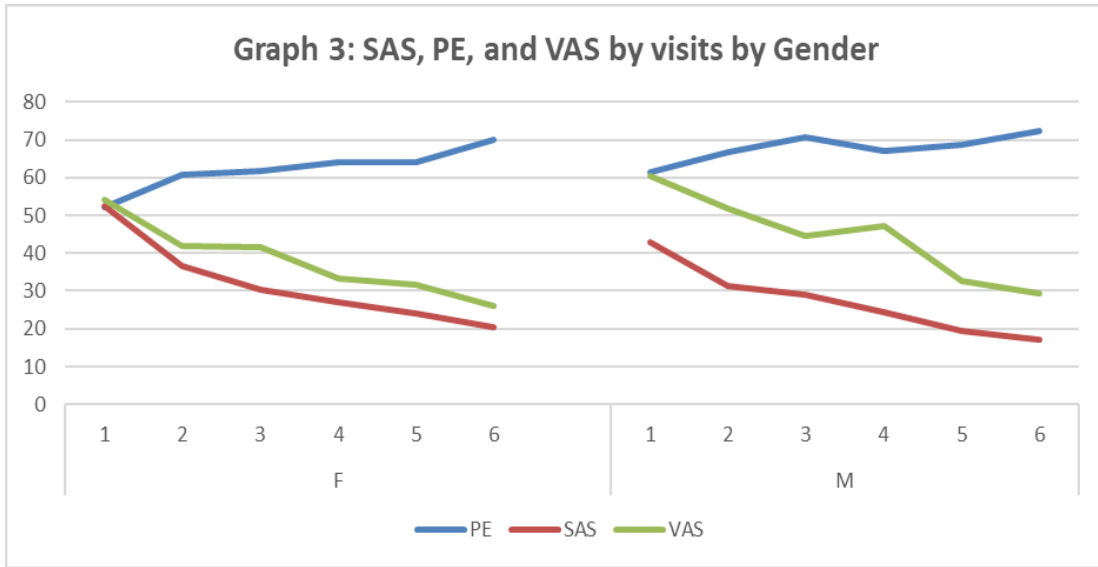
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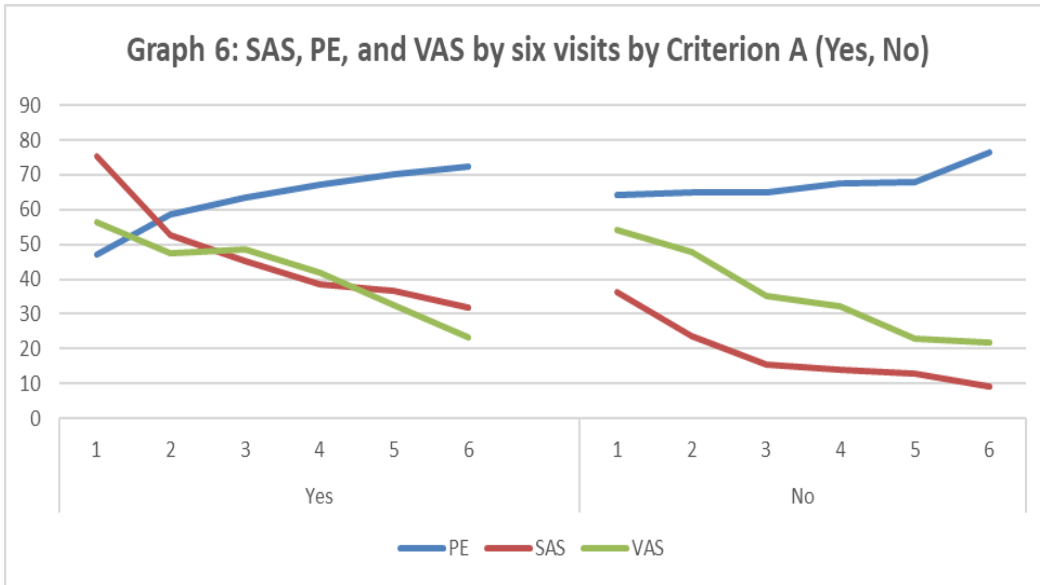
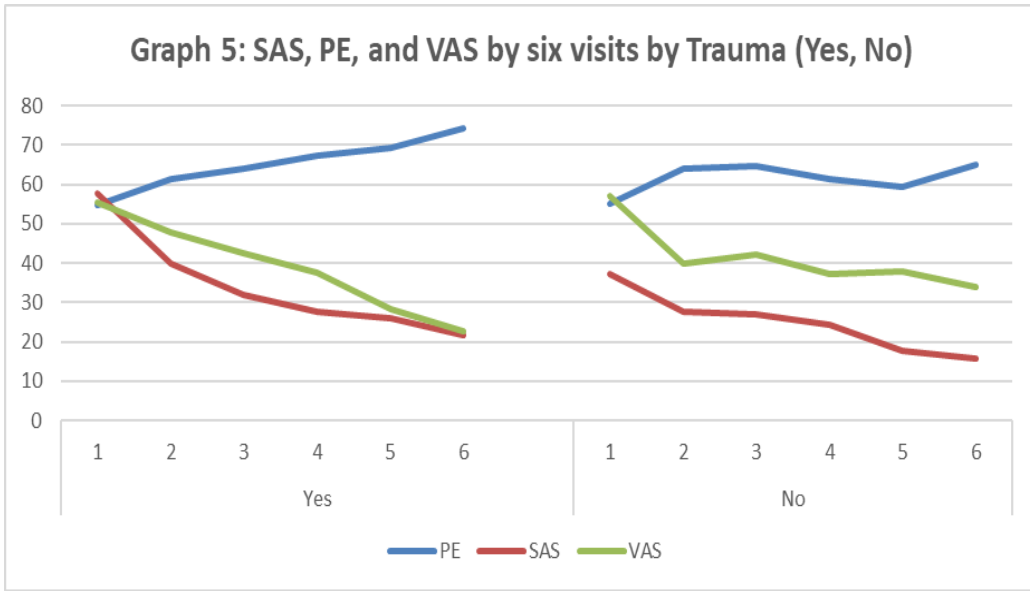
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Figure 1: Treatment impact measured by Stress anxiety spectrum (SAS), Visual analogue scale (VAS) and perceived energy (PE) by six visits by different stratifications in 62 patients suffering symptom or complaint of a body part, Chiren Therapy Centre, Limerick, Ireland, September 2019 – September 2023.







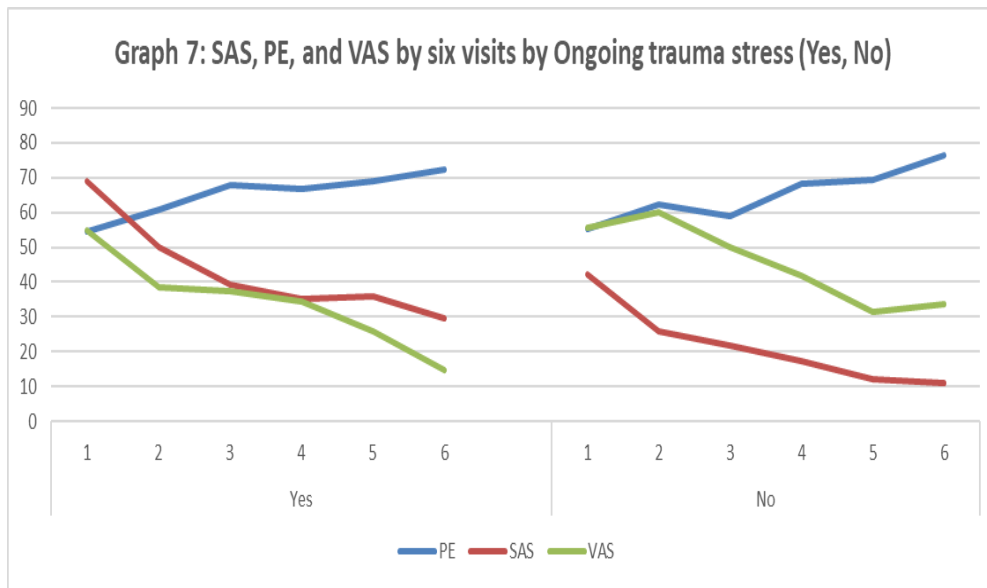


Figure 2: Comparison of Intensity of top 15 Stress Anxiety Symptoms at Visits 1 and 6: Analysis of 62 ME86-Symptom or complaint of a body part Patients at Chiren Therapy Centre, Limerick, Ireland (September 2019 – September 2023).

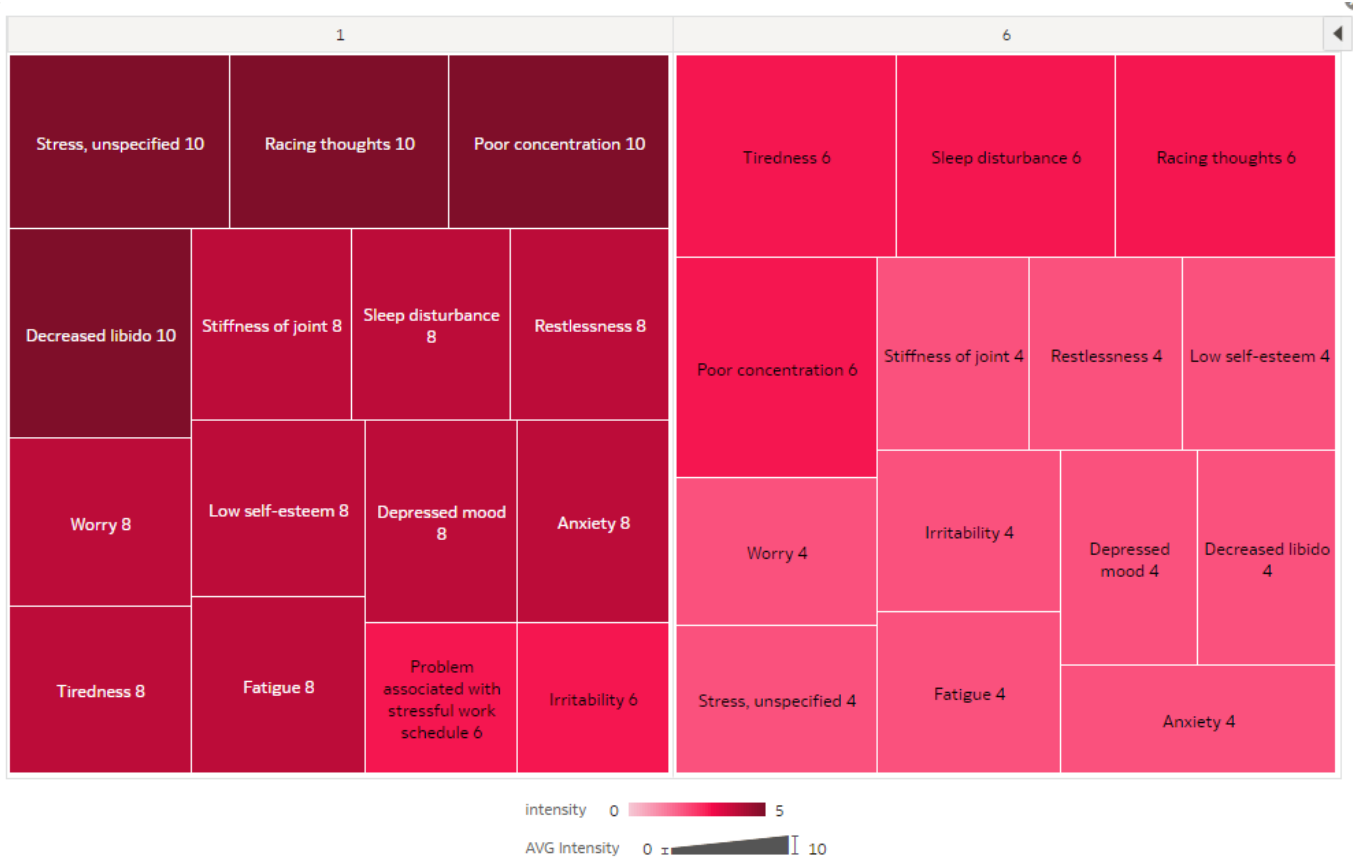


Table 1: Distribution of 213 ME86-Symptom or complaint of a body part patients by International Classification of Diseases version 11. Chiren Therapy Centre, Limerick, Ireland, September 2019 – September 2023.

ME86-Symptom or complaint of a body part patients	Patients
Symptom or complaint of the neck	45
Symptom or complaint of the shoulder, unspecified	40
Chronic back pain, not otherwise specified	26
Symptom or complaint of the knee	21
Symptom or complaint of the hip	20
Symptom or complaint of the low back	18
Symptom or complaint of the leg or thigh	8
Symptom or complaint of the hand or finger	7
Symptom or complaint of the back	6
Back syndrome with radiating pain	5
Symptom or complaint of the ankle	4
Symptom or complaint of the chest	3
Symptom or complaint of the elbow	3
Symptom or complaint of the foot or toe	2
Symptom or complaint of the wrist	2
Other specified symptom or complaint of the shoulder	1
Shoulder syndrome	1
Symptom or complaint of the shoulder	1

Table 2: Causal link between traumatic events and stress anxiety spectrum symptoms in 213 patients suffering Symptom or complaint of a body part, stratified by Age group and gender. Chiren Therapy Centre, Limerick, Ireland, September (2019 to September 2023).

		SAS		Chi-Square	P-value
		> 40	<= 40		
	Trauma exposure				
	Yes	79	28		
	No	37	69		
	Grand Total	116	97	32.532	0.0000
The p-value is 0.0001. significant at p < 0.05.					
Age group	Trauma exposure	> 40	<= 40	Chi-Square	P-value
<= 40	Yes	20	3	17.045	0.0000
	No	9	21		
> 40 to 60	Yes	42	14	8.871	0.0029
	No	17	21		
> 60	Yes	17	11	6.661	0.0099
	No	11	27		
	Grand Total	116	97	38.419	0.0000
The p-value is 0.0000. significant at p < 0.05.					
Gender	Trauma exposure	> 40	<= 40	Chi-Square	P-value
F	Yes	56	13	33.754	0.0000
	No	17	40		
M	Yes	23	15	3.326	0.0682
	No	20	29		
	Grand Total	116	97	38.023	0.0000
The p-value is 0.0000. significant at p < 0.05.					

Table 3. Percentage of variation by indicator, stratified by Trauma Re call groups, after five treatments in 62 patients suffering Symptom or complaint of a body part. Chiren Therapy Centre, Limerick, Ireland, September (2019 to September 2023).

	PE increases	%	SAS % Reduction	VAS % Reduction	HADS Anxiety Reduction	% Depression Reduction	%
No recall	15	58	41	24	29		
<= 10	35	60	56	31	41		
> 10 to 20	17	70	59	34	46		
> 20	40	62	71	35	49		
Overall	27	62	57	31	41		