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Consensus on Diagnosis and Treatment of Ulcerative Colitis with Integrated Traditional Chinese and Western Medicine

Specialized Committee on Digestive System Disease of Chinese Association of Integrative Medicine

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Diagnosis and Treatment Plan (draft) of Ulcerative Colitis (UC) with integrated traditional Chinese and western medicine has been implemented for 6 years [1], in recent years, the diagnosis and treatment of this disease at home and abroad have made great progress [2~8]. In the past two years, after repeated discussions by dozens of experts from this professional committee, a consensus was reached at the Suzhou meeting in August 2010. The consensus opinions on the diagnosis and treatment of this disease with integrated traditional Chinese and western medicine are now published as follows.

1 Concept

UC is an unexplained chronic inflammation and ulcerative lesion of the large intestinal mucosa, clinically characterized by diarrhea, bloody mucopurulent stools, abdominal pain, and tenesmus. UC belongs to the categories of "diarrhea", "dysentery" and "intestinal dysentery or afflux" in traditional Chinese medicine. In addition, the chronic relapse type belongs to the category of "resting dysentery"in traditional Chinese medicine, and the chronic persistent type belongs to the category of "chronic dysentery"in traditional Chinese medicine.

2 Type

2.1 Classification in Western medicine [2, 9]

① Initial onset type: initial onset without previous history. ②Chronic recurrence type: the most common type in the clinic. The symptoms are mild, and there are often remission periods of varying length after treatment, which alternate with the onset period that generally lasts 3 to 4 weeks. ③ Chronic persistent type: the intestinal symptoms last for several months or years after the initial onset, and maybe accompanied by parenteral symptoms, during which acute onsets may occur. Compared to the chronic relapse type, colon with this type is broader involved, and the lesions tend to be progressive. ④ Fulminant type: the symptoms are severe, with more than 10 times of bloody stools per day and symptoms of systemic poisoning, maybe accompanied by complications such as toxic megacolon, intestinal perforation, sepsis. Except for the fulminant type, the above types can mutually transform.

2.2 Traditional Chinese Medicine Syndromes [1, 10~12]

2.2.1 Large Intestinal Damp Heat Syndrome

Main Symptoms: ① Diarrhea, bloody mucopurulent stools; ② Abdominal pain or tenesmus; ③ Anal burning pain; ④ yellow thick or greasy coating on the tongue. Secondary Symptoms: ① body heat;② dry mouth and bitter mouth; ③ little dark red urine; ④ slippery pulse or soft pulse. Syndrome Type Determination: 2 Main Symptoms (① is mandatory) add 2 Secondary Symptoms, or Main Symptom ① add 3 Secondary Symptoms.

2.2.2 Spleen Qi Weakness Syndrome

Main Symptoms: ① Diarrhea, loose stools, with mucus or a small amount of purulent blood; ②Less appetite and food; ③ Fatigue; ④ Pale tongue or with tooth marks, thin and white coating. Secondary Symptoms: ① abdominal bloating and borborygmus; ② abdominal pain, relieved by pressing ③ sallow complexion; ④ weak or creeping pulse. Syndrome Type Determination: 2 Main Symptoms (① is mandatory) add 2 Secondary Symptoms, or Main Symptom ① add 3 Secondary Symptoms.

2.2.3 Spleen and Kidney Yang Deficiency Syndrome

Main Symptoms: ① Prolonged dysentery; ② abdominal cold and pain, relieved by warmth and pressing; ③Limp waist and knees, cold limbs; ④ Pale and fat tongue, with white coating or tooth marks. Secondary Symptoms: ① Abdominal bloating and borborygmus; ② White complexion; ③ Lack of qi,laziness to speak; ④ Heavy and thin pulse or weak pulse. Syndrome Type Determination: 2 Main Symptoms (① is mandatory) add 2 Secondary Symptoms, or Main Symptom ① add 3 Secondary Symptoms.

2.2.4 Liver Depression and Spleen Deficiency Syndrome

Main Symptoms: ①Dysentery often occurs due to emotional tension; ② abdominal pain with the desire to defecate, relieved after defecation; ③Fullness and discomfort in chest and hypochondrium; ④ wiry pulse or small wiry pulse. Secondary Symptoms: ① Susceptible sigh; ②Belching; ③ Poor appetite and abdominal bloating; ④ Frequent flatus; ⑤ Pale red tongue with thin white coating. Syndrome Type Determination: 2 Main Symptoms (① is mandatory) add 2 Secondary Symptoms, or Main Symptom ① add 3 Secondary Symptoms.

2.2.5 Mixed Cold and Heat Syndrome

Main Symptoms: ① Bloody mucous stools; ② Lingering abdominal pain, relieved by warmth and pressing; ③ Fatigue,timidity and chilly; ④ Red or pale red tongue, with thin yellow coating. Secondary Symptoms: ① Uncomfortable stools; ② Thirsty but don't like drinking or like hot drinks; ③ Pale yellow urine; ④ Slow or soft pulse. Syndrome Type Determination: Main Symptoms ① and ② are mandatory, add 1 Main Symptom or 1 to 2 Secondary Symptoms.

2.2.6 Blazing Heat Toxin Syndrome

Main Symptoms: ① Sudden onset, mass bloody mucous or bloody stools; ②Abdominal pain, aggravate by pressing; ③Fever; ④Red and crimson tongue with yellow and greasy coating. Secondary Symptoms: ① Thirsty; ②Abdominal bloating; ③Deep-colored urine,③yellow and red urine;; ④Slippery pulse. Syndrome Type Determination: Main Symptoms ① and ② are mandatory, add 1 Main Symptom or 1 to 2 Secondary Symptoms.

Syndrome Differentiation Explanation:: In addition to the above 6 syndrome types, there can also be concurrent symptoms such as blood stasis, yin deficiency, etc

3 Diagnostic criteria in Western medicine

3.1 Diagnostic criteria [2, 8, 9]

3.1.1 Clinical manifestations

Persistent or recurrent diarrhea, bloody mucopurulent stools, with abdominal pain, tenesmus, and various degrees of systemic symptoms. The course is more than 4-6 weeks, and there may be parenteral manifestations of joints, skin, eyes, mouth and liver and gall, etc.

3.1.2 Colonoscopy

Lesions mostly start from the rectum and show a continuous, diffuse distribution. Mucosal blood vessel texture is blurry, disordered, and congested, with edema, embrittlement, bleeding, and purulent secretion attached. It is also common to see rough mucous membranes, which are fine particles. Diffuse, multiple erosions or ulcers can be seen in the obvious lesions. It can be seen in patients in the remission phase that the colonic sac becomes shallow, dull or disappears, and there are false polyps and bridge-shaped mucosa, etc.

3.1.3 Barium enema examination

① rough mucous and/or particle-like changes.

② the edge of the intestine is jagged or burr-like, and there are multiple small filling defects and/or micro-niche on the intestinal wall.

③ shortened intestinal tube, the pouch disappears and is lead tube-like, or the lumen is narrow.

3.1.4 Mucosal pathology examinations

Different manifestations in the active phase and the remission phase. The active phase: ① diffuse, chronic inflammatory cells, neutrophils, and eosinophil infiltration in the intrinsic membrane. ② acute inflammatory cell infiltration in crypts, especially neutrophil infiltration and cryptitis between epithelial cells, and even crypt abscesses are formed, which can ulcerate into the intrinsic membrane. ③ crypt epithelial hyperplasia, decreased goblet cells. ④ mucosal surface erosion, ulcer formation and granulation tissue hyperplasia can be observed. The remission phase: ① the neutrophils disappear and the chronic inflammatory cells decrease. ② irregular crypt size and shape, disordered arrangement. ③ widened gap between the glandular epithelium and the muscular layer of the mucosa, atrophy of the inherent gland may be seen. ④ metaplasia of Pan's cell.

3.1.5 Pathological examination of surgically specimens

The above characteristics of UC can be seen visually and histologically.

On the basis of excluding bacterial dysentery, amoebic dysentery, chronic schistosomiasis, intestinal tuberculosis and other infectious colitis, and Crohn's disease, ischemic colitis, radiation colitis, etc., UC can be diagnosed according to the following criteria: ① patients with the above-mentioned typical clinical manifestations are clinical suspects, and further examinations are arranged. ② patients with any of the above items of 3.1.1 and 3.1.2 or 3.1.3 can be diagnosed with possible UC. ③ if the characteristic manifestations of the pathological examinations in 3.1.4 or 3.1.5 are added, the diagnosis can be confirmed. ④Initial cases, those with atypical clinical manifestations and colonoscopy changes, are not diagnosed with UC for the time being, and need to be followed up for 3-6 months to observe the onset. ⑤mild chronic rectitis and sigmoiditis discovered by colonoscopy cannot be equaled to UC. Changes of the condition should be observed to carefully look for the cause.

3.2 Diagnosis instruction [1, 2, 13~15]

A complete diagnosis should consist of clinical type of the disease, severity, stage of disease, extent of disease, and complications.

3.2.1 Clinical types

are classified into the initial type, chronic relapse type, chronic persistent type and fulminant type. The initial onset type refers to initial onset without previous history; the fulminant type refers to severe symptoms, bloody stools more than 10 times a day, with systemic poisoning symptoms, maybe accompanied by complications such as toxic megacolon, bowel perforation, sepsis, etc. Except for the fulminant type, the types can mutually transform.

3.2.2 Severity

is classified into mild, moderate and severe. Mild: patients with diarrhea less than 4 times a day, with light bloody stools or no bloody stools, no fever, rapid pulse or anemia, normal erythrocyte sedimentation rate (ESR); moderate: between mild and severe; severe: diarrhea more than 6 times a day, with obvious bloody mucopurulent stools, body temperature>37.5 ℃, pulse>90 times/min, hemoglobin (Hb)<100g/L, ESR>30mm/h。

3.2.3 Stage of disease

is classified into the active phase and remission phase. See the notes in Table 1 for the staging criteria. Intractable (refractory) UC refers to failure to induce or maintain remission therapy, usually cases with glucocorticoid resistance or dependence. The former means that the condition is not relieved after 4 weeks of full administration of prednisone, while the latter refers to patients whose onset cannot be controlled if prednisone is reduced to 10 mg/d, or those relapse within 3 months after withdrawal.

3.2.4 Extend of disease

is classified into rectum, straight sigmoid colon, left semicolon (below the splenic curvature of the colon), extensive colon (the lesion extends above the splenic curvature), or the whole colon.

3.2.5 Extraintestinal manifestations and complications

Extraintestinal lesions may involve systems such as joints, skin, eyes, liver and gall; complications may include major bleeding, perforation, toxic megacolon, and cancerization, etc.

3.2.6 Main Symptoms and intestinal mucosa lesion activity index

UC Main Symptoms and intestinal mucosal lesion activity index are shown in Table 1.

Table 1 UC Main Symptoms and intestinal mucosal lesion activity index score (Sutherland disease activity index)

Item	Score			
	0 point	1 point	2 point	3 point
Diarrhea	no	1~2 times/d	3~4 times/d	5 times/d
Bloody stools	no	a little	obvious	Blood-based
Mucosa manifestation	normal	Mildly brittle	Moderately brittle	Severely brittle with exudation
Condition Assessment by physician	normal	Mild	Moderate	Severe

Total score < 2 points for symptom relief; 3 to 5 points for mild activity; 6 to 10 points for moderate activity;

11 to 12 points for severe activity

4 Efficacy evaluation criteria

Complete remission: the clinical symptoms disappear, mucosal lesions basically disappear or the total score of the Main Symptoms and intestinal mucosal lesion activity index decreases by ≥95% according to colonoscopy review. Significant effect: the primary clinical symptoms were significantly alleviated, mucosal lesions were significantly reduced or the total score of the Main Symptoms and intestinal mucosal lesion activity index reduces by ≥70% according to colonoscopy review. With effect: the primary clinical symptoms are somehow relieved, mucosal lesions are somehow alleviated or the total score of the Main Symptoms and intestinal mucosal lesion activity index reduces by ≥30% according to colonoscopy review. No effect: After treatment, the clinical symptoms, endoscopic and pathological examination results did not improve or worsen, or the total score of the Main Symptoms and intestinal mucosal lesion activity index decreases by <30%. Efficacy evaluation criterion is based on the calculated formula according to the nimodipine method: efficacy index = [(pre-treatment lesion activity index score - post-treatment lesion activity index score) ÷ pre-treatment lesion activity index score] × 100 %.

5 Treatment

5.1 Treatment principles

It needs to be formulated according to the different grading, staging, and segmentations. Grading refers to the use of different drugs and different treatments according to the severity of the disease; staging refers to the disease being classified into the active phase and the remission phase. The primary goal of the active phase is to control inflammation and relieve symptoms, and the remission phase should aim at continuing to maintain remission and preventing relapse; Segmental treatment refers to determining the extent of the disease to select different methods of administration. Local treatment can be used for distant colitis. Systemic treatment is the primary method for patients with extensive colitis or extra-intestinal symptoms. Its clinical treatment methods include etiological treatment and symptomatic treatment, holistic treatment and intestinal partial treatment, integrated Western medicine treatment and traditional Chinese medicine treatment.

5.2 Essentials of integrated traditional Chinese and Western medicine treatment

① Patients with mild to moderate UC can be treated with traditional Chinese medicine syndrome differentiation or Chinese herbal preparations, or oral administration of sulfasalazine (SASP) or 5-aminosalicylic acid (5-ASA) preparations. Combined administration of traditional Chinese and Western drugs can be given if there is an absence of effect. Distal colitis can be treated with local rectal administration. When the above treatment is not effective, oral prednisone can be used.

② Refractory UC (hormone dependence or hormone resistance) should be treated with integrated traditional Chinese and Western medicine internal medicine comprehensive scheme in an early phase. If necessary, immunosuppressive agents such as purine drugs, methotrexate, or Infliximab intravenous drip can be chosen.

③ Severe UC is recommended to be treated with integrated Chinese and Western medicine. Patients who do not respond to oral prednisone, aminosalicylic acid drugs or local treatment,

or who develop systemic poisoning symptoms such as high fever and thready and weak pulse, should be treated with glucocorticoids intravenous drip 7~10d. If there is no effect, intravenous drip of cyclosporine or infliximab should be considered, and if necessary, it should be switched to surgical treatment.

④ Maintenance treatment: When the acute onset is controlled, it is advised to use traditional Chinese medicine for maintenance treatment, and it can also be combined with a small dose of aminosalicylic acid preparations.

5.3 Western medicine treatment [2~6, 16~20]

5.3.1 Treatment in the active phase

Treatment of mild UC: SASP can be administered orally 0.75~1 g/time, 3-4 times/day (folic acid should be supplied simultaneously); or 5-ASA preparation with equivalent dose can be used. For patients with lesions distributed in the distal colon, SASP or 5-ASA suppositories 0.5~1 g/time, 2 times/d can be administered; it is also possible to administer 5-ASA enema 1~2 g, or hydrocortisone succinate sodium enema solution 100~200 mg, retention enema, 1 time/night. Use budesonide 2 mg if necessary, retention enema, 1 time/night.

Treatment of moderate UC: patients can be treated with the above dose of salicylic acid preparations, and for those with poor response, the dose can be appropriately increased, or change to oral glucocorticoids. Prednisone 30 to 40 mg/d is commonly used, orally administered by several times.

Treatment of Severe UC: Severe UC generally has a wide range of lesions, and the disease develops rapidly. The treatment should be given in time after diagnosis. The dosage should be sufficient, and the treatment method is as follows: ① If the patient has not used oral glucocorticoids, oral administration of prednisolone 40~60 mg/d can be given, and observe for 7~10 d. Prednisolone can also be directly administered intravenously. For those who have already used glucocorticoids, intravenous hydrocortisone 300 mg/d or methylprednisolone 48mg/d should be administered. ② Parenteral administration of broad-spectrum antibiotics such as nitroimidazole and quinolone preparations, ampicillin or cephalosporin antibiotics to control secondary intestinal infections. ③ The patient should be placed in bed, with proper infusion to supply electrolytes, to prevent disturbed water and salt balance. ④ For patients with large blood volume in stools, with Hb below 90g/L, and with continuous bleeding, blood transfusion should be considered. ⑤ For patients with severe disease and malnutrition, elemental diet can be given, and parenteral nutrition should be given to those with very severe disease. ⑥ For patients who do not respond after 7-10 days of intravenous glucocorticoid, cyclosporine intravenous drip of 2~4 mg/(kg · d) for 7-10 days can be considered. Due to the immunosuppressive effect of the drug, renal toxicity and other adverse reactions, the blood drug concentration should be strictly monitored. Therefore, from the comprehensive consideration of hospital monitoring conditions, it is recommended to use in a few medical centers. Other immunosuppressive agents such as tacrolimus (FK506) may also be considered. Refer to pharmacopoeia and textbooks for its dosage and usage. ⑦ If the above mentioned drugs are not effective, promptly consultation of the internal and surgical departments should be done to determine the timing and method of surgical excision of the colon. ⑧ Use spasmolytic and antidiarrheal agents with caution to avoid toxic megacolon. ⑨ Closely monitor the patient's

vital signs and abdominal signs, and detect and treat complications early.

Other treatments [19, 21~23]: ① Leukocyte elution therapy: suitable for patients with severe UC. It can be performed in capable institutions. ② Probiotics treatment: suitable for UC patients with dysbacteriosis, and it can also be used for adjuvant treatment of UC in the active phase. ③Treatment with new biological agents: such as anti-tumor necrosis factor-α monoclonal antibody, which is suitable for the treatment of Intractable (refractory) UC. Agents that are currently used in China such as intravenous drip of infliximab 5mg/kg at 0, 2, 6 week induce remission, and maintenance treatment every 8 weeks thereafter can improve the surgical rate of patients with moderate to severe UC and reduce the dose of glucocorticoids. Before the administration, the condition should be strictly evaluated to exclude potential active tuberculosis and various infections. The patient should be closely observed during the administration, and various adverse reactions should be paid attention to.

5.3.2 Treatment in the remission phase

After the symptoms are relieved, SASP or 5-ASA drugs should be continued for maintenance treatment for at least 1 year or long-term. The maintenance treatment dose of SASP is generally 2~3g/d orally, and an equivalent dose of 5-ASA drugs can also be administered. Glucocorticoids should not be used for maintenance treatment. 6-thiopurine or azathioprine is used for patients who failed the maintenance treatment with the above drugs or are dependent on glucocorticoids.

5.3.3 Surgical treatment

Absolute indications: major bleeding, perforation, those with clear or highly suspected cancerization, and those with severe dysplasia found by histological examination. Relative indications: severe UC with toxic megacolon, ineffective intravenous administration; stubborn symptoms after internal treatment, physical decline, with glucocorticoids resistance or dependence, ineffective replacement therapy; UC complicated with extra-intestinal complications such as pyoderma gangrenosum and hemolytic anemia, etc.

5.3.4 Monitoring of cancerization

Patients with generalized colitis and total colitisof more than 8 to 10 years, those with left hemicolitis and straight sigmoiditis with more than 30 to 40 years, and UC patients with primary sclerosing cholangitis should be monitored with colon microscopic examination, at least once every 2 years with multiple biopsies. Those with dysplasia found by histological examination should be closely followed up. If severe dysplasia is observed and confirmed, surgery should be performed immediately.

5.4 Traditional Chinese Medicine Treatment [1, 10, 11, 20, 24, 25]

5.4.1 Syndrome Differentiation and Treatment

(1) Large Intestinal Damp Heat Syndrome

TreatmentMethod: Clearing away heat and drying dampness, regulating qi and promoting blood circulation

Recipe: Peony Decoction (peony, radix scutellariae, coptis chinensis, rhubarb, betel nut, angelica, costustoot, cinnamon, licorice) modification.

Modification: if the stools have much purulent blood, add pulsatilla, callicarpa bodinieri and burnet to remove pattogenic heat from the blood and stop the dysentery;

If the stools are white with much mucus, add rhizoma atractylodis and coix seed to tonify the spleen and eliminate dampness; for patients with severe abdominal pain, add rhizoma corydalis, lindera aggregata, aurantii immaturus fructus to regulate qi and relieve pain; for patients with much body heat, add pueraria lobata, honeysuckle, forsythia to detoxify and abate fever.

Chinese Patent Medicine: ① Xianglian Pills 3~6 g/time, 2~3 times/d; ② Xianglian Antidiarrheal Tablets 4 tablets/time, 3 times/d..

(2) Spleen Qi Weakness Syndrome

Therapy: Tonify the spleen and nourish qi, eliminate dampness and stop diarrhea.

Recipe: Shenling Baizhu Powder (Ginseng, poria, atractylodes, platycodo, Chinese yam, white hyacinth bean, amomum, coix seed, lotus seed meat, licorice) modification.

Modification: For those patients with bloody purulent stools, add patriniae, coptis chinensis, costus root; for those with stools with indigestible food, add medicated leaven and fructus aurantii immaturus to help digest and remove stagnation; for those with abdominal pain and fear cold and like warmth, add baked ginger, and add aconite for those with particular cold to warm and tonify the spleen and kidneys; for those with chronic diarrhea and qi depression, add astragalus, rhizoma, radix to enhance yang and improve the depression.

Chinese Patent Medicine: ①Bupi Yichang Pills 6 g/time, 3 times/d; ②Shenling Baizhu Granules 3-6 g/time, 3 times/d.

(3) Spleen and Kidney Yang Deficiency Syndrome

Treatment Method: Warm yang and remove cold, tonify the spleen and kidneys.

Recipe: Fuzi Lizhong Decoction (Aconite, ginseng, dried ginger, atractylodes, licorice) modification.

Modification: For patients with obvious yang deficiency, add psoralen and nutmeg to warm and tonify the spleen and kidneys; for those with severe abdominal pain, add white peony to relieve pain; for those with abdominal bloating, add lindera aggregata, fennel and fructus aurantii immaturus to regulate qi and relieve fullness; for those with slippery and continuous stools, add red halloysite and terminalia to restrain the intestines and stop diarrhea.

Chinese Patent Medicine: ①Sishen Pills 9 g/time, 2 times/d; ②Guben Yichang Tablets 8 tablets/time, 3 times/d.

(4) Liver Depression and Spleen Deficiency Syndrome

Treatment: Soothing the liver and regulating qi, invigorating or tonifying the spleen and improving health.

Recipe: The main prescriptions for Tongxie Yaofang (Tangerine peel, atractylodes, peony, saposhnikovia divaricata) modification.

Modification: For those with poor bowel movements and frequent flatus, add fructus aurantii immaturus and betel nut to regulate qi; for those with faint abdominal pain, loose stools, fatigue, add codonopsis, poria, fried lentils to tonify the spleen and reduce dampness; those with chest and hypochondrium bloating and pain, add green tangerine peel, cyperus rotundus for soothing the liver and regulating qi; for those with yellow and white mucus, add coptis chinensis and radix aucklandiae to clear the intestinal and dry dampness.

Chinese Patent Medicine: Guchang Antidiarrheal Pills (Colon Pills) 4 ~ 5 g/time, 3 times/d;

(5) Mixed Cold and Heat Syndrome

Treatment: Warm yang and tonify the spleen, clear away heat and dry dampness.

Recipe: Wumei Pills (Black plum meat, coptis chinensis, cortex phellodendri, ginseng, angelica, aconite, cassia twig, capsicum annuum, dried ginger, asarum) modification.

Modification:For those with bloody purulent stools, remove Sichuan pepper, or capsicum annuum and asarum, add ash bark and raw garden burnet; for those with severe abdominal pain, add paniculate swallowwort root and rhizoma corydalis.

Chinese Patent Medicine: Wumei Pills 2 pills/time, 2~3 times/d.

(6) Blazing Heat Toxin Syndrome

Treatment: Clear heat and detoxify, cool blood and stop dysentery

Recipe: Pulsatilla Decoction (Pulsatilla, Coptis chinensis, cortex Phellodendri, ash bark) modification.

Modification: For those with fresh blood in stools and red tongue, add alkanin, raw garden burnet, radix rehmannia; for those with high fever, add buffalo horn powder, gardenia, honeysuckle; for those with cold sweating limbs and fine and weak pulse, administer intravenous drip of Shenfu Injection or Shengmai Injection.

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5.4.2 Traditional Chinese Medicine Enema Treatment

① Xilei Powder 1.5 g add 100 ml 0.9% sodium chloride, retention enema, 1 time/d. ② 50 ml of Kangfuxin Liquied Solution add 50 ml of 0.9% sodium chloride, retention enema, 1 time/d (this product can also be administered orally, 10 ml/time, 3 times/d). ③ Jiechangning Enema, dissolve 5 g ointment in 50-80 ml of warm boiled water, retention enema, 1 time/d. ④ Traditional Chinese medicine compound, retention enema, drugs for healing up sore and promoting gran (borneol, catechu, pearl powder, etc.), promoting blood circulation and removing stasis (notoginseng powder, raw cattail pollen, etc.), clearing heat, detoxifying and drying

dampness (natural indigo, sophora, cortex phellodendri, etc.) can be selected based on syndrome differentiation.

5.4.3 Suppository Treatment

For patients with ulcerative proctitis, or with rectal or sigmoid colitis where the lesion is in the lower position and with bloody purulent stools and obvious tenesmus, anal suppository can be administered for treatment. The drug selection is similar to enema medicine, such as Chinese Patent Medicine for clearing heat and detoxifying such as wild chrysanthemum suppository, usage: 1 capsule, anally administered, 1~2 times/d.

5.4.4 Acupuncture Treatment

① Acupuncture Treatment: The main acupoints are Hegu, Tianshu, Shangjuxu. For those with severe dampness and heat, add Quchi and Inner Chamber; for those with severe cold dampness, add Zhongwan and Qihai; for those with spleen and qi deficiency, add spleen shu, stomach shu and Guanyuan; for those with spleen and kidney yang deficiency, add spleen shu and kidney shu; for those with yin deficiency, add Zhaohai, Taixi; for those with blood stasis, add xuehai, diaphragm shu. reinforcing method for deficiency syndrome, reducing method for substantial syndrome, and add moxibustion for people with cold.

② Moxibustion Treatment: Select acupoints of Zhongguan, Tianshu, Guanyuan, Spleen Shu, Stomach Shu, large intestine Shu. For patients with obvious cold, add Shenque. Use moxa sticks or moxa cones for 30 min moxibustion, 1~2 times/d. Alternate moxibustion on the acupoints of the abdomen and back.

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