**Thermopunktur test**

Presently, the main problem of energy channels evaluation is the problem of metrology, connected with obtaining accurate numerical information about a particular channel activity. In this connection we have chosen the Acabane test among other different methods of channel testing, as it seems to be the most suitable for this signal system with respect to the specific character of its performance. Besides, it has a solid ideological grounding, being at the same time easy to perform and quite bearable for the patients.

The test has been known since ancient times under the name of ‘sacrificial stick test’. It was used to be performed with the help of a burning sandalwood stick, which in time with the pulse wave was brought to certain ‘input – output’ channel points until the first painful sensations appeared. Such points are conveniently located in the finger and toe nail bed corner areas (2 or 3 mm from the edge of the nail skin vallum). The testing technique was based on counting the passes of the stick, necessary to produce the first pain sensations. The number of the passes served a kind of a numerical evaluation of the channel energy.

Let’s consider the biological purpose of such points to understand the testing principle under examination. The influence of heat on usual skin areas (devoid of BAP –biologically active points, and channels) provokes recurrent pain reactions of the same type, which depend on the heat source warming-up intensity. Meanwhile, in BAP areas and, especially, in ‘input-output’ channel areas the threshold of temperature pain sensitivity depends, in the first place, on the channel’s activity.

We have discovered that ‘input-output’ points, located in the most unprotected areas of the body, serve to commute the energy and information transfer between the body’s physiological systems and the environment, in the light diapason as well. High sensitivity to light in the areas of BAP localization is confirmed by the existence of people who can read printed or written text with their fingertips. Thus, in the1970s, the newspapers were full of the articles about N.Kuligina’s phenomenon. She was claimed to possess ‘finger-sight’, the nature of which still remains a mystery. So, it is quite possible that the channels of some people can transmit information in the light diapason to the central nervous system.

If the sandalwood stick testing reveals the channel lowered energy potential, the physical coercion applied to its ‘input-output’ points will be beneficial, because this toning-up and a certain ‘energy charging’ rise the level of the channel’s activity. In this case, the threshold of pain sensitivity will be low, proportional to the degree of the channel’s hypo-functioning, and the number of testing pulses will be bigger. If the channel is hyper-functioning, any additional external coercion at the ‘input-output’ points will be undesirable for the energy system, and the pain will be felt at once. The number of testing pulses will be minimal in this case, and will keep dropping in comparison with other channels average parameters, proportionally to the degree of the channel’s hyper-function.

It was not by chance, that even in ancient times the testing pulses were synchronized with the pulse wave. The pulse component is the most important synchronizing factor for the whole body. At the same time, it’s a physiological derivative of all 12 main channels mutual cooperation, closely connected with the work of the most essential vital activity systems of the body. The pulse compound is, in a certain way, a measure of the body’s physical and energy activity. The higher is the metabolism intensity, the higher is the number of the heart beats and the biological time speed.

When the body is at rest with a slow heart rhythm the intervals between the transmitted pulses are bigger and the pulses themselves are longer. When the heart rhythm is fast, all physiological and channel energy systems are in the state of excitation and the biological time accelerates, the intervals between the testing pulses become shorter and so do the pulses themselves. We have discovered that in both cases equal amounts of energy pass through the tested point. The difference lies in the length of the testing coercion. In the case of tachycardia, when the biological time of the body quickens, the total test time shortens, and in the case of brachycardia, when the metabolism, the energy and the time processes slow down, testing takes more time. Thus, the parameters of the described method testing factor combine with the body’s activity, which makes the error minimal. This is the difference between this discontinuous testing method and the one, based on continuous heat coercion.

At the same time, making testing passes at the pulse wave height, we, kind of, ‘conceal’ a certain coercion on the channel for the pulse component, because this coercion cannot be avoided during the test, based on the heat radiation influence on BAP, mainly in the infrared diapason.

We have discovered that the coercion performed in the course of the testing process in time with the pulse wave at the same time has synchronizing influence on all the 24 energy channel branches and, consequently, on all the 5 primary elements. In this sense, the testing itself does the body good, as we had a lot of chances to see for ourselves. In a way, the body gets a sort of energy subsidy, necessary for a certain channel and the corresponding physiological system. For thousands of years in pre-historic and ancient times man used to get such energy charge warming himself by the open fire or walking outside, practically naked, in hot sunny weather. Modern civilization has deprived us of such direct contacts with natural energy factors.

Developing the methods of biological rhythm estimation, I had to perform tests on myself practically daily for many years. I didn’t notice any harmful side-effects. On the contrary, I found out that the testing itself was accompanied by a certain body stimulation due to it being additionally charged with energy in the process. I also observed a certain energy balance harmonization, as in the process of testing every channel gets additional energy, according to its demand.

In 1952, Koben Akabane, a physician from Japan, improved the ancient test having suggested using a metal spiral continuously heated by electricity until the pain sensations were registered, instead of a sandalwood stick. The state of the channel in that case could be evaluated by the time, necessary for the spiral to get hot enough to cause pain sensations. It was measured in seconds. After Acabane published his suggestion, the long-forgotten old testing method got its widely-known name. But Acabane’s test spiral coercion was applied permanently, not in time with the pulse wave. This fact, in our opinion, lowers its metrological characteristics as compared to the initial old discontinuous variant.

We have tried to modify the test by combining the assets of both variants. For this purpose we used a point infrared light diode instead of a sandalwood stick. The diode is fed by impulse voltage, strictly synchronized in time with the pulse wave by means of a special electronic tracking loop. The number of pulses emitted before the first pain sensation felt as a light burning is computed by an electronic counter and displayed on the indication panel. The last model of our counting device (“Merid – 2000”) provides the test energy evaluation in joules alongside with the pulse count, to ensure the higher degree of accuracy. Usually, the transient torque of the threshold pain sensitivity takes the patients by surprise. Some of them cry out, others flinch with pain or draw back their limb. By regulating the on-off time ratio and the testing pulse edge, we have achieved a milder threshold coercion, which eases the negative sensations within testing.

Figures 2 and 3 below present the channel localization of the diagnostic points.

It takes from 5 to 10 minutes to measure all the 24 channel branches. The procedure can be performed either by a hospital nurse or even by the patient himself after receiving a short instruction. On the whole, we have managed to lower the general test error to less that10%.

In this connection it should be noted that the Akabane test, as a metrological instrument, fits the study of the 5 primary elements better than, for example, the BAP evaluation method based on measuring the electroconductivity of the biologically active points.

It’s a well-known fact that each of the 5 primary elements corresponds to certain environmental facto; *fire* corresponds to heat, *water* – to cold, *earth* – to humidity, *metal* – to dryness, *wood* – to wind. In our variant of the test we use the most YANish factor – heat as a specific testing irritant, by applying a concentrated coercion of electromagnetic radiation in the infrared diapason on the BAP. This coercion is natural for the body and envisaged by Nature itself. Since ancient times man has been able to sense heat, radiated by the open fire or by the rays of the sun, through the channel ‘input-output’ points, located in the fingers and toes most unprotected areas, and this coercion has always had a certain toning-up and healing effect, partly because of the energy doze the body receives, especially when the channel, and consequently, the corresponding physiological system have low energy potential.

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| Figure 2   1. ‘input-output’ points of the hand channels   1a IG - small intestine  1b TR – triple heater, C – heart  1c MC – pericardium  1d G - I large intestine  1e P - lungs | Figure 3   1. ‘input-output’ points of the foot channels   2a V – urinary bladder  2b R – kidneys  2c VB – gall bladder  2d E – stomach  2e F- liver  2f RP - spleen |

For instance, when a person gets cold his *fire*  channels, i.e. the heart, the triple-heater and the pericardium, are the first to be affected. Their ‘input-output’ points are located on the third through fifth fingers. Then we enjoy warming up our hands by the open fire without feeling pain. The *fire* energy gets into the above-mentioned channels through the input points at the end the terminal falanxes, which serve as a kind of communication ‘windows’ between the body cardiovascular system and the environment. Then, through the channels, the stream of energy gets to the heart’s conducting system and stimulates the heart activity.

The heart conducting system consists of P-cells with especially developed inter-cellular slit contacts, that, according to the latest data, carry light and electric energy along the acupuncture channels (Moshansky V.F., 1993). The data that we have obtained by comparing the results of electrophysiological heart tests and the synchronous channel testing permits us to conclude that **the** **heart conducting system is a natural physical and morphological representative of the heart-channel end system (C).**

Thus, the energy of the fire that man uses to get warm stimulates, first of all, the *fire* channels, and through them the heart conductivity system and the work of the whole cardiovascular system at large. This stimulation provokes the growth of the strength and frequency of heart beats, which leads to the increase of the output and volume of the blood current circulation and, finally, increases the body heat production.

On the contrary, when it’s hot and the *fire* channels are normally in the state of hyper-function, it won’t occur to anyone to warm up his hands by the fire. The person, who should have a fancy to do so, would experience immediate pain and other negative sensations. In this particular situation cold becomes the best coercion factor, which comes to the body’s rescue and softens the heat of the *fire* by strengthening the *water* channels energy. Really, any cooling influence, like bathing, which has the maximum correlation with the kidney and urinary bladder channels function, seems enjoyable.

Different measurements of electric activity or resistance of the BAP are used nowadays to evaluate the channels activity.

As the application of strong currents for the purposes of channel diagnostics results in an electric breakthrough, micro currents are used presently for channel examination, as the time of their duration is extremely short. As a result, the coercion pulse is commensurable with the noise electric signals that can always be found on the skin, which subjects the results of the measuring to considerable distortion and insufficient recurrence, the measuring devices themselves being expensive due to complicated design.

On the other hand, electric coercion, used for channel energy evaluation alternative methods, is not a specifically directed irritating factor for the BAP. Man as a species has existed for over a million years, during which he has been using fire extensively, while electricity has been widely used only for the last 100 years. So, we have no specialized receptors in our body to receive comparatively strong electric currents. It would be absolutely ridiculous to try to get warm in cold weather by applying electricity to certain points in the body. It would be absolutely unnatural.

Therefore we believe that the dynamic rate of change and the accuracy of channel activity evaluation performed by measuring BAP zones electric parameters are inferior to those of the described test and the healing effect of electricity is often unpredictable and may be even opposite to the expected one.

We would like to say a few words about the interpretation of the Akabane test results from the positions of physiology. In fact, there is only a slight difference between studying the threshold of temperature pain sensitivity by means of the Akabane test and classical methods of research. The difference consists in the following factors: the source of the temperature coercion operates in a pulse mode, the temperature is rather stable and doesn’t exceed 80° and the contact surface area is small. The threshold of sensitivity itself is measured in strictly fixed abnormal zones of the skin surface (known as biologically active points – BAP), which have certain channel and other connections with corresponding organs and physiological systems of the body.

The comparatively stable heat radiation temperature of the measuring device is provided for by its design. The infrared type light diodes have a semi-conductor junction of the p – n type, which emits in the infrared diapason and is shaped as a sphere, directly contacting the skin. This construction enables the user to work with high energy transformation efficiency to avoid inertia and to minimize the heating of the radiator. In addition, due to the absence of the heat inertia the radiator can be operated in the modulated signal mode, which permits to establish the information-bearing contact with the channel and to influence its parameters and, consequently, the parameters of the physiological system it controls.

So, the main differences and advantages of this test in comparison with other known methods can be formulated as follows:

1. Unlike electric measuring, this test is performed with a substantial energy coercion on the channel. By analogy with the latent stenocardia diagnostic test, which uses exercise, we resort to a peculiar energy load test, which uses heat energy to define the level of the channel energy potential. It’s important to remember that this energy load is trope and natural for the body. It should be furtherly noted that it’s not by chance, that the ‘input-output’ points are located in the areas most accessible for this kind of coercion – on the fingertips, as they serve to receive and analyse through direct contact such external natural factors as heat.

Having a low energy function during the energy-load test, the channel absorbs the radiated energy intensively and works as a light-guide. In this case the number of the testing pulses will be greater and proportional to the channel’s hypo-function degree of evidence.

In case of the channel’s energy redundancy, we get the opposite reaction, connected with the body’s prompted pain reply to the testing coercion, as the body doesn’t need extra energy donation. Thus, in case of the channel ‘energy vacuum’, it can sometimes take in up to 300 or even 400 pulses to replenish the marked hyper-function, while the normal pulse intake varies from 5 to 8 pulses, and when in hyper-function it cannot absorb more than 2 or 3 pulses. So, in some cases the dynamic diapason of the test covers values that differ by scores of times ( for example, in case of diabetes along the RP channel). The method of the skin electrical resistance evaluation at the BAP fails to register such changes. The test described in this chapter is the best suited for this purpose .Moreover, the higher is the diapason the more reliable and accurate the performance of this metrological device is.

2. High specificity of this test and its high information capacity are confirmed by the fact that during our research work we found out that in the course of testing, especially when it was performed on young people whose BAP are almost all open, normal channel energy activity parameters reproduce the ratio of the channel’s active points number (Fig. 4)

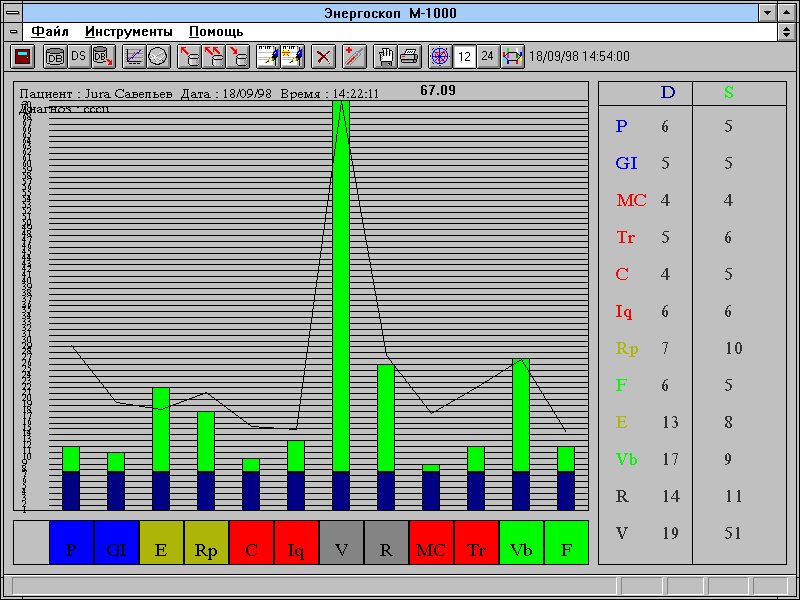


Figure 4.

. Thus, if there are 67 BAP on the urinary bladder channel and 9 BAP on the heart channel, their energy activity ratio can be 67 / 9. So, the standard test parameter fluctuation limits practically copy the number of the channel’s BAP. We have also come to the conclusion that the standard test parameter fluctuation limits depend on the anatomy and functional peculiarities of every particular channel. We have used this principle to build our own system of standard parameters evaluation with reference to the tested individuals’ age and gender. As people grow older, the number of the ‘open points’ decreases and the standard test parameters become more equable, but the proportion remains the same.

3. In the course of the research, conducted by means of our system of pulse diagnostics, we have discovered that the channel energy is subjected to the sinusoidal fluctuation changes. Thus, Fig. 5 shows the main channel’s energy fluctuation in time, and the ‘time-section’ indicator displays one of the channel’s main energy component activity changes within the time-limit of one minute. Undulating channel activity fluctuations with the period of about 16 seconds can be easily traced. Fig. 5 also shows conventional testing pulses, which, when the described testing method is used, fall on different phases of each channel energy cycle.

In this respect the fundamental difference between the suggested method and, say, the single point resistance electric measuring, or continuous heat coercion on the BAP test is that in our case the testing pulses (the same way as in the ancient ‘sacrificial’ stick testing technique) are given in time with the pulse wave and get to different phases of the channel’s energy rhythm activity. Consequently, we obtain the average-weighted value of the channel’s energy component, while the result of the single, for instance, skin electric resistance measuring depends on the phase when the testing pulse is received. That’s why the values obtained by such measuring are characterized by great diversity and insufficient recurrence , as the testing pulse can be received in the recurrent phase of the energy cycle only by chance.

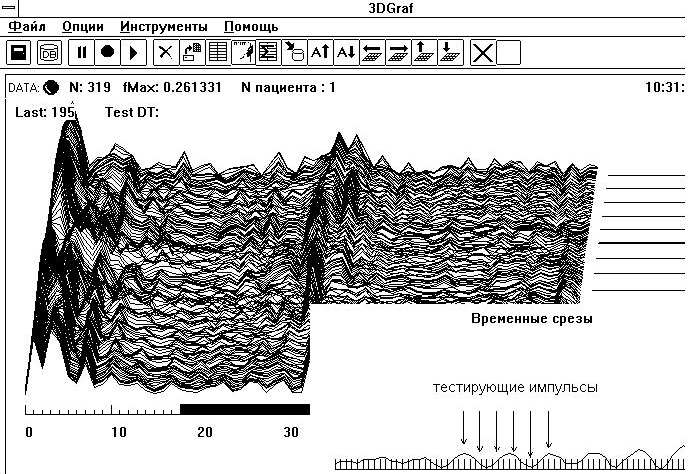
4. As tachycardia, as well as bradycardia bring about the changes of the bioenergetics processes and the channel’s biorhythm frequency change, by synchronizing the testing pulses in time with the body’s pulse wave we, at the same time, smooth out this factor. Hence, in case of tachycardia the channel testing time reduces, and in case of brachycardia it increases. But the total energy, which gets to the BAP through the heat radiator, will depend only on the channel being ‘full’ or ‘empty’. It means that, if the channel energy in both cases is admittedly equal, the total energy, which gets to the BAP through the heat radiator in the course of testing, will be equal too.

So, in comparison with the BAT continuous heating variant, the discontinuous testing coercion method provides high measuring accuracy, since time-quantified energy feeding permits to give the pulses, correlated with the body’s general vital activity in the feedback contour function. Secondly, only through sequencing the pulses along a more continuous period of time, we can solve the problem of the channels’ average –weighted activity, especially if their own biorhythm fluctuation periods are lengthy.

5. In our research work we applied the system of channel evaluation through counting the number of testing pulses. This system is quite suitable for every-day practice. The general length of the testing pulses can be defined, say, in milliseconds, which makes the results even more accurate.

Figure 5.

1.file; 2. options; 3. instruments; 4. help; 5. patient’s number; 6. time section; 7. testing pulses; 8 wave energy



Unfortunately, the necessity to operate with the values of hundreds and thousands of milliseconds demands the use of special computer diagrams, while evaluation through the testing pulses enables to perform simple visual but, at the same time, effective diagnostics of the patient.

6.The feedback with the body following its own demand is an important feature of the suggested testing method. The feedback eliminates the energy over doze in the process of testing as well as during the treatment coercion, as the device functions in the body feedback contour.

**2.2.Recommendations on testing**

To carry out the Akabane test properly the operator needs some skills and the patient should be absolutely concentrated on his own sensations to give the adequate reaction. So, it is important that the testing should be carried out in an isolated room, where the patient’s attention will not be distracted. We start by explaining to the patient the principles on which the test is based and the character of the sensations he is to experience, which increases the reliability of the results due to the patient’s adequate reaction.

The temperature in the room should be optimal. If it is too cold, the feet will be the first to get cold, which will lead to the urinary bladder (V) hypo-function through the *water* energy decrease. The shortage of *water* energyprovokes the *fire* channels energy increase through the destructive connections, which will result in the increase of the activity of the channels, controlling the state of the cardiovascular system. In the long run it will lead to the increase of the body’s overall heat production due to the metabolism strengthening. At once, the difference in the main dipole parameters will also increase, but this phenomenon will be discussed later. As we can see a physical factor, insignificant at first glance can bring about a certain distortion of the test results. At the same time, this simple example shows how the most important physiological body reactions are regulated at the channel level. That is why the channel testing in general, as well as other physiological tests, must be conducted with the metabolism parameters being within the physiological standards.

For the sake of convenience and with the purpose of increasing its metrological characteristics, our device can radiate heat in different modes of radiation power. By modifying the testing pulses power, we can modify the test’s resolving capacity and duration. Working at a high power level (say, at 8 power units), we can shorten the time of the test, simultaneously lowering its resolving capacity. For example, we use this method to monitor the patient’s physical state after some treatment procedures or during mass examinations. If the patient undergoes the testing procedure for the first time and his channel profile is unknown, it’s better to use low testing energy level, say of the 5th or 6th radiation energy grade. Then, the length of the test will increase, but the parameters dynamic range will also increase. It helps to discover a pathology most efficiently.

Using different radiation power values for testing either different people or one and the same person, we observe considerably differing value fluctuation scales in connection with differing heart beats frequency.

How can this problem be solved?

We carry out and assess every test on the basis of the following general rules:

1. Since every test characterizes individual bioenergetics section, in which all the channels are closely connected with one another, the testing pulses power, frequency and on-off time ratio must not be modified in the course of one particular examination.

2.To construct the general pathology model, based on the results of the group examination, or on several examinations of one and the same patient, we use the method of reducing the results of the tests to the same denomination. For this purpose we deduce the simple average of the 24 channels parameters. Then the parameter of every channel is divided by the simple average parameter value. If the result is >1, it means that the channel is in hyper-function. If the result is < 1.0, we observe the case of hypo-function. This scaling method permits to compare the results of the tests performed on different patients and under different conditions.

To get comparable results of the same kind in the test absolute values, it is necessary to use one fixed radiation power value in strictly standard testing conditions, which is more difficult to carry out in practice. Besides the testing pulses should be radiated with the fixed frequency value, which will lead to ideological as well as metrological errors. That is why we solve these problems by means of the scaling method.

3.On defining each channel energy potential of the patient we construct his individual energy model at the five primary elements level. If the drawing is made, either on paper, or a computer one, it will facilitate working out the treatment scheme.

4. By considering the model together with the results of the surveys and other special tests (for example the Lucher’s test), we decide on the channel disbalance zones optimal correction.

5.The disbalance between the right and the left branches of the same channel is of primary importance, especially in urgent cases, since it is connected with the general asymmetry of the body at the energy level. The presence of the asymmetry between the right and the left branches of the same channel demands correcting interference in more than 40% of cases. The most effective coercion is achieved directly through the ‘input-output’ point or through the LО – locking check-point and the preceding element point on the hypo-functioning channel.

6. It is desirable that the patient should abstain from taking any sleeping pills or tranquilizers on the eve of the test, as they can distort the results of the threshold temperature pain sensitivity. Usually we start the test from the twin lung channel points, pass to the large intestine points, etc, in the order the points are located on the limb, for instance in the counter-clock direction.

The results of the test are registered in a standard table and later analyzed, taking into consideration the laws of the 5 primary elements interdependence.

Accompanying information.

To get the most complete evaluation of the patients’ state dynamics , we practice filling out the general questionnaire with the purpose of segregating the patients on the basis of the diagnosis, the channel pathology development geneses, and a series of specific test questions, formulated from the positions of channel diagnostics and reflexotherapy. A list of current observations is filled out during every test. The list includes information about the test, for example, the date and the time, as well as questions about the patient’s current state. This set of questions comprises information on the patient’s physiological parameters (heart beat frequency, blood pressure), and the questions to the patient, which enable him to assess his physical state within a certain scale. In particular, some systems include the patient’s state of health self-assessment within Robson’s 10-point scale. For instance, if the patient is subject to headaches, but does not have any at the time of testing, he writes down the figure 1 in the questionnaire. If he has a splitting headache, he writes down the figure 10. If headache is of average intensity, the mark will be 5 or 6. In this way the patient’s subjective sensations are converted into quite accurate numerical parameters. Eventually, providing there is enough observation data representational mathematic modeling of the reasons, which cause the headaches, can be carried out. In the long run, all these methods permit computer processing of the data obtained in the course of observations with the help of mathematic support programmes that we have worked out.