

中西藥併用實證研究

累積18年中藥不良反應通報研究資料

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淺談中藥與西藥相互作用

任何的藥物之間，都有可能產生相互作用，在不同的年齡、性別，有個體上的差異，反應程度不一，可能輕微，可能嚴重。藥物的相互作用，是一體的兩面，臨床上利用中醫辨症結合西醫辨病的治療方式達到相輔相成、標本兼治的效果，進而縮短療程。然而中西藥如何合理使用來達到協同作用，同時將副作用減至最低，卻是一門很重要的學問。中西藥物相互作用機制可發生在藥物的吸收之前，例如：胃腸道酸鹼度的變化、胃腸蠕動、胃排空時間的長短及在胃腸內發生結合、吸附作用等。在體內分部運輸過程中，亦可發生在體內代謝，例如：體內代謝酵素(CYP、MAO)的誘導或是抑制，以及排泄過程中，從而影響藥物(中藥或西藥)在體內的濃度，而造成藥效方面產生一定程度的變化。從藥物藥效學的觀點，類似性質同時於體內作用，可能具有增加療效的成果，但劑量若控制不好，可能也會產生不良的副作用。



糖尿病

西醫臨床常用於治療糖尿病之藥物種類

作用分類	學名	商品名	常見副作用
胰島素分泌促進劑—磺胺尿素類	Chlorpropamide Tolbutamide Glipizide Glyburide Glimepiride	Diabinese Tolbutamide Glipizide Gliben Amaryl	低血糖（冒冷汗、心悸、頭痛、痙攣、昏亂），發燒、喉嚨痛、皮膚疹、黃疸症狀等。
胰島素分泌促進劑—苯丙胺酸衍生物	Nateglinide Repaglinide	Starlix NovoNorm	低血糖（冒冷汗、顫抖、心悸、頭痛、昏亂）、腹痛、腹瀉、皮膚疹等。
雙胍類	Metformin	Glucophage	胃腸不適、口中金屬味、乳酸中毒（如換氣過度、肌肉疼痛、嗜睡）、低血糖等。
胰島素增敏劑—Thiazolidinediones	Pioglitazone Rosiglitazone	Actos Avandia	頭痛、水腫、腹痛、黃疸、噁心、嘔吐等。
α -葡萄糖苷酶抑制劑	Acarbose Miglitol	Glucobay Diaban	脹氣、腹瀉、腹痛、皮膚、眼睛變黃等。
雙基性肽酶-4抑制劑	Sitagliptin	Januvia	偶有鼻咽炎、上呼吸道感染，腹瀉、腹痛、嘔吐等。
胰島素	Insulin Lispro Insulin Aspart Regular Insulin Isophane Insulin Susp Insulin Glargine Insulin Detemir	Humalog NovoRapid Humulin R Insulatard HM Humulin N Lantus Levemir	低血糖（冒冷汗、心悸、頭痛、痙攣、昏亂）、體重增加等。
昇糖素類似胜肽促進劑	Exenatide Liraglutide	Byetta Victoza	噁心、嘔吐、腹瀉、低血糖等。

臨床常用中藥方

- 補益劑：六味地黃丸、知柏地黃丸、杞菊地黃丸、濟生腎氣丸、八味地黃丸
- 清熱劑：白虎加人參湯、甘露飲
- 和解劑：加味道遙散
- 理血劑：血府逐瘀湯
- 潤燥劑：玉泉丸

依據全民健保資料庫檢索中醫臨床常用於治療失眠之方劑

排名	方劑名稱	排名	方劑名稱
1	六味地黃丸	6	濟生腎氣丸
2	白虎加人參湯	7	加味道遙散
3	玉泉丸	8	八味地黃丸
4	知柏地黃丸	9	血府逐瘀湯
5	杞菊地黃丸	10	甘露飲

糖尿病

臨床常用中藥

黃耆



- 功用**：益氣升陽，固表止汗，利水消腫，托瘡生肌。
- 主治**：氣虛乏力，食少便溏，脫肛，便血，崩漏，自汗，水腫，癰疽難潰或久潰不斂，血虛痿黃，內熱消渴。
- 性味**：味甘，性微溫。

中西藥交互作用

西藥 種類	西藥學名	實驗 種類	可能交互 作用機轉	可能交互 作用結果	建議處理方式	參考 文獻
降血糖 藥	Sitagliptin Glimepiride Metformin Glibenclamide Acarbose Repaglinide Rosiglitazone Pioglitazone Insulin	體外 實驗	中藥具降血 糖作用	降血糖作用 加成	由醫師等人決 定調整劑量	[1]
免疫抑 制劑	Cyclosporine	體外 實驗	黃耆的免疫 刺激作用	會與Cyclospo- rine的免疫抑 制作用相互抵 銷掉	隔開服用	[2]

參考文獻：黃耆

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- LG Miller (1998) Herbal medicinals: selected clinical considerations focusing on known or potential drug-herb interactions. *Arch Intern Med* 158: 2200-2211.

山藥



- **功用**：補脾養胃，生津益肺，補腎澀精，養陰止渴。
- **主治**：脾虛食少，久瀉不止，肺虛喘咳，腎虛遺精，帶下，尿頻，虛熱消渴，外用治癰腫，一切腫塊硬痛。
- **性味**：味甘，性微溫。

糖尿病

中西藥交互作用

西藥種類	西藥學名	實驗種類	可能交互作用機轉	可能交互作用結果	建議處理方式	參考文獻
胰島素	Insulin Monocomponent	動物實驗	中藥具降血糖作用	降血糖作用加成	由醫師等人決定調整劑量	[1,2,3]
	Insulin Actrapid HM					
	Insulin Aspart					
	Insulin Glargine					
	Biphasic Insulin Aspart					
	Insulin Detemir					
雙基胜肽酶-4抑制劑	Sitagliptin					
磺胺尿素類	Glibenclamide					
	Glimepiride					
雙胍類	Metformin					
胰島素增敏劑 Glitazone類 (TZD)	Pioglitazone					
	Rosiglitazone maleate					
胰島素分泌促進劑—苯丙胺酸衍生物 Glinides	Repaglinide					
α型葡萄糖苷酶抑制劑	Acarbose					

糖尿病

蒼朮



- **功用：**除溼發汗，健胃安脾，治痿明目。
- **主治：**濕困脾胃，倦怠嗜臥，胸痞腹脹，食慾不振，吐瀉，痰飲，夜盲，風寒夾濕，頭身重痛，痹證肢節痠痛重著，痿躄。
- **性味：**味苦、辛，性溫。

中西藥交互作用

西藥 種類	西藥 學名	實驗 種類	可能交互 作用機轉	可能交互 作用結果	建議處 理方式	參考 文獻
胰島素	Insulin Monocomponent Insulin Actrapid HM Insulin Aspart Insulin Glargine Biphasic Insulin Aspart Insulin Detemir	動物 實驗	中藥具降 血糖作用	降血糖作 用加成	由醫師 等人決 定調整 劑量	[1,2]
雙基胜肽酶-4 抑制劑	Sitagliptin					
胰島素分泌促 進劑—磺胺 素類	Glibenclamide Glimepiride					
雙胍類	Metformin					
胰島素增敏劑 (TZD)類	Pioglitazone Rosiglitazone maleate					
胰島素分泌促 進劑—苯丙 胺酸衍生物 Glinides	Repaglinide					
α 型葡萄糖苷 酶抑制劑	Acarbose					



第八章 慢性腎臟病藥物治療

前言

慢性腎臟病（Chronic Kidney Disease，簡稱 CKD）的藥物治療著重兩個層面：一是如何使用藥物減緩殘餘腎功能下降，其二是如何適當使用藥物，以避免殘餘腎功能惡化及藥物產生的副作用。綜合國內外臨床研究發現，**血管張力素轉化酶抑制劑**（angiotensin converting enzyme inhibitors，簡稱 ACEi）、**第二型血管張力素受體拮抗劑**（angiotensin II receptor blockers，簡稱 ARB）、pentoxifylline、維生素 D、重碳酸鹽、克裏美淨細粒（Kremezin®）等，對於減緩糖尿病及非糖尿病的 CKD 病人腎功能惡化及降低蛋白尿方面有正向的效果；但是，每種藥物使用時機及臨床療效各有不同，大部份的研究顯示，要讓藥物產生預期效果的使用時機應在早期 CKD 時期，本章將闡述上述藥物使用時機及已知的臨床效果。另外，臨床常使用的藥物如口服降血糖藥、非類固醇消炎劑、第二類環氧化酶抑制劑、statins/fibrates 類藥物、抗微生物製劑、肌肉鬆弛劑、顯影劑等，假如用在不同時期的 CKD 病人而未調整劑量，除了可能促使殘餘腎功能惡化之外，病人也會產生不良副作用。本章亦將闡述上述藥物如何調整劑量及應注意的藥物副作用。





第一節 延緩慢性腎臟病惡化的藥物治療

一、血管張力素轉換酶抑制劑及血管張力素第二型受體拮抗劑

建議強度	建議內容	證據等級	文獻編號
A	ACEi 可以預防第一或第二型糖尿病病人發生微量白蛋白尿。	1++	1
A	發生微量白蛋白尿的第一型糖尿病病人無論是否有高血壓，應以 ACEi 治療。	1++	2-6
A	發生微量白蛋白尿的第二型糖尿病病人無論是否有高血壓，應以 ACEi 或 ARB 治療。	1++	2-6
A	ACEi 與 ARB 可列為治療有明顯蛋白尿的非糖尿病 CKD 病人的首選藥物。	1++	6-8



建議強度	建議內容	證據等級	文獻編號
A	ACEi 與 ARB 是 <u>減緩糖尿病 CKD 或有明顯白蛋白尿 (ACR 超過 0.3 g/g)</u> 的非糖尿病 CKD 病人腎病惡化的 <u>首選藥物</u> 。	1++	3,4,8-11
Good practice point	腎絲球過濾率 $<45 \text{ ml/min/1.73m}^2$ 病人，使用 ACEi 與 ARB， <u>應降低起始劑量</u> 。		
Good practice point	開始或調整 ACEi 與 ARB 治療後一週內，建議應評估腎絲球過濾率與血鉀濃度。		
Good practice point	發生其他疾病、須使用顯影劑或腸鏡檢查或重大手術等，如有影響腎功能之虞，建議 <u>暫停 ACEi 與 ARB</u> 。		



ACEi 與 ARB 都具有保護心臟血管與腎臟的效果。ACEi 與 ARB 在不影響全身性血壓情況下，可以透過放鬆腎絲球出球小動脈，以降低腎絲球內微血管高血壓，達到減少蛋白尿與減緩 CKD 功效。目前台灣上市的 ACEi，包括 captopril、enalapril、imidapril 與 ramipril 等；ARB 包括 candesartan、irbesartan、losartan、olmesartan、telmisartan 與 valsartan 等；其他能抑制腎素 – 血管張力素 – 醛固酮系統的藥物，包括 aliskiren（腎素抑制劑）與 spironolactone（皮質醛酮抑制劑）。



5. 減緩慢性腎臟病惡化速度

在一項包含七個隨機對照試驗、共 1,389 名具有明顯蛋白尿的糖尿病與非糖尿病的 CKD 病人統合分析中，使用 ACEi 可減緩 CKD 惡化速度或減少 40% 惡化成末期腎臟病的病人數目。⁴ 另一項統合分析包含 10 個隨機對照試驗、共 1,594 名具有明顯蛋白尿的非糖尿病之 CKD 病人，ACEi 可以降低 30% 惡化成末期腎臟病的風險。⁹ 以上兩項統合分析均未校正降低血壓的影響；另一項統合分析包含 11 個隨機對照試驗、共 1,860 名具有明顯蛋白尿的非糖尿病之 CKD 病人，在校正血壓影響後，仍證實 ACEi



6. 合併 ACEi 與 ARB 的治療

雖然過去有兩項統合分析都已證實，合併 ACEi 與 ARB 的治療比單用 ACEi 的治療能更有效降低尿蛋白，^{12,13} 但其中只有一項統合分析探討合併 ACEi 與 ARB 的治療比單用 ACEi 更能減緩 CKD 惡化，但並未進一步探討是否與血壓降低相關。¹² 最近一項包含 33 個隨機對照試驗、共 68,405 名心臟衰竭病人的統合分析指出，合併 ACEi 與 ARB 的治療比單一治療增加高血鉀、低血壓與腎功能惡化的風險；¹⁴ 因此，再進一步釐清合併治療的療效前，暫不建議使用。



7. 腎素抑制劑 (aliskiren) 與皮質醛酮抑制劑 (spironolactone)

在 599 名具有第二型糖尿病、高血壓的 CKD 病人，已服用最高建議劑量 losartan 情況下，aliskiren 可以進一步降低蛋白尿；¹⁵ 但在以 8,561 名具有 CKD 與心血管疾病高風險的第二型糖尿病病人所進行之雙盲隨機分組臨床試驗中，所有病人已接受 ACEi 或 ARB 治療，再接受 aliskiren 合併治療的病人不僅未降低 CKD 悪化與心血管疾病風險，反而高血鉀症風險顯著升高。¹⁶

皮質醛酮抑制劑 (spironolactone) 則缺乏大型雙盲隨機分組臨床試驗，探討其在 CKD 的療效。¹⁷ 而一項包含 11 個隨機分組臨床試驗、991 名已使用 ACEi 或 ARB 治療的 CKD 病人統合分析發現，皮質醛酮抑制劑雖能降低蛋白尿，對於血壓、腎功能則無影響，但明顯增加了高血鉀症的風險。¹⁸



建議強度	建議內容	證據等級	文獻編號
A	糖尿病合併 CKD 的病人建議使用 <u>pentoxifylline</u> 降低蛋白尿。	1+	24
A	國內 CKD 病人使用 <u>ARB</u> 情形下，合併 <u>pentoxifylline</u> 治療可能可以再使蛋白尿降低。	1+	23

(一) 簡介

Pentoxifylline 是 methyl-xanthine 類衍生物，藉由非選擇性抑制 phosphodiesterase 而產生抗發炎與免疫調節等功能；¹⁹ 由於它可促進周邊血管灌流，臨床上常用於治療周邊血管或腦血管疾病。動物實驗已證實，pentoxifylline 在 mesangial prolif-

(二) 藥品

Pentoxifylline (Trental, 循血敏，一錠 400 公絲) 為持續性膜衣錠，不能撥半或磨粉，通常成人劑量一日三次，一次 400 公絲，腎功能不全病人需減少劑量；腎絲球

(三) 藥物不良反應

一般症狀包括噁心、嘔吐、腹瀉、頭痛、頭暈等，如果出現皮膚潮紅、心跳加快、胸悶或低血壓等現象，可能是因為服用劑量過高，需要將劑量適量調節；此外，兒童、視網膜出血、急性心肌梗塞、懷孕婦女及對於 pentoxifylline 或 methylxanthines 類如咖啡因、茶鹹等過敏者，不可使用。

(四) 建議治療時間

藥物治療需維持多長時間？目前並無一致性結論。

四、維生素 D

建議強度	建議內容	證據等級	文獻編號
A	CKD 病人使用 paricalcitol 可能可以降低蛋白尿。	1++	43-44
		1+	42
B	IgA 腎病變的病人使用 calcitriol，可能可以降低蛋白尿。	1-	39-40

(一) 簡介

維生素 D 是一種脂溶性維生素，為人體必需營養素之一；維生素 D 是所有具 cholecalciferol 之生物活性固醇類物質的統稱，主要作用為促進腸胃吸收鈣和磷。維生素 D 有很多種形式，最常見的是麥角鈣醇 (ergocalciferol, vitamin D2) 與膽鈣醇 (cholecalciferol, vitamin D3) 。

六、Statins 類藥物 / fibrates 類藥物

建議強度	建議內容	證據等級	文獻編號
B	CKD 病人合併明顯蛋白尿可考慮使用 statins。	1+	59-61
B	糖尿病腎病變病人合併有蛋白尿者，建議使用 fibrates。	1-	62

Statins (HMG-CoA reductase inhibitors) 是 3-hydroxy-3-methyl-glutaryl-CoA reductase 的競爭型抑制劑，干擾膽固醇生合成，可降低血中 total cholesterol、LDL、VLDL、TG、apolipoprotein B 濃度及增加 HDL。目前台灣上市的 statins 包括，lovastatin (Mevacor) 、pravastatin (Mevalotin) 、simvastatin (Zocor) 、fluvastatin (Lescol) 、atorvastatin (Lipitor) 、rosuvastatin (Crestor) 、pitavastatin (Livalo) 。

Fibric acid derivatives (fibrates) 藉由活化 peroxisome proliferator-activated receptors (PPAR α) 刺激脂蛋白分解，主要作用在降低 TG、增加 HDL，亦可小幅度降低 LDL；目前台灣的 fibrates 包括 gemfibrozil (Lopid) 、fenofibrate (Lipanthyl) 、bezafibrate (Benzalip) 。

圖一 末期腎臟病發生率



圖二 末期腎臟病盛行率



二、世界各國末期腎臟病的盛行率

美國腎臟資料系統 (USRDS) 每年都有更新各國 ESRD 的發生率及盛行率。⁸ 目前最新發表的 USRDS 2014 年資料，在西元 2012 年的資料中，墨西哥哈利斯科 (Jalisco, Mexico) 、美國、新加坡和日本有比較高的發生率，分別是每百萬人口 466.5、358.7、285.3 和 285.3 人。然而 ESRD 盛行率比較高的國家則是日本、美國、新加坡和葡萄牙，盛行率分別是每百萬人口 2,365、1,976、1,741 和 1,670 人。ESRD 盛行率比較低的國家是烏克蘭、南非和俄羅斯等，盛行率分別是每百萬人口 131、164 和 212 人。然而台灣 ESRD 的盛行率在 2012 年是每百萬人口 2,902 人，仍為盛行率最高的國家。

Original Article

Increased risks of chronic kidney disease associated with prescribed Chinese herbal products suspected to contain aristolochic acid

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SUMMARY:

Aim: Nephropathy associated with aristolochic acid (AA) has been documented by human and animal studies. Ancient Chinese herbology claimed to reduce toxicity in their mixtures. It was the objective of this study to determine the risk of chronic kidney disease (CKD) associated with AA-related Chinese herbal products (CHP) or mixtures of herbs in a national cohort.

Methods: A retrospective follow-up study was conducted, using a systematic random sample (200 000 people) in the National Health Insurance reimbursement database during 1997–2002. The incidence rates of CKD and end-stage renal disease (ESRD) were calculated for the whole sample and those that had used CHP suspected to contain AA. Cox regression models were constructed to control potential confounders, including age, sex, hypertension, diabetes mellitus, and use of non-steroidal anti-inflammatory drugs and acetaminophen.

Results: A total of 199 843 persons were included in the final analysis, 102 464 (51.3%) men and 97 379 (48.7%) women, with an average incidence rate of 1964/10⁶ person-years for CKD and 279/10⁶ person-years for ESRD. After controlling other risk factors, the hazard ratios for development of CKD seemed to increase for patients that had consumed more than 30 g Mu-Tong, and more than 60 g Fangchi.

Conclusion: Prescription of more than 30 g Mu-Tong or more than 60 g Fangchi CHP was associated with an increased risk of developing CKD. In addition to prohibiting the use of Guan-Mu-Tong and Guang-Fangchi, patients who have used these CHP should continue to be followed up.

KEY WORDS: aristolochic acid, Chinese herbal products, chronic kidney disease.

ARTICLE IN PRESS

Risks of Kidney Failure Associated With Consumption of Herbal Products Containing Mu Tong or Fangchi: A Population-Based Case-Control Study

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Background: Taiwan has a remarkably high incidence of end-stage renal disease (ESRD). The objective of this study is to determine the association between prescribed herbal products containing aristolochic acid and ESRD.

Study Design: Population-based case-control study.

Setting & Participants: All new ESRD cases in Taiwan and a simple random sample (200,000 people) drawn from the national health insurance reimbursement database in 1997-2002.

Predictor: Age; sex; hypertension; diabetes; cumulative doses of nonsteroidal anti-inflammatory drugs, acetaminophen, and adulterated herbal supplements potentially containing aristolochic acid before the development of chronic kidney disease; and indications for prescribing such herbs, including chronic hepatitis, chronic urinary tract infection, chronic neuralgia, or chronic musculoskeletal diseases.

Outcomes & Measurements: Occurrence of ESRD through construction of multiple logistic regression models.

Results: There were 36,620 new ESRD cases from 1998 through 2002. After exclusion of cases with chronic kidney disease diagnosed before July 1, 1997, there were 25,843 new cases of ESRD and 184,851 controls in the final analysis. Women, older age, hypertension, and diabetes were significantly associated with increased risks of the development of ESRD. After adjustment for known risk factors, cumulative doses >60 g of Mu Tong (OR, 1.47 [95% CI, 1.01-2.14] for 61-100 g; OR, 5.82 [95% CI, 3.89-8.71] for >200 g) or Fangchi (OR, 1.60 [95% CI, 1.20-2.14] for 61-100 g; OR, 1.94 [95% CI, 1.29-2.92] for >200 g) were associated with increased risk of the development of ESRD with a dose-response relationship. This relationship persisted when analyses were limited to participants who consumed <500 pills of nonsteroidal anti-inflammatory drugs and those without diabetes.

Limitations: No measurement of renal function, no contact with patients, over-the-counter sales were not recorded, and potential underestimation of exposure dose for cases and ORs.

Conclusions: Consumption of >60 g of Mu Tong or Fangchi from herbal supplements was associated with an increased risk of developing kidney failure.

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INDEX WORDS: Aristolochic acid; Chinese herb nephropathy; end-stage renal disease; Mu Tong; Fangchi.

Compared with other countries,^{1,2} Taiwan has a remarkably high incidence and prevalence of chronic kidney disease (CKD) and end-stage renal disease (ESRD). Multiple causes have been reported, including an increasing proportion of aged patients,³ in-

creased incidence of diabetic nephropathy,³ high prevalence but low awareness for CKD,⁴ and the comprehensive coverage of Taiwanese national health insurance.³ In addition, there have been case reports of renal failure caused by Chinese herbal products^{5,6} or herbs contain-

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Review Article

Observational Studies on Evaluating the Safety and Adverse Effects of Traditional Chinese Medicine

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Background. This study aims to share our experiences when carrying out observational studies of traditional Chinese medicine (TCM). **Methods.** We have proactively monitored the safety profiles of *Duhuo Jisheng Tang* (DJT), *Suan Zao Ren Tang* (SZRT), and TMN-1. A list of adverse events (AEs), complete blood counts, and liver and kidney function tests were obtained from the participants during their scheduled hospital visits. Retrospective observational studies were conducted based on the reimbursement database of the National Health Insurance system, Taiwan, to explore the relationship between the use of TCM that have been adulterated by aristolochic acid and the risk from both nephrotoxins and carcinogens. **Results.** A total of 221, 287, and 203 AEs were detected after SZRT, DJT, and TMN-1 had been taken, respectively. Dizziness, headache, stomach ache, and diarrhea were judged to be probably related to SZRT treatment. Retrospective observational studies found an association between the consumption of aristolochic acid-containing Chinese formulae such as *Mu Tong* and an increased risk of CKD, ESRD, and urinary tract cancer. **Conclusion.** Prospective and retrospective observational studies seem to have specific advantages when investigating the safety and adverse effects of TCM therapies, as well as possibly other alternative/complementary therapies.

1. Introduction

Traditional Chinese medicine (TCM), a long and widely used form of medical care in ethnic Chinese communities and nearby regions, has recently been adopted by other ethnic groups worldwide [1–5]. Most indications and contraindications of TCM therapies currently in the market are solely based on documentation found in ancient books [6] associated with a traditional belief that these herbs and/or their combinations are usually safe. Randomized controlled trials

therapeutic principles of TCM usually take a holistic view involving activating systems, improving system connection, and enhancing human disease resistance [11]. TCM doctors usually prescribe herbs tailored to the patient's symptoms/signs and constitution, which often requires some modification of the ancient Chinese formulae. As a result, herbal formulae that consist of modified prescriptions of herbs continue to appear and are also prescribed without any systematic evaluation [1]. Thus there remains a big question in TCM research as to how to evaluate TCM prescriptions:

TRADITIONAL CHINESE MEDICINE. TANG JL, LIU BY, MA KW. *LANCET*. 2008 DEC 6;372(9654):1938-40

included in systematic reviews. Selective publication of positive trials is another problem.^{10,12}

The quality of TCM trials could be improved by adopting the bias-reduction points in the CONSORT guidelines. Meanwhile, the patient, intervention, comparator, and outcome should also be carefully documented. For example, it is important to compare TCM with a placebo or an intervention of proven efficacy rather than interventions with unknown effects. Furthermore, patients' inclusion and exclusion criteria, and indications and contraindications of the tested therapy, must be specified clearly in a language comprehensible to users who have never learnt TCM. Tested herbal products also need to be standardised to ensure manufacturing consistency. Standardisation is similarly important for diagnosis and procedural treatments, such as acupuncture.

Because TCM and western medicine differ, debates arise about which outcomes to use. Patients' views

in access to effective care for poor people.

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Research Paper

Integrating traditional Chinese medicine healthcare into diabetes care by reducing the risk of developing kidney failure among type 2 diabetic patients: A population-based case control study

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Table 1

Frequency distribution of various risk factors and crude and adjusted Odds Ratios (ORs) with 95% Confidence Intervals (CIs) for newly occurred type 2 DM patients with kidney failure and for control subjects.

Risk factor	Case subjects		Control subjects		Crude OR (95% CI)	Adjusted OR (95% CI)
	N = 1346	%	N = 14,059	%		
Sex						
Female	497	36.9	5566	39.6	1.00 (Referent)	1.00 (Referent)
Male	849	63.1	8493	60.4	1.12 (1.00–1.26)	1.21 (1.08–1.36)
Age (years)						
20–39	51	3.8	1151	8.2	1.00 (Referent)	1.00 (Referent)
40–59	543	39.7	7158	50.9	1.71 (1.28–2.30)	1.59 (1.18–2.15)
60–74	582	43.2	4512	32.1	2.91 (2.17–3.90)	2.50 (1.85–3.38)
> 75	179	13.3	1238	8.8	3.26 (2.37–4.50)	2.55 (1.83–3.55)
Hypertension						
No	319	23.7	4447	31.6	1.00 (Referent)	1.00 (Referent)
Yes	1027	76.3	9612	68.4	1.49 (1.31–1.70)	1.21 (1.06–1.39)
TCM^a usage						
No	844	62.7	7411	52.7	1.00 (Referent)	1.00 (Referent)
Yes	502	37.3	6648	47.3	0.66 (0.59–0.74)	0.69 (0.61–0.77)
Number of diabetic complications						
0	591	43.9	7302	51.9	1.00 (Referent)	1.00 (Referent)
1	381	28.3	4310	30.7	1.09 (0.96–1.25)	1.19 (1.04–1.37)
2	206	15.3	1766	12.6	1.44 (1.22–1.70)	1.70 (1.43–2.03)
> = 3	168	12.5	681	4.8	3.05 (2.52–3.68)	3.76 (3.07–4.61)
Number of medical treatments for diabetes						
None	160	11.9	1048	7.5	1.00 (Referent)	1.00 (Referent)
1	276	20.5	2232	15.9	0.81 (0.66–1.00)	0.75 (0.60–0.92)
2	427	31.7	4959	35.3	0.56 (0.46–0.68)	0.49 (0.40–0.59)
3 or more	483	35.9	5820	41.4	0.54 (0.45–0.66)	0.40 (0.32–0.49)
Chronic urinary tract infection > 12 times in 1 year						
No	1321	98.1	13,832	98.4	1.00 (Referent)	1.00 (Referent)
Yes	25	1.9	227	1.6	1.15 (0.76–1.75)	0.94 (0.61–1.43)
Aminoglycosides, total amount prescribed, DDD^b						
0	822	61.1	9309	66.2	1.00 (Referent)	1.00 (Referent)
1–3	440	32.7	4141	29.5	1.20 (1.07–1.36)	1.13 (1.00–1.28)
> 3	84	6.2	609	4.3	1.56 (1.23–1.98)	1.46 (1.14–1.87)

^a TCM refers to traditional Chinese medicine.

^b DDD refers to define daily dose.

^c Trend includes zero group (i.e., non-TCM user).

^d *p* Values are two-sided.

Table 2

Frequency distribution of various risk factors and crude and adjusted Odds Ratios (ORs) with 95% Confidence Intervals (CIs) for newly occurred of type 2 DM patients with kidney failure and for control subjects.

Risk factor	Case subjects		Control subjects		Crude OR (95% CI)	Adjusted OR (95% CI)
	N=1346	%	N=14,059	%		
Sex						
Female	497	36.9	5566	39.6	1.00 (Referent)	1.00 (Referent)
Male	849	63.1	8493	60.4	1.12 (1.00–1.26)	1.21 (1.07–1.36)
Age(years)						
20–39	51	3.8	1151	8.2	1.00 (Referent)	1.00 (Referent)
40–59	543	39.7	7158	50.9	1.71 (1.28–2.30)	1.59 (1.18–2.15)
60–74	582	43.2	4512	32.1	2.91 (2.17–3.90)	2.50 (1.85–3.38)
> 75	179	13.3	1238	8.8	3.26 (2.37–4.50)	2.55 (1.83–3.55)
Hypertension						
No	319	23.7	4447	31.6	1.00 (Referent)	1.00 (Referent)
Yes	1027	76.3	9612	68.4	1.49 (1.31–1.70)	1.21 (1.06–1.39)
Number of diabetic complications						
0	591	43.9	7302	51.9	1.00 (Referent)	1.00 (Referent)
1	381	28.3	4310	30.7	1.09 (0.96–1.25)	1.19 (1.04–1.37)
2	206	15.3	1766	12.6	1.44 (1.22–1.70)	1.70 (1.43–2.03)
≥ 3	168	12.5	681	4.8	3.05 (2.52–3.68)	3.76 (3.07–4.61)
Number of medical treatments for diabetes						
None	160	11.9	1048	7.5	1.00 (Referent)	1.00 (Referent)
1	276	20.5	2232	15.9	0.81 (0.66–1.00)	0.75 (0.60–0.92)
2	427	31.7	4959	35.3	0.56 (0.46–0.68)	0.49 (0.40–0.59)
3 or more	483	35.9	5820	41.4	0.54 (0.45–0.66)	0.40 (0.32–0.49)
Total amount of prescribed LWDHW ^a , g						
Non-TCM user	844	62.7	7411	52.7	1.00 (Referent)	1.00 (Referent)
Non-LWDHW TCM user	402	29.9	5409	38.5	0.65 (0.58–0.74)	0.68 (0.60–0.77)
LWDHW						
1–30	85	6.3	1074	7.6	0.69 (0.55–0.88)	0.69 (0.54–0.87)
> 30	15	1.1	165	1.2	0.80 (0.47–1.36)	0.84 (0.49–1.44)
Cochran-Armitage test for trend ^b : Z = 3.29, p < 0.001 ^c						
Chronic urinary tract infection ≥ 12 times in 1 year						
No	13,21	98.1	13,832	98.4	1.00 (Referent)	1.00 (Referent)
Yes	25	1.9	227	1.6	1.15 (0.76–1.75)	0.94 (0.61–1.43)
Aminoglycosides, total amount prescribed, DDD ^d						
0	822	61.1	9309	66.2	1.00 (Referent)	1.00 (Referent)
1–3	440	32.7	4141	29.5	1.20 (1.07–1.36)	1.13 (1.00–1.28)
> 3	84	6.2	609	4.3	1.56 (1.23–1.98)	1.46 (1.14–1.87)
Cochran-Armitage test for trend ^b : Z = -4.32, p < 0.001 ^c						

^a LWDHW refers to Liu-Wei-Di-Huang-Wan.

^b Trend includes zero group (i.e., non-TCM user).

^c p Values are two-sided.

^d DDD refers to define daily dose.

statistically significantly decrease in the risk kidney failure that is associated with the use of TCMs. This study has a number of

detection of most, if not all, cases of kidney failure. The other major risk factors for kidney failure, namely age, sex, history of

中藥安全監測評估問卷

五、中藥安全監測評估問卷

*請問您在過去一個月是否無緣無故出現以下症狀？以發生次數計算。

	次數							至門診或醫院就診	
	0	1	2	3	4	5	>5	無	有
1. 腹痛	<input type="checkbox"/>								
2. 腹脹	<input type="checkbox"/>								
3. 腹瀉	<input type="checkbox"/>								
4. 嘴吐	<input type="checkbox"/>								
5. 嘔心	<input type="checkbox"/>								
6. 身體起疹子，並經醫師診斷為蕁麻疹	<input type="checkbox"/>								
7. 身體發癢	<input type="checkbox"/>								
8. 皮膚有紫斑	<input type="checkbox"/>								
9. 黃疸(皮膚泛黃)	<input type="checkbox"/>								
10. 皮膚起水泡或局部紅腫	<input type="checkbox"/>								
11. 身體水腫	<input type="checkbox"/>								
12. 血壓過低(收縮壓低於 100 毫米汞柱，舒張壓低於 60 毫米汞柱)	<input type="checkbox"/>								
13. 心搏徐緩(心跳每分鐘少於 50 下)	<input type="checkbox"/>								
14. 呼吸困難	<input type="checkbox"/>								
15. 發燒(體溫高於 38 度)	<input type="checkbox"/>								
16. 咳嗽	<input type="checkbox"/>								
17. 流鼻水	<input type="checkbox"/>								
18. 喉嚨痛	<input type="checkbox"/>								
19. 抽筋	<input type="checkbox"/>								
20. 嗜睡	<input type="checkbox"/>								

其他，請詳細描述發生的症狀、次數及是否至門診或醫院就診

不良事件之因果判定

服藥以後：

先整體問：如過去一週有何不舒服症狀。

- 「有」，則依該項AE的鑑別診斷往下詢問，問完後再問上週所描述之AE是否消失或持續、減輕或加重。
- 「無」，則再提出上週所描述之AE是否消失或持續、減輕或加重，無AE則不必。

中藥不良反應因果關係評估問卷：腹瀉

Site No : _____ Patient No : _____ Case No : _____ Name : _____ Vist : _____

3-【腹瀉】因果關係評估問卷

※鑑別診斷：如果病人曾因此就診，請翻閱其醫師診斷書。

- 1 *您的排便次數是？
 1天 1-2 次 1天 3-5 次 1天超過 5 次

- 2 *您的排便型態是？(可複選)
 水樣 鬆軟 糊狀
 有血液或血絲 有膿 有粘液
 油膩(呈油脂狀) 有未消化的食物

- 3 *您是否也出現下列症狀？(可複選)
 脹滿感 食慾不振 嘴心
 打嗝 腹痛 排便困難
 心窩不適 灼熱感 嘴吐
 發燒 腸絞痛 腹急後重
 疲倦衰弱 體重減輕 水腫

- 4 *您何時開始覺得腹瀉？____ dd/____ mm/____ yyyy

當您開始感覺腹瀉時，

*距第一次服中藥時間為____ 時/天

*距前一次服中藥時間為____ 時/天

- 5 *您是否因發生腹瀉而停吃中藥？
 否 是，停藥後腹瀉的程度？

加重

持續

減輕或消失，是否再續吃中藥？

否 是，腹瀉的情形是否加重或再發生？

否 是

- 6 *您是否同時使用其它藥物(如：輕瀉劑或減肥藥)？

否 是，藥物為_____

- 7 *您以前是否有類似的腹瀉情形？

否 是，原因為_____

- 8 *您最近是否曾食用可能不潔或過期的食品？

否 是，該食品為_____

- 9 *您是否曾罹患某些疾病(例如：過敏性腸胃徵候群、吸收不良徵候群)？

否 是，該疾病為_____

- 10 *您最近是否情緒劇烈變化或有壓力事件？

否 是，該事件為_____

- 11 *您是否因腹瀉而使用藥物？

否 是，藥名/劑量/途徑/已服用日數_____

藥物來源： 醫師處方

自行買藥

時序性

一致性

LAI JN, CHEN HJ, CHEN CC, LIN JH, HWANG JS, WANG JD, DUHUO JISHENG TANG FOR TREATING OSTEOARTHRITIS OF THE KNEE: A PROSPECTIVE CLINICAL OBSERVATION, CHIN MED, 2007 ;2:4.

Chinese Medicine



Research

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Duhuo Jisheng Tang for treating osteoarthritis of the knee: a prospective clinical observation

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31

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RESEARCH

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Is *Duhuo Jisheng Tang* containing *Xixin* safe? A four-week safety study

Shu-Ching Hsieh^{1,2}, Jung-Nien Lai^{3,4}, Pau-Chung Chen², Chao-Chung Chen⁵, Huey-Jen Chen⁶, Jung-Der Wang^{2,7,8*}

Abstract

Background: Though the nephrotoxicity and carcinogenicity of aristolochic acid (AA) are known, its safety in clinical usage is not clear. This study aims to evaluate the safety of *Duhuo Jisheng Tang* (DJT) in a four-week study to treat osteoarthritis (OA) of the knee.

Methods: A qualitative and quantitative investigations on DJT were conducted. A list of adverse events (AEs), complete blood counts, and liver and kidney function tests were measured for participants with knee OA at their scheduled hospital visits. Each detected AEs was independently assessed for severity and causality by site investigators (Chinese medical doctors) and study nurses.

Results: A total of 71 eligible subjects were included in the clinical study where 287 AEs were reported. DJT did not contain detectable aristolochic acid (AA) under thin-layer chromatography (TLC) analysis and gas chromatography coupled with mass spectrometry (GC-MS). There were no significant changes in liver or kidney functions.

32

Conclusion: In four-week use of DJT no renal tubular damage, no severe incidences of AEs and adverse drug

獨活寄生湯：風寒濕痺、腰膝冷痛、屈伸不利 高血壓及孕婦慎服

[適應症]

- 膝退化性關節炎（僵硬、疼痛）

[用法、用量]

口服

- [劑量]
- 建議劑量為每天二次，每次2.5公克
- [用法]

可能需要持續治療2週以上

- [副作用]
- 可能發生輕微的潮熱
- [注意]

- 腰膝痠軟、畏惡風寒四週治療尚未見改善成效



Open Access

Research

BMJ Open Non-aristolochic acid prescribed Chinese herbal medicines and the risk of mortality in patients with chronic kidney disease: results from a population-based follow-up study

Chuan Fa Hsieh,^{1,2} Song Lih Huang,³ Chien Lung Chen,⁴ Wei Ta Chen,⁵ Huan Cheng Chang,^{4,6} Chen Chang Yang^{1,7}

ABSTRACT

Objectives: To evaluate the relationship between the use of non-aristolochic acid (AA) prescribed Chinese herbal medicines (CHMs) and the risk of mortality in patients with chronic kidney disease (CKD).

Design: Nationwide population-based follow-up study.

Setting: Longitudinal health insurance database sampled from the Taiwan National Health Insurance Research Database.

Participants: A total of 47 876 patients with CKD were identified. Participants who had ever used AA-containing CHMs, had cancer or HIV prior to the diagnosis of CKD, died within the first month of CKD diagnosis and who were not Taiwanese citizens were excluded. A total of 13 864 participants were eligible for final analysis.

Primary and secondary outcome measures: All-cause mortality among patients with CKD between 2000 and 2008.

Results: After controlling for potential confounders, we found that participants who started to receive non-AA prescribed CHMs after the diagnosis of CKD had a lower risk of mortality as compared with non-users of non-AA prescribed CHMs (adjusted HR (aHR) 0.6; 95% CI 0.4 to 0.7, $p<0.001$). Moreover, participants who had used non-AA prescribed CHMs prior to and after the diagnosis of CKD also had a lower risk of mortality than non-users (aHR 0.6; 95% CI 0.5 to 0.8, $p<0.001$). In subgroup analyses, we found that such an inverse association was present only among patients who were not eligible to receive erythropoietin therapy (ie, serum creatinine ≤ 6 mg/dL and/or haematocrit value $\geq 28\%$).

Conclusions: Patients who received non-AA prescribed CHMs after the diagnosis of CKD, yet before the start of erythropoietin therapy had a lower risk of mortality than those who did not.



Concurrent Use of Conventional Drugs with Chinese Herbal Products in Taiwan: A Population-based Study

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Table 4. Top five co-prescribed Chinese herbal products and conventional drugs, by case and co-prescription frequency, 2007

Drug-CHP	Total no. of cases (%)	Total no. of co-prescriptions (%)	Average no. of co-prescriptions per person
Total	120,729 (100)	845,103 (100)	7.0
Acetaminophen*	34,217 (28.3)	123,307 (4.1)	3.6
SH: <i>Corydalis Rhizoma</i>	7289 (6)	10,426 (0.3)	1.4
HF: <i>Supplemented Free Wanderer Powder</i>	6948 (5.8)	10,754 (0.4)	1.5
Diclofenac*	13,045 (10.8)	85,363 (2.8)	6.5
SH: <i>Salviae Miltiorrhiza Radix</i>	5706 (4.7)	9342 (0.3)	1.6
HF: <i>Channel-Coursing Blood-Quickening Decoction</i>	6033 (5)	8782 (0.3)	1.5
Dextromethorphan†	13,927 (11.5)	67,778 (2.3)	4.9
SH: <i>Fritillariae Bulbus</i>	6323 (5.2)	8924 (0.3)	1.4
HF: <i>Pueraria Decoction</i>	5683 (4.7)	7546 (0.3)	1.3
Ambroxol†	8202 (6.8)	67,641 (2.3)	8.2
SH: <i>Puerariae Radix</i>	6573 (5.4)	8707 (0.3)	1.3
HF: <i>Ephedra, Apricot Kernel, Licorice, and Gypsum Decoction</i>	6009 (5)	7399 (0.2)	1.2
Ibuprofen*	8396 (7)	54,572 (1.8)	6.5
SH: <i>Glycyrrhizae Radix (Gan cao)</i>	5638 (4.7)	8316 (0.3)	1.5
HF: <i>Pinellia Heart-Draining Decoction</i>	4821 (4)	7184 (0.2)	1.5

*An analgesic (also known as a painkiller) is any member of the group of drugs used to relieve pain. †A cough medicine is a medicinal drug used in an attempt to treat coughing and related conditions

藥物類別	西藥項目	與西藥項目最常併用 之中藥複方	最常併用之 中藥單方
抗感染消 炎止痛疾 病用藥	NSAIDS: ACETYL SALICYLIC ACID (ASPIRIN)、 IBUPROFEN、DICLOFENAC、NAPROXEN、 KETOPROFEN	疏經活血湯、芍藥甘草湯、 葛根湯、加味逍遙散、獨活 寄生湯、麻杏甘石湯	延胡索、丹參、 桔梗、黃芩、貝 母
神經系統 疾病用藥	DEPRENYL、GALANTAMINE、DONEPEZIL、 MEMANTINE、RIVASTIGMINE	酸棗仁湯、半夏瀉心湯、川芎 茶調散、平胃散、天王補心丹	酸棗仁、夜交藤、 大黃、厚朴
身心科疾 病用藥	CHLORDIAZEPOXIDE、CLONAZEPAM、 DIAZEPAM、LORAZEPAM、OXAZEPAM、 FLUNITRAZEPAM、NITRAZEPAM、 ZOPICLONE、ZALEPLON、ZOLIPIDEM、 ALLOBARBITAL、AMOBARBITAL、 APROBARBITAL、BARBITAL、 BRALLOBARBITAL、PENTOBARBITAL、 PHENOBARBITAL、ALPRAZOLAM； ESTAZOLAM、FLUDIAZEPAM	柴胡加龍骨牡蠣湯、血府逐 瘀湯	麥門冬、砂仁、 黃耆、牛膝、石 菖蒲、杜仲、遠 志

第二節 腎毒性藥物

一、非類固醇抗發炎藥物

建議強度	建議內容	證據等級	文獻編號
A	年老、血中白蛋白不足或原先腎功能不全的病人使用非類固醇抗發炎藥物，會 <u>增加急性腎衰竭機率</u> ，宜謹慎使用並減少劑量、縮短使用時間。	2++	63,65,74
A	儘可能不要長期合併使用非類固醇抗發炎藥物及利尿劑。	2+	64
A	對於有腎前氮血症病人如需使用非類固醇抗發炎藥物，選擇 Coxibs 腎功能惡化情況會較為緩和。	2+	66-67
A	使用非類固醇抗發炎藥物，尤其是 Coxibs，原本高血壓病人 <u>血壓控制會更加不良</u> ，或需增加降壓藥物劑量。	2+ 2++	68 69,71
B	充血性心臟衰竭病人使用非類固醇抗發炎藥物，會 <u>惡化其心臟症狀</u> ，故宜謹慎。	1-	75

消炎止痛用藥-NSAIDS合併中藥與洗腎發生風險之相關性-1

- **加味逍遙散**、**葛根湯**這些中藥處方對於腎臟功能的潛在保護作用，值得進一步研究其保護腎臟功能的機轉。
- **疏經活血湯**與**血府逐瘀湯**在中醫的分類裡面都是活血化瘀的處方，這似乎也提示了中醫運用促進血液循環的處方，能夠直接或間接的改善或減緩腎臟損傷。

消炎止痛用藥-NSAIDS合併中藥與洗腎發生風險之相關性-2

- 平胃散、香砂六君子湯、大黃、丹參在全人口檔呈現顯著的上升洗腎風險。
- 用合併使用有無分層分析及累積香砂六君子湯服用劑量分層分析的各種做法都呈現，NSAIDs合併服用香砂六君子湯並沒有增加洗腎的風險；

NSAIDs合併中藥並沒有導致
增加洗腎風險的交互作用

疾病介紹與疾病治療策略

中醫

屬「不得臥」、「不得眠」、「不寐」等範疇。主要是思慮勞倦太過或受驚恐，亦有久病、年邁體虛所致。主要是由於氣血、陰陽失和，臟腑功能失調以致不得安寐。

治療

- 心火熾盛：可見不寐，心煩不安，口乾舌燥，小便少顏色深。治法以清瀉心火，安神寧心為主，可用導赤散加減。
- 肝鬱化火：症見急躁易怒，頭暈頭脹，口苦，可能伴隨目赤耳鳴，便秘，小便顏色深。治療以清肝瀉火鎮心安神，可選用龍膽瀉肝湯。
- 痰熱內擾：可見胸悶心煩，噯氣，伴隨頭重目眩等症狀。治法以化痰清熱，和中安神為依據，可用溫膽湯加減。
- 胃氣失和：症狀有腹部不適脹滿，胸悶，噯氣，大便排不乾淨。治療以和胃健脾為主，方劑可用半夏秫米湯隨症加減。
- 陰虛火旺：可見心悸心煩，腰痠足軟，伴隨頭暈耳鳴，健忘遺精等症狀。治療上以滋陰降火交通心腎為方向，可用六味地黃丸合黃連阿膠湯作加減。
- 心脾兩虛：症狀有睡覺多夢且易醒，心悸，健忘，精神差且飲食少。治療以補益心脾養心安神，方劑用歸脾湯加減。

失眠

目前治療失眠的藥物主要有兩大類，苯二氮平類(Benzodiazepines, BZDs)藥物及新型的非苯二氮平類(non-BZD)安眠藥物，如：Zolpidem、Zopiclone、Zaleplon等，醫師可依照患者病情選擇使用。

- 專一性的助眠劑：
 - 苯二氮平(BZD)：最常使用的藥物：酣樂欣(Halcion)、樂得眠(Loramet)、悠樂丁(Eurodin)。長效或中效的苯二氮平，易引起白天嗜睡，使用短效或中效藥品後，可能會有反彈性失眠。但使用藥物最低有效劑量或逐漸停藥後可以減輕此症狀。
 - 非苯二氮平藥(non-BZD)：較新的藥物，藥效溫和，安全性較高。常用藥物：使蒂諾斯(Stilnox)、宜眠安(Imovane)。此類藥物較不影響睡眠結構，保有睡眠品質，不會有隔日思睡的副作用。
- 其他處方藥：抗組織胺、抗憂鬱劑、抗焦慮劑
 - 對於憂鬱導致的失眠，可使用鎮靜性抗鬱劑，如：Trazodone、Mirtazapine、Amitriptyline。
 - 抗組織胺。如Diphenhydramin是常使用來幫助睡眠的非處方藥。
 - 其他替代療法方面，退黑激素(Melatonin)是生理時鐘的指標，與生物節律同步而行，它也是促進睡眠與環境之光暗週期同步化之荷爾蒙。

西醫臨床常用於治療睡眠障礙之藥物種類

作用分類	學名	商品名	常見副作用
非BZD (Benzodiazepine) 類助眠藥	Zolpidem Zolpiclone	Stilnox Imovane	暈眩、頭痛、嗜睡、 夢遊、腹瀉、噁心、 疲累
BZD (Benzodiazepine) 類助眠藥	Estazolam Flurazepam Lorazepam Diazepam Alprazolam	Eurodin Dalmadorm Ativan Dupin Xanax	暈眩、頭痛、嗜睡
褪黑激素	Melatonin		
抗組織胺	Diphenhydramine	Venan	暈眩、頭痛、嗜睡、 口乾
抗憂鬱劑	Amitriptyline	Laroxyl	便祕、口乾、頭痛、 暈眩、視覺模糊、肝 功能異常、心律不整
	Trazodone	Mesyrel	便祕、噁心、口乾、 視覺模糊、疲累、心 律不整
	Mirtazapine	Remeron	食慾上升、體重增 加、肝功能異常、口 乾、嗜睡

失眠

臨床常用中藥方與西藥

- 安神劑：酸棗仁湯、天王補心丹、柴胡加龍骨牡蠣湯、甘麥大棗湯、歸脾湯
- 和解劑：加味逍遙散
- 祛痰劑：溫膽湯
- 清熱劑：龍膽瀉肝湯
- 補益劑：知柏地黃丸、六味地黃丸

依據全民健保資料庫檢索中醫臨床常用於治療失眠之方劑

排名	方劑名稱	排名	方劑名稱
1	酸棗仁湯	6	溫膽湯
2	加味逍遙散	7	歸脾湯
3	天王補心丹	8	龍膽瀉肝湯(丸)
4	柴胡加龍骨牡蠣湯	9	知柏地黃丸
5	甘麥大棗湯(甘草小麥大棗湯)	10	六味地黃丸

失眠

牡蠣



- **功用：**平肝潛陽，軟堅散結，收斂固澀。
- **主治：**肝陽上亢，肝脾腫大遺精，滑泄，崩漏，帶下，胃酸過多之胃痛泛酸。
- **性味：**味鹹，性微寒。

中西藥交互作用

西藥種類	西藥學名	實驗種類	可能交互作用機轉	可能交互作用結果	建議處理方式	參考文獻
抗生素	Tetracycline		易與Ca、Mg、Fe結合，難以吸收。	西藥療效降低	隔開服用	[1]
抗結核病	Rifinah (RIF+INH)		易與Ca、Mg、Fe結合，難以吸收。	西藥療效降低	隔開服用	[2]
	Rifater (RIF+INH+PZA)					
	Rifinah					
	Isoniazid					
抗生素	Gentamycin		中藥含鈣離子，會降低西藥和血漿蛋白結合。	西藥Free type增加，濃度及耳腎毒性增加	隔開服用	[3]

Original Article

Increased Risk of Hospitalization Related to Motor Vehicle Accidents Among People Taking Zolpidem: A Case–Crossover Study

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ABSTRACT

Background: Several epidemiological and experimental studies have found a positive association between the risk of motor vehicle accidents (MVAs) and use of zopiclone and benzodiazepines. There is, however, little evidence of any risk of MVA attributable to the use of zolpidem 1 day before such accidents. We attempted to determine whether the use of zolpidem 1 day before is associated with an increased risk of an MVA.

Methods: Using a 1-million-person randomly sampled cohort from the Taiwan National Health Insurance

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Quality of life and climacteric complaints amongst women seeking medical advice in Taiwan: assessment using the WHOQOL-BREF questionnaire

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Key words: CLIMACTERIC, QUALITY OF LIFE, WHOQOL-BREF, INSOMNIA, EMOTIONAL DISTURBANCE, DETERMINANTS, SEEKING MEDICAL ADVICE

ABSTRACT

Table 3 Regression coefficients (Coeff) and standard errors (SE) of most frequent complaints, adjusted for age, marriage, religion and education

Variable definitions	WHOQOL Domain											
	Physical		Psychological		Social		Environmental		Over all QOL (WHOQOL Q1)		General health (WHOQOL Q2)	
	Coeff	SE	Coeff	SE	Coeff	SE	Coeff	SE	Coeff	SE	Coeff	SE
Hot flushes (yes/no)	-0.08	0.37	0.10	0.36	0.18	0.40	-0.23	0.33	-0.03	0.12	-0.08	0.37
Night sweating (yes/no)	0.33	0.36	0.27	0.35	0.11	0.38	0.23	0.32	0.01	0.12	0.33	0.36
Emotional disturbance (yes/no)	-0.24	0.40	-0.62	0.39	-0.11	0.43	-0.05	0.36	-0.34	0.13*	-0.24	0.40
Arthralgia and bone soreness (yes/no)	0.41	0.49	0.07	0.48	0.20	0.53	0.07	0.44	0.00	0.16	0.41	0.49
Insomnia (yes/no)	-0.98	0.33**	-0.76	0.32*	-0.72	0.35*	-0.69	0.29*	-0.08	0.11	-0.98	0.33**
Palpitations (yes/no)	0.01	0.35	0.23	0.34	0.16	0.38	0.33	0.32	0.30	0.11*	0.01	0.35
Headaches (yes/no)	-0.58	0.42	-0.45	0.42	0.04	0.45	-0.41	0.38	-0.07	0.14	0.05	0.15
Numbness of extremities (yes/no)	-0.59	0.67	-0.43	0.68	-0.61	0.73	-0.31	0.62	0.36	0.23	-0.15	0.24
Poor memory (yes/no)	0.26	0.32	0.08	0.32	0.24	0.35	0.25	0.30	0.02	0.11	-0.06	0.11
Frequent urination (yes/no)	-0.76	0.42	-0.17	0.42	-0.05	0.45	-0.49	0.38	-0.11	0.14	0.09	0.15
Reduced libido (yes/no)	0.23	0.33	0.10	0.33	-0.63	0.36	0.08	0.31	0.10	0.11	0.00	0.12
Dry eyes (yes/no)	-0.07	0.37	0.01	0.37	0.23	0.40	0.46	0.34	0.03	0.12	0.02	0.13
Tinnitus (yes/no)	-0.47	0.33	-0.41	0.33	-0.41	0.36	-0.51	0.30	-0.14	0.11	-0.06	0.12
Abdominal fullness (yes/no)	-0.50	0.34	-0.46	0.34	-0.43	0.36	-0.28	0.31	-0.08	0.11	-0.24	0.12*
Dry mouth (yes/no)	0.00	0.35	-0.36	0.35	-0.20	0.38	-0.12	0.33	0.26	0.12*	0.01	0.12
Cold feeling of extremities (yes/no)	-0.75	0.37*	0.05	0.36	-0.02	0.40	-0.30	0.33	-0.23	0.12	-0.75	0.37*
Dropsey (edema) of face or body (yes/no)	-0.41	0.46	-0.68	0.45	-0.12	0.49	-0.20	0.41	-0.11	0.15	-0.41	0.46
Listlessness (yes/no)	-0.82	0.56	-1.07	0.54	0.30	0.59	-0.71	0.50	0.01	0.18	-0.82	0.56
Bitter sensation in mouth (yes/no)	0.25	0.38	0.43	0.37	0.36	0.40	0.07	0.34	-0.12	0.12	0.25	0.38
Anorexia (yes/no)	0.79	0.63	0.94	0.62	-0.57	0.68	1.15	0.57*	0.20	0.21	0.79	0.63
Tightness or pain in chest (yes/no)	-0.62	0.36	-0.85	0.35*	-0.82	0.39*	-0.82	0.33*	-0.23	0.12	-0.62	0.36
<i>R</i> ²		0.25		0.24		0.16		0.22		0.24		0.25

*p < 0.05; **p < 0.01; ***p < 0.001

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Original Article

Quality of life and sleep quality amongst climacteric women seeking medical advice in Northern Taiwan

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ABSTRACT

Objective: To investigate the impact of the subjective sleep quality and quantity on health-related quality of life (QOL) amongst women between the ages of 40 and 60 years seeking medical advice (SMA) in Taiwan.

Methods: A total of 1098 climacteric women were drawn from two hospitals and each subject was asked to fill out a World Health Organization quality of life questionnaire. In addition, the Pittsburgh Sleep Quality Index was employed to evaluate the sleep quality and quantity of the climacteric women. Multiple linear regression analysis was first employed to reveal influential demographic factors and sleep parameters related to the QOL outcome variables. Structural equation modeling was then built on the identified important variables to validate the causal relationships between menopausal symptoms, sleep parameters, and QOL.

Results: The mean scores for the physical and environmental domains were significantly lower than those of the premenopausal women, as were the overall quality of life and general health for perimenopausal women. Although usual quantitative sleep parameters did not significantly predict QOL in the climacteric women, after controlling for demographic factors, severity of the menopausal symptom, and menopausal status, subjective sleep quality and daytime dysfunction were found to be major determinants of the scores in different QOL domains.

The prescribing of Chinese herbal products in Taiwan: a cross-sectional analysis of the national health insurance reimbursement database[†]

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Table 3. Most commonly prescribed Chinese herbal products, by most common diagnoses (ICD-9 codes) and prescription frequency, 2004

Chinese herbal products	Single herb	Herbal formulae	Most common diagnoses (ICD-9 codes)	Total no. of prescriptions	Prescription fre- quency	
					Total no.	%
Yin Qiao San		✓	Acute Nasopharyngitis (ICD 460)	25 407	4594	18.1
Ma Xing Gan Shi Tang		✓			3460	13.6
Jie geng	✓				3331	13.1
Shin Yi Ching Fey Tang		✓			3128	12.3
Ge Gen Tang		✓			2764	10.9
Jie geng	✓		Symptoms of the chest and respiratory system (ICD 786)	14 826	2137	14.4
Ma Xing Gan Shi Tang		✓			2080	14.0
Bei mu	✓				2052	13.8
Zhi Sou San		✓			1882	12.7
Xing ren	✓				1568	10.6
<u>Suan Zao Ren Tang</u>		✓	General symptoms (ICD 780)	13 951	3672	26.3
<u>Jia Wei Xiao Yao San</u>		✓			2848	20.4
Ye jiao teng	✓				2057	14.7
<u>Tian Wang Bu Xin Dan</u>		✓			1892	13.6
Chai Hu Jia Long Gu Mu Li Tang		✓			1718	12.3
Shin Yi Ching Fey Tang		✓	Allergic Rhinitis (ICD 477)	10 196	2432	23.9
Xiao Qing Long Tang		✓			2092	20.5
Cang Er San		✓			1845	18.1
Shin Yi San		✓			1735	17.0
Chan tui	✓				1372	13.5
Jia Wei Xiao Yao San		✓	Menstruation/other abnormal bleeding disorders from the female genital tract (ICD 626)	9960	2858	28.7
Yi mu cao	✓				1768	17.8
Xiang fu zi	✓				1745	17.5
Dang Gui Shao Yao San		✓			1271	12.8
Gui Zhi Fu Ling Wan		✓			1092	11.0

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Prescription pattern of traditional Chinese medicine for climacteric women in Taiwan

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Key words: TRADITIONAL CHINESE MEDICINE, TAIWAN, CLIMACTERIC

ABSTRACT

Background Traditional Chinese medicine (TCM) has become more popular as a therapy for symptom relief among menopause-aged women. The aim of this study was to analyze the utilization of TCM for climacteric women in Taiwan.

Methods The study analyzed frequency distributions among 19 379 women aged

Table 3 The three most common herbal formulae prescribed by traditional Chinese medicine doctors for each of the five most common disease categories in women around climacteric age

<i>Disease category</i>	<i>Number of prescriptions (%)</i>
<i>Symptoms, signs and ill-defined conditions</i>	28 154 (21.5%)
<u>Jia-wei-xiao-yao-san</u>	3 426 (12.2%)
Chuan-qiong-cha-diao-san	3 149 (11.2%)
<u>Suan-zao-ren-tang</u>	2 850 (10.1%)
<i>Diseases of the respiratory system</i>	28 061 (21.4%)
Yin-qiao-san	3 861 (13.8%)
Chuan-qiong-cha-diao-san	3 283 (11.7%)
Ma-xing-gan-shi-tang	3 040 (10.8%)
<i>Diseases of musculoskeletal system and connective tissue</i>	19 339 (14.8%)
Shu-jing-huo-xie-tang	5 854 (30.3%)
Du-huo-ji-sheng-tang	3 831 (19.8%)
Shao-yao-gan-cao-tang	2 467 (12.8%)
<i>Diseases of the digestive system</i>	16 986 (13.0%)
Ban-xia-xie-xin-tang	2 851 (16.8%)
Ping-wei-san	2 619 (15.4%)
Xiang-sha-liu-jun-zi-tang	1 629 (9.6%)
<i>Diseases of the genitourinary system</i>	14 078 (10.8%)
Jia-wei-xiao-yao-san	3 604 (25.6%)
Dang-gui-shao-yao-san	1 204 (8.6%)
Long-dan-xie-gan-tang	1 008 (7.2%)
Total	106 618 (81.5%)

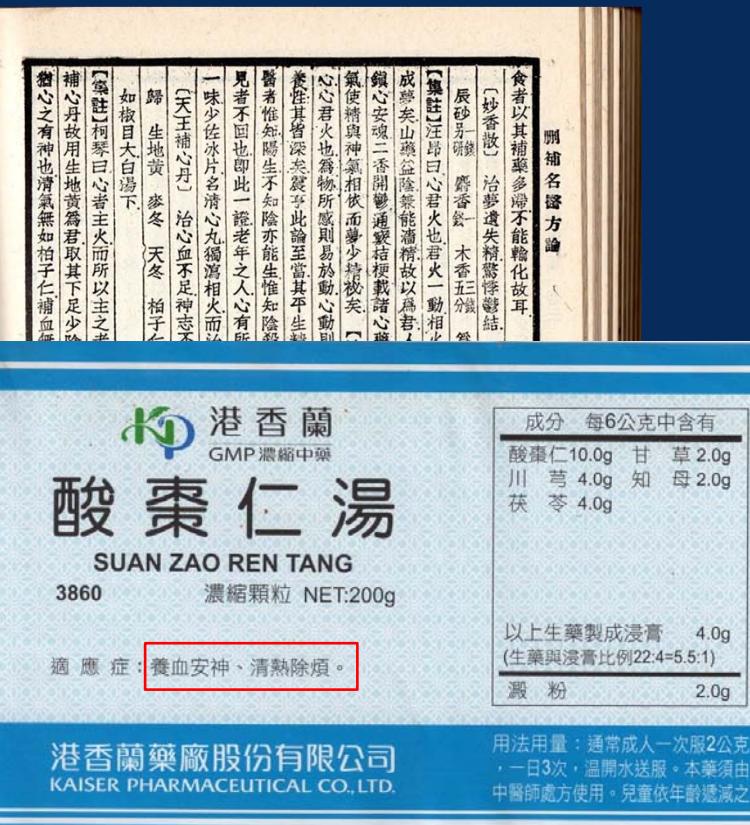
酸棗仁湯治失眠，川芎知草茯苓煎，
養血除煩清虛熱，安然入睡夢鄉甜。

湯頭歌訣

酸棗為君先煮湯，
川芎知草茯苓煎，
養血除煩清虛熱，
安然入睡夢鄉甜。

金匱要略

210 A.D.



以清氣分之火，心氣和而神自歸矣。當歸之甘，以補心血，丹參之寒，以生心血，玄參之鹹，以清血中之火，血足而神自藏矣。更加桔梗爲舟楫，遠志爲向導，和諸藥，入心而安神，明以此養生，則百體從令，何有健忘怔忡，津液乾涸，舌生瘡，大便不利之虞哉。

【酸棗仁湯】 治虛勞，虛煩不得眠。 酸棗仁升一甘草一知母二白茯苓二川芎二以上五味以水八升，煮棗仁得六升，內藥煮取三分，分溫三服。

【集註】 稱讚輔曰：經云肝藏魂，人臥則血歸於肝，又曰肝者藏火之本，又曰陽氣若煩勞則張，躁極必傷肝，煩勞則精絕，肝傷精絕，則虛勞煩不得臥矣。棗仁酸平，處少陽木化而治肝，極者宜收宜補，用酸棗仁至二升，以生心血，養肝血，所謂以酸收之，以酸補之是也。顧肝鬱欲散，散以川芎之辛散，使輔棗仁通肝，調榮，又所謂以辛補之也。肝急欲緩，緩以甘草之甘緩，使防川芎疏泄過急，此所謂以土養之也。然終恐勞極則火發，散陰陽，旺陽分不行於陰，而仍不得眠，故佐知母，恐陰水以平陰，將水壯而魂自寧，火清而神自靜矣。此治虛勞，肝極之神方也。

【硃砂安神丸】 治心神皆亂，驚悸怔忡，寤寐不安。 硫砂研黃連各半，當歸錢生地黃錢三，甘草錢一。 以上爲細末，酒泡蒸，餅丸，如橘子大。 硫砂具光明之體，色赤，通心，重能鎮怯，安神，抑火之浮遊，以養上焦之元氣，爲安神之第一品。 心若熱，配黃連之苦寒，清心熱也。 更佐甘草，能勝熱，甘以生津，抑陰火之浮遊，以養心之主。 心火用當歸之甘溫，歸心血也。 更佐地黃之寒，以補之心血，足則肝得所藏，而魂自安，心熱解則肺得其職，而魄自寧也。

流傳千年並非代表無副作用

Table 3. Probable adverse drug reactions detected by the panel of investigators (Chinese medical doctors) and study nurses

Cases adjudged by the panel to be probable ADRs	No. of cases	Risk per 10 ³ person-days ^a	Risk per 10 ³ person-sachets ^a
Digestive system			
Abdominal distention	7	4.2	1.4
Diarrhea	6	3.6	1.2
Abdominal pain	3	1.8	0.6
Nausea	2	1.2	0.4
Hyperacidity	2	1.2	0.4
Body as a whole			
Headache	3	1.8	0.6
Dizziness	3	1.8	0.6
Respiratory system			
Cough	5	3.0	1.0
Sore throat	3	1.8	0.6
Rhinorrhea	3	1.8	0.6
Cardiovascular system			
Varicosity	2	1.2	0.4
Metabolic and nutritional disorders			
Edema	2	1.2	0.4

Notes:

^aThe number of cases was used as the numerator for the calculation of the risk. The denominators for the calculation of the risks were 1,691 person-days and 5,122 person-sachets.

stomachache
diarrhea
dizziness

Yeh CH, Arnold CK, Chen YH, Lai JN. **Suan zao ren tang as an original treatment for sleep difficulty in climacteric women: a prospective clinical observation.** *Evid Based Complement Alternat Med.* 2011;673813.

TABLE 3: Major variables of the measurements between weeks 1 and 4 and baseline are summarized as mean difference with a 95% confidence interval.

Variable definition	Baseline mean (SD)	Week 1 mean (SD)	Paired T-Test mean difference (95% CI)	Week 4 mean (SD)	Paired T-Test mean difference (95% CI)
Pittsburg sleep quality index	13.0 (2.9)	11.0 (3.4)	(-2.86, -1.26)***	9.0 (3.2)	(-4.93, -3.10)***
Subjective sleep quality	2.4 (0.5)	1.9 (0.6)	(-0.62, -0.27)***	1.5 (0.7)	(-1.10, -0.69)***
Sleep latency	2.4 (0.8)	2.1 (0.9)	(-0.44, -0.04)*	1.8 (1.0)	(-0.86, -0.36)***
Sleep duration	2.4 (0.8)	2.1 (0.8)	(-0.44, -0.07)**	1.8 (0.8)	(-0.77, -0.36)***
Habitual sleep efficiency	1.8 (1.1)	1.4 (1.1)	(-0.67, -0.16)**	1.1 (1.1)	(-1.04, -0.49)***
Sleep disturbances	1.6 (0.6)	1.6 (1.3)	(-0.27, 0.39)	1.4 (0.6)	(-0.39, -0.03)*
Daytime dysfunction	1.5 (1.0)	1.1 (0.9)	(-0.67, -0.22)***	0.9 (0.8)	(-0.88, -0.34)***
WHOQOL-BREF Scores					
Physiological domain	12.3 (2.0)	13.0 (1.9)	(0.29, 1.05)***	13.5 (2.3)	(0.64, 1.63)***
Psychological domain	11.4 (2.3)	11.7 (2.6)	(0.00, 0.78)	11.9 (2.6)	(0.02, 0.96)*
Social domain	12.9 (2.0)	13.0 (2.1)	(-0.36, 0.48)	12.8 (2.5)	(-0.70, 0.43)
Environment domain	13.5 (2.1)	13.6 (2.2)	(-0.22, 0.42)	13.6 (2.5)	(-0.42, 0.59)
FSH (mIU/mL)	51.2 (26.2)	—	—	51.9 (28.5)	(-4.40, 4.29)
LH (mIU/mL)	29.3 (14.9)	—	—	30.3 (15.9)	(-1.32, 3.31)

Abbreviation: WHOQOL-BREF: the World Health Organization's quality of life instrument—short version; CI: confidence interval; FSH: follicle-stimulating hormone; LH: luteinizing hormone.

* $P < .05$ by paired *t*-test compared with baseline; ** $P < .01$ by paired *t*-test compared with baseline; *** $P < .001$ by paired *t*-test compared with baseline.

Yeh CH, Arnold CK, Chen YH, Lai JN. **Suan zao ren tang as an original treatment for sleep difficulty in climacteric women: a prospective clinical observation.** *Evid Based Complement Alternat Med.* 2011:673813.

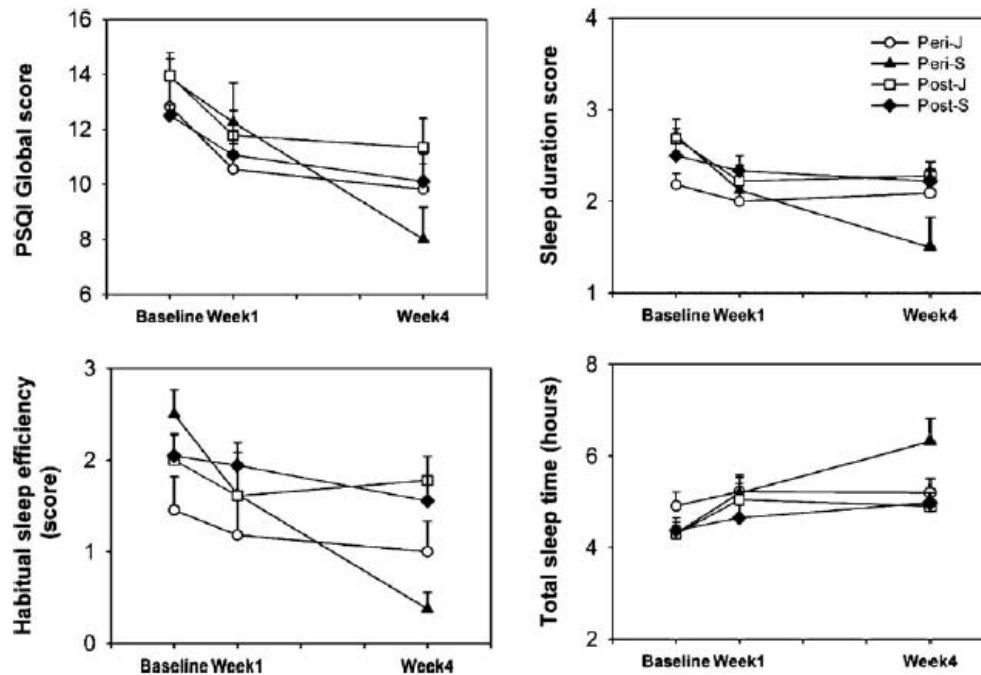


Fig. 2. Changes in Pittsburgh Sleep Quality Index (PSQI) global and selected sleep parameters scores at each visit among post- and perimenopausal women based on intention to treat. Data are expressed as mean \pm SE. Peri-J: perimenopausal women in the JWSYS group (○) ($n = 11$); Peri-S: perimenopausal women in the SZRT group (▲) ($n = 8$); Peri-J: postmenopausal women in the JWSYS group (□) ($n = 19$); Peri-S: postmenopausal women in the SZRT group (◆) ($n = 22$).

Wu HC, Chen YH, Lai JN, Hwang JS, Wang JD. **Improving sleep quality in climacteric women with insomnia: A randomized, head-to-head trial between *Jia-Wei-Shiau-Yau San* (JWSYS) and *Suan-Zao-Ren Tang* (SZRT)**. *Eur J Intern Med*. 2011;3(3):e143-51.

Research Article

Suan Zao Ren Tang as an Original Treatment for Sleep Difficulty in Climacteric Women: A Prospective Clinical Observation

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European Journal of Integrative Medicine 3 (2011) e143–e151

Original article

Improving sleep quality in climacteric women with insomnia: A randomized, head-to-head trial between *Jia-Wei-Shiau-Yau San* (JWSYS) and *Suan-Zao-Ren Tang* (SZRT)

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Abstract

Background: *Jia-Wei-Shiau-Yau San* (JWSYS) was reported to reduce various menopausal-related symptoms, and *Suan-Zao-Ren Tang* (SZRT) is a

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Finished Herbal Product as an Alternative Treatment for Menopausal Symptoms in Climacteric Women

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and JUNG-DER WANG, M.D., Sc.D.⁴

ABSTRACT

Background: There is a paucity of scientific evidence supporting the efficacy of herbal medicines in treating menopausal symptoms.

Objective: The aim of this study was to evaluate safety and efficacy of the finished herbal product TMN-1 in the treatment of menopausal symptoms in climacteric women.

Design and setting: A multicenter, prospective, observational follow-up study was conducted from July 2003 to December 2004 in four hospitals in Taiwan.

Participants: Initially, 126 women were included who were between 45 and 55 years of age, were experiencing hot flashes, and were without hormone replacement therapy. Women were excluded if they had any signs of active cancer. Of the participants, 82% completed the study. The reasons for withdrawal included adverse effects ($n = 7$), failed to return ($n = 7$), lack of efficacy ($n = 6$), and from protocol deviation ($n = 3$).

Intervention: Every participant received TMN-1 treatment 4 g, 3 times per day, for 12 weeks.

Main outcome measure: Primary measures were change in frequency of hot flashes and severity of



Integrating traditional Chinese medicine healthcare into dementia care plan by reducing the need for special nursing care and medical expenses

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Table 3

Adjust hazard ratio (aHR) with 95% confidence interval (CI) of the different advanced nursing care.

Variables	TCM group 4094 (100%)		Non-TCM group 5344 (100%)		aHR (95% CI)	
	Number (%)	Average occurrence time, (year)*	Number (%)	Average occurrence time, (year)*	aHR	95% CI
Endotracheal Tube care	99 (2.4%)	7.4	248 (4.6%)	6.2	0.72	0.58–0.86
Urinal indwelling	1260 (30.8%)	6.3	2038 (38.1%)	5.6	0.62	0.51–0.73
Catheterization Care						
Nasogastric tube Care	953 (23.3%)	5.8	1906 (35.7%)	4.9	0.58	0.49–0.66

* We defined the average occurrence time was the duration from the 1st dementia diagnosis to the 1st application of advanced nursing treatment.

aHR = Adjust Hazard Ratio, CI = confidence interval, TCM = traditional Chinese medicine.

Table 4**Hospital cost grouped according to different duration of traditional Chinese medicine (TCM).**

TCM use	Cumulative hospital cost (USD)	Average hospital cost (USD)	Standard deviation	P-value of <i>t</i> test	P-value of ANOVA test
TCM non-TCM users	44,937,157	8419.93	18216.96	[Reference]	[Reference]
TCM users	30,894,887	7546.38	15472.56	<i>P</i> =.015	<i>P</i> <.001
< 100 Days	12,093,291	7342.62	13932.03	–	
100–199 Days	8,440,075	7423.11	16368.90	–	
≥200 Days	10,387,127	7886.96	16455.60	–	

TCM=traditional Chinese medicine.

Table 5**The length of hospital stay grouped according to different duration of traditional Chinese medicine (TCM).**

TCM use	Cumulative hospital days	Average hospital days	Standard deviation	P-value of <i>t</i> test	P-value of ANOVA test
TCM non-TCM users	267,775	50.17	120.09	[Reference]	[Reference]
TCM users	184,010	44.95	115.86	<i>P</i> =.035	<i>P</i> <.001
< 100 Days	72,725	44.16	102.08	–	
100–199 Days	48,087	42.29	106.63	–	
≥200 Days	63,350	48.10	137.47	–	

TCM=traditional Chinese medicine.

Traditional Chinese medicine therapy decreases the pneumonia risk in patients with dementia

Shun-Ku Lin, MD^a, Yueh-Ting Tsai, MD, PhD^b, Pei-Chia Lo, MD^b, Jung-Nien Lai, MD, PhD^{c,d,*}

Abstract

Pneumonia is a frequent complication in dementia patients and is associated with high mortality rates. The aim of this retrospective cohort study was to determine whether traditional Chinese medicine (TCM) therapy can decrease pneumonia risk in dementia patients. The cohort dataset was obtained from the Longitudinal Health Insurance Database 2005, a sublibrary of the National Health Insurance Research Database, containing all medical data of 1 million beneficiaries, randomly selected from the all Insurers in year 2005.

Newly diagnosed dementia patients ($n=9712$) without pneumonia were analyzed from January 1997 to December 2003. After matching by sex, age, urban level, Charlson comorbidity index, insured amount, and comorbidities, 1376 pairs (1:1) of TCM and non-TCM users were acquired. Every dementia patient was individually recorded from 1997 to 2012 to identify pneumonia incidence (onset after 3 months of dementia diagnosis).

Demographic characteristics, Charlson comorbidity index, comorbidities, behavioral and psychological symptoms of dementia, and psychotropic drugs were also investigated. Cox proportional regression was used to compute hazard ratios and 95% confidence intervals (CIs) after adjustment for the above-mentioned variables.

There were 419 (30.5%) and 762 (55.4%) pneumonia cases in the TCM and non-TCM cohorts during a mean follow-up period of 7.6 years. The adjusted hazard ratios (95% CI) for pneumonia admission was 0.62 (0.55–0.70) for the TCM group.

Patients who received TCM therapy at higher cumulative doses or for longer periods experienced increased protection from pneumonia admission. Ma-Xing-Gan-Shi-Tang, Yin-Qiao-San, and Xiao-Qing-Long-Tang might represent possible formulae reducing the incidence of pneumonia. TCM might be associated with a lower risk of pneumonia in dementia patients.

Table 2

Multivariable Cox model measured hazard ratios and 95% CIs of TCM for pneumonia in matched cohort.

TCM use	Case number	Pneumonia admission	
		Incidence density (1/years)	Adjusted hazard ratio (95% CI)
Non-TCM user	762	7.4%	Reference
TCM use	419	3.5%	0.62 (0.55–0.70)
TCM use cumulative time		Cochran–Armitage trend test $Z < 0.001$	
<200 days	242	4.7%	0.66 (0.57–0.77)
200–399 days	53	3.5%	0.53 (0.40–0.71)
400 days \leq	124	3.0%	0.47 (0.39–0.58)
TCM use cumulative dose		Cochran–Armitage trend test $Z < 0.05$	
<1000g	175	4.8%	0.68 (0.58–0.81)
1000–1999g	66	4.2%	0.58 (0.45–0.75)
2000g \leq	178	3.2%	0.50 (0.42–0.59)

CI = confidence interval, TCM = traditional Chinese medicine.

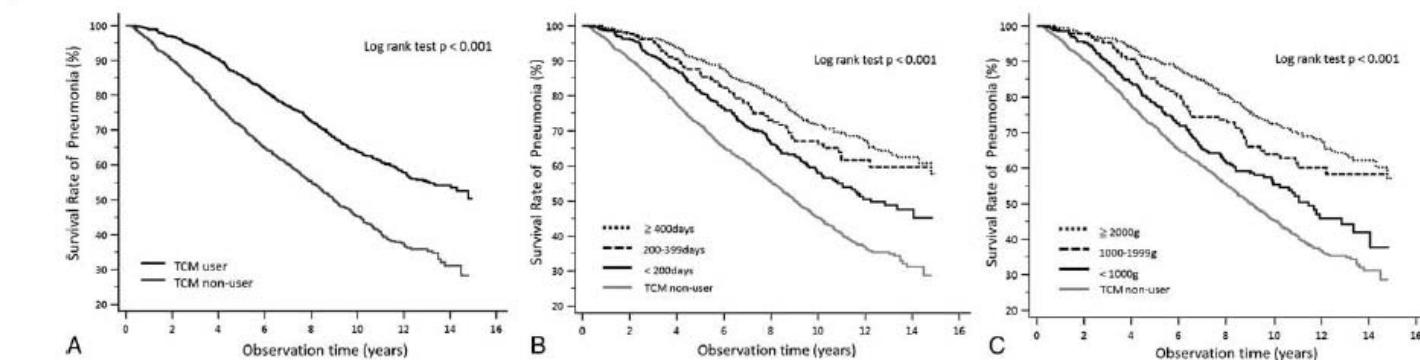


Figure 2. (A) Survival curve of hospitalized pneumonia in patients with dementia. Kaplan–Meier survival curves and log-rank analyses revealed significant differences in the rates of pneumonia admission between traditional Chinese medicine (TCM) and non-TCM users (log-rank test, $P < 0.001$). (B) Survival curve of hospitalized pneumonia in patients with dementia according to traditional Chinese medicine time stratification. TCM usage for <200, 200–399, and ≥ 400 days resulted in significantly reduced rates of pneumonia admission (log-rank test, $P < 0.001$). (C) Survival curve of hospitalized pneumonia in patients with dementia according to traditional Chinese medicine dose stratification. Patients with cumulative doses of <1000g, 1000–1999, and ≥ 2000 g showed significantly reduced rates of pneumonia admission compared to patients without TCM use (log-rank test, $P < 0.001$).

中藥與西藥併用，該間隔多少時間？

許多民眾都會問，中藥與西藥共同使用時須間隔多少時間？這樣的資訊在現代科學論文中，尚無確切的證據，也會隨著藥物種類的不同，而有不同程度的變化，一般在原來西藥用藥的基礎上，可以間隔30分鐘，以減少藥物直接在胃腸道物理反應與作用，若對藥效的改變，則可以間隔兩個小時再輔以中藥治療，以減少藥物藥效間的相互作用。

藥食同源- 可同時供食品原料使用之中藥材

截至目前為止，我方衛生署中醫藥委員會共計公告
215項藥食兩用中藥材

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- ◆ **第二次公告(共9項)**：山藥、牡蠣(殼)、橄欖、麥芽、生薑、蜂蜜、葛苣、昆布、枸杞子
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- ◆ **第四次公告(共21項)**：蓮藕、蓮子、杏脯(果)、柿、黃精、牛蒡(根)、繁縝(鵝腸菜)、木耳、赤小豆(紅豆)、乳汁、芥菜、食鹽、香薷、粟、海藻、雀麥(燕麥)、蔴(小蔴)、蒟蒻、薄荷、蠶豆、鶴鱵(山雞)
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5

食品與藥物間的相互作用

1. 牛奶：

本身含有鈣 會與奎諾酮(Quinolone)類及四環黴素類抗生素結合成不溶性複合體，不容易被身體吸收，因此降低療效。所以有服用以上抗生素時，應避免與牛奶同時服用，時間間隔至少30分鐘至兩小時。

2. 高纖食品：

有服用心血管藥物及高血脂藥物病患要注意，治療心衰竭、心律不整藥物digoxin，如果大量進食含有高纖維之食物，會增加胃腸蠕動，會減低16~32% digoxin的吸收量，可能減少藥物在體內的活性，但digoxin的有效濃度與產生毒性濃度範圍非常接近，一定要在醫師的指示下服用，不可自行調整藥量。

此外 高纖膳食，如：燕麥、穀、果膠等可降低血脂，但是及幾乎所有的降血脂藥(HMG-CoA還原酶抑制劑)，會因為同時攝食高纖食物，而減少胃腸道對藥品的吸收，因此應避免併用，或至少要分開2小時服用。以lovastatin為例，藥物的吸收量會隨著進食而增加50%，導致藥效增加，但會因為與高纖食物併用，明顯減少lovastatin的吸收。

3. 葡萄柚汁：

葡萄柚中的黃酮類(flavonoids)會抑制肝臟CYP3A4酵素，經由該酵素代謝的藥物如降血脂藥lovastatin會蓄積體內造成藥性增加，甚至副作用的產生。過敏藥物terfenadine、抗血栓藥物warfarin、抗黴菌藥品ketoconazole等藥物也會被葡萄柚汁抑制其代謝，產生不良交互作用。心臟病及高血壓患者如果有在服用鈣離子通道阻斷劑，也切記不可在服藥前兩小時及服藥後五小時內飲用，葡萄柚汁會抑制該類藥物的代謝。

4. 乾酪、乳酪、香腸等含有酪胺酸(tyramine)食物：

憂鬱症患者在服用單胺類氧化酵素抑制劑(MAOI)類抗憂鬱藥若同時併用，會引發高血壓。

5. 酒精：

許多藥物之間都可能發生交互作用，嚴重可能致命，應特別加以注意，中樞神經系統抑制劑，如benzodiazepine類鎮靜安眠藥，其鎮靜安眠效果可能因併用酒精而加強。

中藥可跟西藥併服嗎？

全國中西藥交互作用研究計畫主持人

研究結果的確值得關注：荷爾蒙 療法增加臺灣乳癌之發生風險

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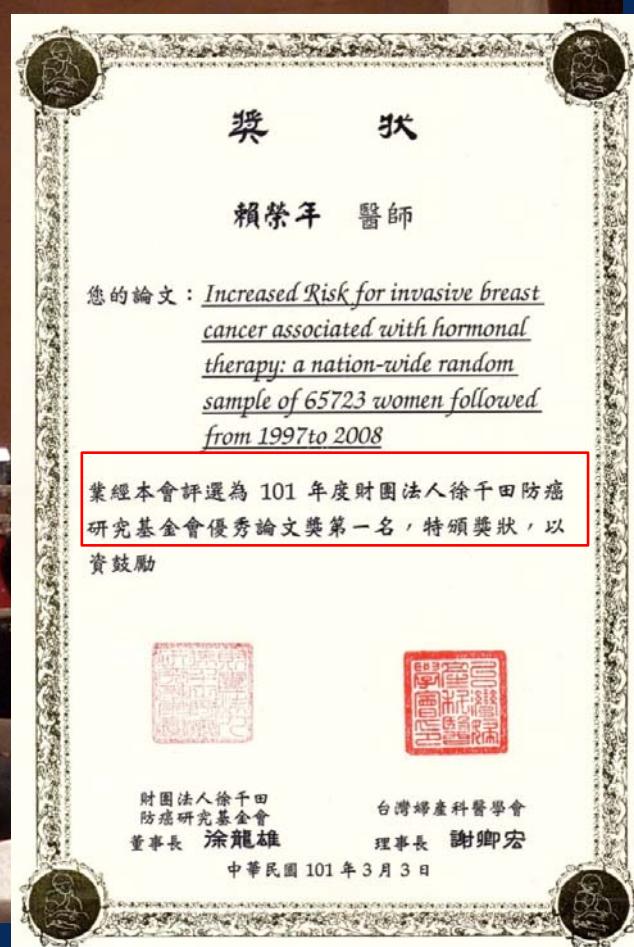
 PLOS one

Increased Risk for Invasive Breast Cancer Associated with Hormonal Therapy: A Nation-Wide Random Sample of 65,723 Women Followed from 1997 to 2008

Jung-Nien Lai^{1,2}, Chien-Tung Wu³, Pau-Chung Chen⁴, Chiun-Sheng Huang^{5,6}, Song-Nan Chow⁷, Jung-Der Wang^{4,8,9*}

Conclusions: 5,156 (20%) women ever used E+P, 2,798 (10.8%) ever used E-alone, and 17,717 (69%) ever used other preparation types. The Cox model revealed adjusted hazard ratios (HRs) of 2.05 (95% CI 1.37–3.07) for current users of E-alone and 8.65 (95% CI 5.45–13.70) for current users of E+P. Using women who had ceased to take hormonal medication for 6 years or more as the reference group, the adjusted HRs were significantly elevated and greater than current users and women who had discontinued hormonal medication for less than 6 years. Current users of either E-alone or E+P have an increased risk for invasive breast cancer in Taiwan, and precautions should be taken when such agents are prescribed.

首屆迎咗安 TAOG 2012 Congress Banquet



TITLE	<p>CONCURRENT USE IN TAIWAN OF CHINESE HERBAL MEDICINE THERAPIES AMONG HORMONE USERS AGED 55 YEARS TO 79 YEARS AND ITS ASSOCIATION WITH BREAST CANCER RISK: A POPULATION-BASED STUDY. (中藥與荷爾蒙西藥併用對於更年期婦女乳癌發生風險的人群研究)</p>
JOURNAL	<p>EVIDENCE-BASED COMPLEMENTARY AND ALTERNATIVE MEDICINE 2014;2014:ID 683570 (SCI)</p>
CONTENT	<p>過去研究發現臺灣婦女服用荷爾蒙療法後，尤其是ESTROGEN PLUS PROGESTERON 製劑，隨著服用荷爾蒙的劑量增加顯著的增加臺灣婦女乳癌的發生風險。基於此發現，本篇進一步研究中西藥併用的乳癌的發生風險，中醫療法併用更年期婦女荷爾蒙療法後，隨著中醫療法劑量介入的增加而顯著的下降乳癌的發生風險。</p>



中西醫併治 夾擊乳癌



CARE

33
中西醫併治
夾擊乳癌

賈愛華 · 賴榮年

大塊文化



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西醫不論是手術或化放療，無一不是在對身體進行「大破」的除惡務盡，
而中醫隨行的整合併治，是對時補給，戰後「大立」的體能重整。
為讓病人能得到更好的治療模式，中西醫應該齊門戶之見，攜手合作。

TITLE	<p>THE USE OF CHINESE HERBAL PRODUCTS AND ITS INFLUENCE ON TAMOXIFEN INDUCED ENDOMETRIAL CANCER RISK AMONG FEMALE BREAST CANCER PATIENTS: A POPULATION-BASED STUDY.</p> <p>(中醫療法對於服用諾瓦得士乳癌婦女子宮內膜癌發生風險的人群研究)</p>
JOURNAL	<p>JOURNAL OF ETHNOPHARMACOLOGY 2014;155:1256-1262 (SCI)</p>
CONTENT	<p>此研究結果顯示對於雌激素受體陽性(ESTROGEN RECEPTOR POSITIVE)的乳癌婦女，其因為預防乳癌復發而服用諾瓦得士的荷爾蒙療法後所衍生之副作用(子宮內膜癌)，得以因為中醫療法隨著劑量介入的增加而顯著的下降。</p>

TITLE	<p>THE PRESCRIPTION PATTERN OF CHINESE HERBAL PRODUCTS THAT CONTAIN DANG-QUI AND RISK OF ENDOMETRIAL CANCER AMONG TAMOXIFEN- TREATED FEMALE BREAST CANCER SURVIVORS IN TAIWAN: A POPULATION-BASED STUDY. (當歸對於服用諾瓦得士乳癌婦女子宮內膜癌發生風險的人群研究)</p>
JOURNAL	PLOS ONE 2014;9(12):E113887
CONTENT	<p>延續先前研究發現，進一步探索含當歸之中藥是否可以調節諾瓦得士此外源性荷爾蒙所引起 (EXOGENOUS HORMONE-INDUCED)的子宮內膜癌副作用，研究發現含當歸之中藥的確隨著服用劑量的增加，對於服用諾瓦得士之乳癌婦女有顯著下降三成九子宮內膜癌的發生風險(HR: 0.61, 95%CI: 0.44-0.84)，這意謂著當歸有可能調節外源性荷爾蒙所引起(EXOGENOUS HORMONE-INDUCED)的副作</p>

TITLE	<p>THE PRESCRIPTION PATTERN OF CHINESE HERBAL PRODUCTS CONTAINING GINSENG AMONG TAMOXIFEN-TREATED FEMALE BREAST CANCER SURVIVORS IN TAIWAN: A POPULATION-BASED STUDY.</p> <p>(人參對於服用諾瓦得士乳癌婦女子宮內膜癌發生風險的人群研究)</p>
JOURNAL	<p>EVIDENCE-BASED COMPLEMENTARY AND ALTERNATIVE MEDICINE</p> <p>2014;ID385204 (SCI)</p>
CONTENT	<p>同樣的想法進一步探索含人參之中藥是否可以調節諾瓦得士此外源性荷爾蒙所引起 (EXOGENOUS HORMONE-INDUCED)的子宮內膜癌副作用，而研究結果顯示含人參之中藥的確隨著服用劑量的增加，對於服用諾瓦得士之乳癌婦女有顯著下降三成二子宮內膜癌的發生風險 (HR:0.68,95%CI: 0.51-0.93)，這意謂著人參也同樣的有可能</p> <p>降低外源性荷爾蒙所引起 (EXOGENOUS HORMONE-INDUCED)的子宮內膜癌副作用</p>

TITLE	<p>PRESCRIPTION PROFILE OF CHINESE HERBAL PRODUCTS CONTAINING COUMESTROL, GENESTEIN, AND/OR DAIDZEIN AMONG FEMALE USERS: AN ANALYSIS OF NATIONAL HEALTH INSURANCE DATA IN TAIWAN BETWEEN 1997 AND 2007.</p> <p>(婦女使用含植物雌激素中藥處方之流行病學研究)</p>
JOURNA L	CHINESE MEDICINE 2012;7(1):22 (SCI)
CONTEN T	<p>除了從含人參、當歸之中藥發現可以調節諾瓦得士此外源性荷爾蒙所引起(EXOGENOUS HORMONE-INDUCED)的子宮內膜癌副作用外，服用含植物性荷爾蒙(PHYTOESTROGEN)之中藥是另一個可能與荷爾蒙相關的切入角度，因此首先先進行含植物性荷爾蒙之中藥於女性族群使用的流行病學研究，研究結果顯示在11年的研究期間74%的婦女就診中醫時會服用到含植物性荷爾蒙之中藥，尤其是中醫師在開立治療感冒相關症狀時，特別高比例會開立到含植物性荷爾蒙之中藥，最常開立的單方為葛根，複方為葛根湯。</p>

TITLE	<p>DETECTION OF A NEGATIVE CORRELATION BETWEEN PRESCRIPTION OF CHINESE HERBAL PRODUCTS CONTAINING COUMESTROL, GENISTEIN OR DAIDZEIN AND RISK OF SUBSEQUENT ENDOMETRIAL CANCER AMONG TAMOXIFEN-TREATED FEMALE BREAST CANCER SURVIVORS IN TAIWAN BETWEEN 1998 AND 2008: A POPULATION-BASED STUDY(諾瓦得士乳癌婦女子 宮內膜癌與使用含中藥雌激素之相關性研究)</p>
JOURNAL	JOURNAL OF ETHNOPHARMACOLOGY 2015; 169: 356-362 (SCI)
CONTENT	延續上一篇研究，本篇為進一步探索含植物性荷爾蒙之 中藥與服用諾瓦得士所引起的子宮內膜癌發生風險的相 關性研究。發現有服用中藥組(累積劑量>180G)與非使用 中藥組，使用中藥組並不會增加乳癌患者服用諾瓦得士 所引起的子宮內膜癌發生率，因此使用中藥組與使用諾

研究發現

82

中藥與荷爾蒙併用
有下降乳癌發生的
趨勢

於是主張

短期使用大劑量荷
爾蒙的婦女

一定要中西醫整合療法

中國醫藥大學中醫衛教資源

序號	中醫婦科-單張名稱	QR Code
1	坐月子產後膳食調理	
2	坐月子中醫處方煮服法指導	
3	服用第一方 生化湯注意事項	
4	骨虛損（骨質疏鬆症）的預防保健	
5	帶下病（白帶）中醫調整注意事項	
6	經痛的預防保健	
7	更年期症候群（經絕）的預防保健	
8	中醫坐月子 產後調理三步驟	
9	改善化瘀引致嘔心嘔吐：藥膳與穴道按壓處置	

CMUH中醫各科衛教單張

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2	→慢性疲勞與頑固性疼痛小針刀療法	
3	→顏面神經麻痺(面麻)的穴位按摩自我保健	
4	→中醫鬱症日常保健	
5	→寒病溫治三九天灸療	
6	→冬病夏治三伏天灸療	
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產科衛教諮詢	復健醫療大樓一樓 產科門診 08:30-12:30 · 13:30-17:30	洪靜琦	4144
婦科衛教諮詢	復健醫療大樓一樓 婦產科門診 08:00-12:00 · 13:00-17:00	張秀慧	4145

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2018/12/24	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.12.13~107.12.19
2018/12/17	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.12.06~107.12.12
2018/12/10	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.11.29~107.12.05
2018/12/10	系統相關	預計2018年12月11日（二），中午12點進行正式樣修改，預計完成時間為13點30分
2018/12/4	來函轉知	「適用罕見疾病防治及藥物法之藥物品項」修正草案，業經本部於107年11月28日衛
		撫院字第107140937號公報告，詳參照。
2018/12/3	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.11.22~107.11.28
2018/11/26	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.11.15~107.11.21
2018/11/19	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.11.08~107.11.14
2018/11/12	疫苗週報	107-108年度季節性流感疫苗不良事件通報摘要報告 107.11.01~107.11.07
2018/10/29	疫苗週報	20181024季節性流感疫苗不良事件通報週報

更多消息...

線上通報

帳號: 密碼: 檢查碼: 登入 清除

忘記密碼 申請帳號 亂數帳號申請

不良反應通報中心連絡方式

	西藥	中草藥
電話	02-23960100	04-22052121#4595
傳真	02-23584100	04-22067573
e-mail	adr@tdrf.org.tw	tcmadr.mohw@gmail.com
100 台北市中正區愛國	404 台中市北區育德路2號	
東路22號10樓	(中醫部辦公室)	



不良
反應

不良反應通報中心連絡方式		
	西藥	中草藥
電話	02-23960100	04-22052121#4595
傳真	02-23584100	04-22067573
e-mail	adr@tdrf.org.tw	tcmadr.mohw@gmail.com
100 台北市中正區愛國	404 台中市北區育德路2號	
東路22號10樓	(中醫部辦公室)	

系統操作問題 : (02)29460356轉801

範例一、63歲女性服藥後胃不適

衛生福利部 中醫藥司		1. 發生日期： 2017/08/02
通報中心接獲通報日期： 2017/12/04		
3. 通報者 姓名： 電話： 地址： 是否為醫療人員 <input type="checkbox"/> 否 <input checked="" type="checkbox"/> 是，職稱： 藥師		
1. 病人基本資料 4. 病人識別代號： (供通報者辨識用) 5. 性別： <input type="checkbox"/> 男 <input checked="" type="checkbox"/> 女 <input type="checkbox"/> 不知 6. 出生日期： 或年齡： 63.0		
II. 不良反應情況/ 產品所致問題 9. <input checked="" type="checkbox"/> 中藥不良反應 <input type="checkbox"/> 不良品 10. 不良事件結果 A. 死亡，日期： ，診斷： B. 危及生命 C. 導致病人住院 D. 造成永久性殘疾 E. 延長病人住院時間 F. 需要處置以防永久性傷害 G. 先天性畸形 H. 其他（請敘述） 胃不舒，胃嘈雜，覺胃冷感，舌乾燥感，舌熱感。 11. 不良反應之描述（請依事件發生日期順序填寫） (應包括發生不良反應之部位、嚴重程度及處置) 不良反應症狀： 胃不舒，胃嘈雜，覺胃冷感，舌乾燥感，舌熱感。 不良反應描述： 1. 7/26回診時主訴：天熱口週稍乾燥，膚紅，晨醒頭稍暈，咽乾，吹風膚稍 2. 服藥約四天後，陸續出現胃不舒服， 3. 8/2提前回診向醫師說明不良反應，醫師新處方將竹葉石膏湯刪除，改用消 4. 8/9病患回診表示服用8/2調整後藥品無不良反應，醫師續用該處方。 5. 8/17藥師電聯病患追蹤，後續無不良反應。 參考文獻：中國期刊全文資料庫 有無他人使用相同藥品，是否發生不良反應？ <input type="checkbox"/> 是 <input type="checkbox"/> 否 <input checked="" type="checkbox"/> 不知道 停藥後不良反應是否減輕？ <input checked="" type="checkbox"/> 是 <input type="checkbox"/> 否 <input type="checkbox"/> 無法得知 再投藥是否發生不良反應？ <input type="checkbox"/> 是 <input type="checkbox"/> 否 <input checked="" type="checkbox"/> 無法得知		

7. 可疑藥品或處方 <input type="checkbox"/> 飲片 <input checked="" type="checkbox"/> 濃縮中藥 <input type="checkbox"/> 中成藥 <input type="checkbox"/> 草藥 <input type="checkbox"/> 其他		IV. 懷疑藥品 藥名/許可證字號 劑型 紿藥途徑 劑量/服用頻率 起迄日期 藥				
		竹葉石膏湯/	濃縮中藥	口服	4.5gm/飯後/一天三次	2017/07/26~2017/08/02
21. 併用產品(請務必填寫起迄日期)		產品名/許可證號	劑型	使用途徑	劑量/服用頻率	起迄日期
		杞菊地黃丸/	濃縮中藥	口服	4.5gm/飯後/一天三次	2017/06/28~2017/09/27
		牡丹皮/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/06/28~2017/09/20
		女貞子/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/06/28~2017/09/20
		刺蒺藜/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/06/28~2017/09/20
		石斛/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/06/28~2017/09/20
		燈心草/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/06/28~2017/08/23
		菊花/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/07/26~2017/09/20
		桑葉/	濃縮中藥	口服	0.9gm/飯後/一天三次	2017/07/26~2017/09/20
13. 其他相關資料 人習慣、家族史		K31.89 胃及十二指腸其他的疾病L30.9 Dermatitis unspecified cause				
III. 疑似引起不良反應的醫療器材						
14. 商品名						
15. 許可證字號						
16. 器材種類						
17a. 製造廠		18. 型號# 序號# 批號# 製造日期： 效期：				
17b. 供應商						

人： 年齡、性別。
診斷、診斷碼。
事： 不良反應描述。
後續處置、是否停藥、停藥症狀是否減輕、是否再服藥。
時： 不良反應發生日期、服藥與持續時間。
地： 用藥時序。
物： 通報機構、醫院或診所等。

中藥不良品等級事件評估

等級	不良事件描述
輕度不良品	顏色異常、大小異常、碎裂/破損/缺損、受潮/潮溼、走油、氣味散失、產品包裝問題(例如：空包、密封不全、 <u>未密封</u> 、數量/容量錯誤、容器破裂、無法開啟等)
中度不良品	結晶析出、油水分離、結塊、膠囊藥粉外漏、炮製與標示不符、發霉、蟲蛀、異物接觸藥品表面(未混入藥品內)、標示不清
重度不良品	非藥用部位過多、 <u>明顯變色</u> 、沉澱或混濁、異物混入藥品內、混誤用中藥材、塗改有效期限、缺批號/效期、無標示/無標籤、成分/品名/含量標示錯誤、農藥殘留超出限量基準、總重金屬超標個別重金屬超標、總灰分過高、黃麴毒素超標、微生物總生菌數超標、大腸桿菌檢出、沙門氏菌檢出、水抽提物不足、稀乙醇提取物不足、指標成分不合規定、二氧化硫超標、馬兜鈴酸檢出、摻和其他藥物

108年94件ADR通報來源分佈

中國醫藥大學附設醫院	65
奇美醫療財團法人奇美醫院	8
基層診所	6
長庚醫療財團法人高雄長庚紀念醫院	4
財團法人彰化基督教醫院	3
長庚醫療財團法人嘉義長庚紀念醫院	2
民眾	2
臺北市立聯合醫院忠孝院區	1
臺南市立安南醫院	1
財團法人天主教聖馬爾定醫院	1
衛生福利部彰化醫院	1
合計	94

108年度教育訓練及宣導(目前已完成場次)

日期	場次別	
8月15日	課程：中藥藥品安全監測及通報教育訓練 地點：桃園長庚紀念醫院。	教育訓練
8月20日	課程：中藥藥品安全監測及通報教育訓練 地點：臺北醫學大學	教育訓練
8月29日	課程：中藥藥品安全監測及通報教育訓練 地點：嘉義 大林慈濟醫院	教育訓練
8月31日	課程:中藥臨床用藥安全研討會(對象:醫院暨社區藥局藥師) 地點:北市聯醫 中醫院區	教育訓練
9月19日	課程：中藥藥品安全監測及通報教育訓練 地點：台北馬偕醫院	教育訓練
9月28日	課程：中藥藥品安全監測及通報教育訓練 地點：社會住宅-在地保健室(豐原區永康路282號1樓)	教育訓練 (民眾)
10月12日	課程：中藥藥品安全監測及通報教育訓練 地點：維他露基金會	教育訓練 (民眾)
10月21日	課程：中藥藥品安全監測及通報教育訓練 地點：中國醫藥大學附設醫院	教育訓練 91

已完成
教育訓練：16場
宣導：4場

THANK YOU FOR YOUR ATTENTION



- 流行性感冒(**influenza**)是由流行性感冒病毒引起的急性呼吸道傳染病。
- 臨床特點是起病急、高熱、乏力、全身痠痛、頭痛和輕度呼吸道症狀，病程短，嬰幼兒、老人和伴有呼吸道或心臟患者容易併發肺炎。

治療

感冒常見症狀如：發燒、頭痛、流鼻水及咳嗽等。因此藥物治療目標主要為緩解症狀，詳列如下。

- 解熱鎮痛劑：代表藥物為：Acetaminophen、Non-Steroid anti-inflammatory drugs(NSAID)。
- 鎮咳祛痰劑：鎮咳劑利用抑制咳嗽中樞達到止咳效果；祛痰劑可運用液化痰液或加速纖毛運動，以利痰液的排除。鎮咳劑如 Codeine，祛痰劑如Guaifenesin。
- 抗組織胺和抗過敏製劑：用於治療鼻塞、流鼻水。常用藥物為抗組織胺及血管收縮劑，改善鼻黏膜充血情況，使鼻塞獲得緩解。如：Loratadine。

感冒

西醫臨床常用於治療感冒之藥物種類

作用分類	學名	商品名	常見副作用
Antipyretic-乙醯胺酚	Acetaminophen	Tinten	皮膚紅疹。
Antipyretic-非類固醇類抗發炎藥物	Aspirin	Tapal	腸胃不適、胃潰瘍、腸胃道出血、急性腎功能損傷、腎臟衰竭。
	Diclofenac	Votan	嚴重腹痛、胃痛、黑便、蕁麻疹、呼吸困難等症狀。
	Fenoprofen	Nalfon	噁心、嘔吐、嚴重腹痛、胃痛、黑便、蕁麻疹等。
	Flurbiprofen	Forphen	
	Ibuprofen	Ibuprofen	
	Meclofenamate	Nalfon	
	Naproxen	Naposin	
鎮咳祛痰劑	Dextromethorphan	Medicon	可能會引起暈眩、嗜睡或疲倦感等。
	Benzonate	Bensau	鎮靜、頭痛、發疹、胃腸不適、過敏。
	Compound Opium and Glycyrrhiza Mixture	Compound Glycyrrhiza	心跳不規律、思睡、不安、暈眩、興奮、發汗、視覺模糊、噁心、嘔吐、便秘等。
	Fluidextract of platycodon	Cough Mixture	食慾不振、胃腸不適。
	Guaifenesin	Guaphen	暈眩、嗜睡、噁心嘔吐。
	Codeine	Codeine	噁心、嘔吐、便秘、口乾；暈眩、頭痛、睡眠障礙；視力模糊或複視；排尿困難；皮疹等。

感冒

抗組織胺	Loratadine and Pseudoephedrine	Clarinase	疲倦、口乾、排尿困難、便秘、心跳 快速、呼吸困難、喘鳴、或發生黃疸 等。
	Loratadine	Clarityne	
	Cetirizine	Zyrtec	
	Levocetirizine	Xyzol	
	Fexofenadine	Allegra	
	Buclizine	Lonzumin	嗜睡、口乾、胃腸不適等。
	Ketotifen	Zaditen	嗜睡、口乾、暈眩、食慾或體重增 加、噁心或頭痛。
	Desloratadine	Denosin	頭痛、咽喉炎、口乾、嗜睡、困倦、 疲勞等。
	Dexchlorpheniramine	Somin	可能會引起睏睡、頭痛、口鼻或喉嚨 乾燥感、胃腸不適、排尿困難、心跳 加速或緊張不安等。
	Cyproheptadine	Antisemin	可能會引起睏睡、頭痛、口鼻或喉嚨 乾燥感、胃腸不適、排尿困難、心跳 加速或緊張不安等。

感冒

甘草



- **功用**：補中益氣，緩急止痛，潤肺止咳，瀉火解毒。
- **主治**：倦怠食少，心悸氣短，腹痛便溏，四肢攀急疼痛，臟躁，咳嗽氣喘，咽喉腫痛，癰瘡腫毒，小兒胎毒，藥物食物中毒。
- **性味**：味甘，性平。

中西藥交互作用

西藥種類	西藥學名	實驗種類	可能交互作用機轉	可能交互作用結果	建議處理方式	參考文獻
利尿劑	Amiloride Spironolactone	案例報告	拮抗利尿劑作用	影響利尿劑的效果	由醫師等人決定調整劑量	[1]
免疫抑制劑	Cyclosporine	文獻回顧	甘草的免疫刺激作用	甘草的免疫刺激作用會與Cyclosporin的免疫抑制作用相互抵銷掉	避免併用	[2]
免疫抑制劑	Methotrexate (MTX)	動物試驗	不明	Methotrexate全身暴露量及平均滯留時間則顯著增加	避免併用	[3]
心血管用藥—強心配體	Digoxin	文獻回顧	使血鉀降低	會增強Digoxin的毒性	避免併用	[4,5]
抗心律不整劑、局部麻醉劑	Lidocaine	動物試驗	甘草增加CYP3A4活性	Lidocaine併用甘草時，代謝速率增加。半衰期縮短了39%，總清除率增加了59%	避免併用	[6]
鎮靜催眠劑	Midazolam	文獻回顧	甘草增加CYP3A4活性	Midazolam代謝增加，藥效降低	隔開服用	[7]

(接下頁)

麥門冬



- **功用：**滋陰潤肺，益胃生津，清新除煩，兼能潤腸。
- **主治：**肺燥乾咳，肺癰，陰虛勞嗽，津傷口渴，消渴，心煩失眠，咽喉疼痛，腸燥便秘，血熱，陰虛血滯，乳汁不下。
- **性味：**味甘、微苦，性微溫。

中西藥交互作用

西藥種類	西藥學名	實驗種類	可能交互作用機轉	可能交互作用結果	建議處理方式	參考文獻
支氣管擴張劑	Aminophylline	動物實驗	未明	先口服*麥門冬湯一小時後再給予Aminophylline，三小時後的血中Aminophylline濃度明顯較高。	隔開服用 [1]	

參考文獻：麥門冬

1. 游明謙、許清祥（2004）。中藥麥門冬湯與西藥並用治療氣喘之交互作用研究。行政院衛生署中醫藥委員會研究成果報告（編號：CCMP92-RD-004）。



國立陽明大學醫學院傳統醫藥學研究所副教授
臺灣中醫家庭醫學醫學會理事長

賴榮年 著



感冒應該看中醫

西醫看來簡單的感冒，
中醫卻認為是危害健康之最！

西醫在用藥時，是根據「抗發炎的藥理作用」，
而不是人體在病程中，所表現出各種「有諸內必
形於外」的反應；但這些現象，卻是中醫師了解
病人最重要的「順勢而治」身體情報。

