Case Findings from a Family Practitioner's Office Using Electroacupuncture According to Voll

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Abstract: The selected eleven cases presented here are reported from a family practitioner's office using the Electroacupuncture According to Voll (EAV) diagnostic technique. Six cases had findings of malignant tumors, three were diagnosed as G-I bleeding, one for acute inflammation, and one for chronic degenerative disease. All findings were confirmed by classical means of diagnosis.

AFTER Dr. Reinhold Voll published his works in 1975 and 1980,[1,2] many physicians and dentists throughout the world started to experiment with the technique of Electroacupuncture According to Voll (EAV). In order to study the validity of EAV, the authors used two approaches. The first approach was to design a research project using EAV to identify a selected pathology; allergy, from an unknown population group in which the patients and controls were mixed. The diagnoses were backed up by five other recognized diagnostic methods. This study showed the accuracy of EAV to be slightly greater than 80 percent.[3] The second approach was to use EAV as a diagnostic tool on a group of patients visiting the family practitioner's office in order to detect various kinds of disease. EAV diagnosis was compared with the traditional diagnostic methods. The following case reports are the results of the second approach. Both approaches support the fact that Electroacupuncture According to Voll is an extremely valuable diagnostic method.

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Methods of Study

The EAV procedure used in this study is to place an electroacupuncture probe on an acupuncture point with the requisite contact pressure and to apply direct electric current of approximately one volt and 5 to 10 microamperes. The established points are located primarily on the hands and feet, and the noninvasive procedure does not produce any pain. No chemical or other substances are injected into the body, and the small electric current used to measure the resistance of body parts and tissue are painless and produce no aftereffects. The patient holds one hand on a negative electrode and the physician applies the current to the point to be measured with a brass probe. The probe is connected to a volt ohmmeter, which measures the functional status of the organ or body function reflected by the acupuncture point being measured. The measurement scale is calibrated from 0 to 100. A reading of 50 with no fluctuation of the indicator needle indicates that the organ or body function being measured is in balance and in good health. Readings that are progressively toward 100 represent increasing degrees of either latent or developed inflammation. Readings progressively toward 0 represent increasing degrees of degeneration with scarring, atrophy or even cancer. Where the reading reaches a maximum level and then begins to drop toward 0, but reaches a minimum stable value, the indication is that there may be development of a pathological disturbance.

When the organ is in a healthy state, the needle will rise quickly to its stable position. A needle that rises slowly indicates that the organ is fatigued.

Thus, EAV is used to diagnose early disturbed organ functions, perhaps even before methods such as auscultation, palpation, X-ray and laboratory tests can reveal disease which has developed to a significant degree. The physician using EAV can warn the patient of potential future conditions before they manifest themselves, thereby decreasing the possibility of late discovery of a medical condition.

The eleven cases described in this article were diagnosed by EAV in one of the author's office. The acupuncture points used for diagnosis followed those point identified by the originator of the EAV system, Reinhold Voll, M.D.[4-6] These points shown some modification from the traditional Chinese acupuncture points. In addition to the twelve meridians and two vessels as described in the traditional Chinese acupuncture texts, Dr. Voll also specified points for the lymphatic system, allergy, skin, and nerve, organ, fibroid, articular, and fatty degeneration.

After nearly thirty years of clinical application, Voll's system is well established in Germany. Similarly, it may be worthwhile for physicians in the U.S. to be aware of the diagnostic capabilities of EAV. The ensuing discussion of case findings may illustrate the value of EAV as a diagnostic tool.

Results and Discussion

(1). J.S. — This 48-year-old female first presented on August 18, 1980, with the chief complaint of intermittent abdominal discomfort and pain over a two-week period. EAV investigation was performed on the day of the office visit. Indicator drop was recorded on organ degeneration control points for both sides. The left was from 58 to 50, and right was from 54 to 20. The other points that showed indicator drop were the liver, ovaries, pancreas, and the peritoneum over the large and small intestines and bladder.

On August 27, an X-ray of the abdomen was taken and ascitis was diagnosed. Paracentesis was subsequently performed, and the pathology indicated adenocarcinoma. Additional X-rays were taken on August 29 of the chest and upper G-I. These results were normal.

On September 1, the patient was admitted to St. Francis Hospital, where, on the following day, an exploratory laparotomy was performed. At this time, a subtotal hysterectomy, bilateral salpingo-oophorectomy, and partial omentectomy were also carried out. A total hysterectomy was not accomplished due to the presence of extensive adhesions discovered in the patient's pelvis.

The pathological report revealed massive cystadenocarcinoma of both ovaries with omental metastasis. Pelvic radiation and chemotherapy treatments were administered to the patient.

(2). D.W.—This 68-year-old female was first examined on February 25, 1982. The patient's chief complaint was constipation and a sensation of abdominal bloating. In addition, she complained of hematuria. EAV measurements showed organ degeneration in the lower parts of the body. While the reading dropped from 54 to 30, it regained balance with sigmoid rectal degeneration nosodes 3x (1:1000). Urine analysis showed one plus of albumin and a trace of blood. Occult blood was also found in her stool.

On the following day, the patient was hospitalized and X-rays revealed a definite apple-core lesion of the sigmoid colon. Two subsequent attempts at colonoscopy and flexible sigmoidoscopy evidenced multiple diverticulosis of the sigmoid colon, but a biopsy specimen could not be taken from the left colon due to the presence of excess feces.

After repeated X-rays (barium enema), the patient was explored and excision of the sigmoid colon performed on March 5, 1982. The pathological report showed moderately well-differentiated adenocarcinoma of the colon. Since that time, the patient has been followed in the physician's private office and is currently living a normal life.

(3). D.U. — This 51-year-old male first presented in the family practitioner's office on January 14, 1982, complaining of a severe cough and chest pain of two weeks duration. Seven days prior to the office visit, he had had a benign polyp removed from his colon. Physical examination revealed an enlarged liver, approximately 5 cm below the costal margin, and the patient experienced tenderness on the side of and over the liver area.

EAV readings showed organ degeneration. The right liver measuring points registered at 86 and the left liver measurement read 80, both with substantial indicator drops. In addition, indicator drops were obtained on the measuring points for the large intestine, sigmoid colon, and gall bladder.

On January 15, a liver scan was ordered and carried out at St. Francis Hospital. Findings indicated hepatomegaly with metastatic lesions to the liver. Five days later, a barium enema of the colon was performed and carcinoma of the colon subsequently suspected. On the same day, an endoscopy examination and biopsy was done. Carcinoma of the descending colon-sigmoid colon junction was reported. The pathological report from the biopsy showed well-differentiated adenocarcinoma of the colon. Chemotherapy was administered to the patient.

On February 1, the patient returned to the physician's office. EAV measurements were again taken, and at that time, the large intestine with the left sigmoid point showed an indicator drop from 44 to 20.

The patient expired on April 8, 1982. An autopsy confirmed the diagnosis of carcinoma of the colon with liver metastasis.

(4). R.F.—This 65-year-old female was first seen on May 14, 1981, because she had two large breast masses and several left groin masses and had refused palliative surgery and chemotherapy in favor of natural therapies. She had also had a sigmoid colon cancer with a resection and colostomy for 12 years. When she was first seen, the right breast had a mass 3.6 x 1.6 cm and the left breast had a mass 4.8 x 4.8 cm and a granuloma ulcerated mass 1.3 x 1.3 cm. In addition, a mass of 3.5 x 1.6 cm with two nodules was present in her left groin.

This case was followed for a period of one year while weekly EAV readings were taken on her organ degeneration, breast, sigmoid colon and lymphatics control measurement points (CMP). The organ degeneration control measurement point read as follows on July 9, 1981: left organ degeneration 50/36 and right organ degeneration point, 50/43. When these points were tested against the homeopathic preparation in the medicine testing according to Voll,[2] these findings were recorded: degenerative nosode mamma medullar 3x, 2 ampoules, degenerative nosode mamma simplex 3x, 1 ampoule, degenerative nosode sigmoid colon, 2 ampoules of 3x; and degenerative nosode melanoma metastasis 5x, 1 ampoule.

This patient was followed and given matching homeopathic treatment and acupuncture for pain relief in her lumbar spine for a period of one year. She later developed a brain metastasis and expired two weeks after the first onset of brain symptoms. Inclusion of this case is only to demonstrate that there are indeed electrical changes when cancer is present, and that the nosodes have some specificity in identifying the progress and type of tumors present. All of these diagnoses were confirmed by pathological biopsy specimens. The patient had remained comfortable and even improved symptomatically during the one-year duration that she was followed prior to her death.

(5). N.C.—This 60-year-old female presented initially with the complaint of dark red discharge from the vagina on January 18, 1982. A Pap smear was obtained. The physician's pelvic examination revealed a dark red discharge from the cervical os which suggested the possibility of uterine bleeding. Pelvic findings were otherwise negative. EAV readings, however, showed organ degeneration and matched with degenerative nosodes of malignant uterine polyp 5x and 6x. Uterine organ points showed an indicator drop on both sides, signaling severe degeneration. Results of the Pap smear were negative for malignancy. A suction D & C was performed in the office following EAV readings. The pathological report specified infiltrating adenocarcinoma with

papillary configuration.

The patient was referred to a gynecologist who, on February 12, carried out a total hysterectomy with a bilateral oophorectomy. The pathological report revealed moderately well-differentiated papillary adenocarcinoma of the endometrium Grade 2, hyalized leiomyoma, and endometriosis of the serosal surface of the uterus.

Since the malignancy was confined to the inner half of the myometrium, the Tumor Board of Kapiolani Hospital recommended that it was not necessary to proceed with radiation therapy. During a postoperative office visit, however, EAV measurements showed persistent indicator drop on organ degeneration points and continued matching of nosodes of uterine polyp at 6x. Homeopathic preparations were administered to the patient on an ongoing basis, and she will be followed carefully. When she was last examined there were organ degeneration indicator drops.

(6). J.H.—This 65-year-old male first presented in early June 1979, with recurrent pain over the epigastric region. During the office visit, blood was detected in the patient's stool. On June 6, he was sent for a G-I series. The diagnosis identified a large benign ulcer in the body of the stomach. All other findings were normal.

EAV measurements obtained in the physician's office, however, revealed indicator drops on both the large and small intestines, as well as signs of irritation on the bowel measuring points. The patient was treated conservatively for the gastric ulcer. A repeat of the G-I series carried out on October 3 of the same year showed there had been a complete healing of the large gastric ulcer, and the patient's symptoms were reportedly relieved at that time.

He remained asymptomatic until September 28, 1981, when he returned to the physician's office complaining once again of intermittent epigastric pain. EAV measurements evidenced organ degeneration on the left side, and matching was attained with ventricular ulcer degeneration nosode 4x. On the following day, EAV assessment still registered organ degeneration, as well as indicator drops from 80 to 36, and a drop from 78 to 30 on the stomach measuring points.

The upper G-I series was performed on September 28, and the patient's condition was diagnosed as malignant infiltration adenocarcinoma of the mid-portion (35%) of the stomach. A liver scan was taken on October 2, and the impression was that the liver scintiphotos were grossly abnormal, and although there was no splenomegaly noted, the spleen-to-liver accumulation ratio was grossly abnormal. These findings were compatible with hepatomegaly. On September 30, a total abdominal sonography was performed which revealed the presence of definite ascites and hepatomegaly with increased echo texture, suggestive of cirrhosis. There were also signs of portal hypertension. The ascitic fluid was aspirated and a cell block was executed which was microscopically diagnosed as malignant. At that point, the patient was believed to be suffering from carcinoma of the stomach with metastasis to the liver. An exploratory laparotomy with an open wedge biopsy of the liver was performed. The biopsy report confirmed the existence of poorly-differentiated carcinoma of the liver, probably from the stomach.

Postoperatively, on November 15, 1981, the patient returned to the family practitioner's office. An EAV assessment measured an extremely low energy level of 65 (normal = 84). As a result, homeopathic therapy was initiated. The patient, however, persisted in a run-down condition and sustained ongoing weight loss. He expired on December 3, 1981.

Each of the six cases described in the preceding pages are cancer cases which substantiate that EAV readings do coincide with the actual presence of the disease. With the administration of nosodes (homeopathic preparations), practitioners using EAV can detect the site and severity of cancer. EAV is a technique that could also serve as a guide for patient improvement over the course of any treatment or therapy. If patients could be assessed early by EAV, accurate diagnosis could be achieved. Such early discovery of malignancy would then enable the early initiation of

treatment which would probably result in more beneficial patient outcomes.

The following five cases are classified as benign conditions. The EAV diagnostic technique contributed significantly to the success of the treatment in each case because of its early diagnostic capability.

(7). RB. — This 49-year-old female first visited the physician's office on July 1, 1982. Her chief complaint was that she had been spitting blood for two days. After drinking a cup of cold water she began to cough and expectorated blood.

EAV examination established that the small intestine point matched the homeopathic preparation of duodenal ulcer at the dilution of 8x. Physical examination of the patient revealed that the lungs were clear and that the heart sounded normal. The patient's abdomen was soft and flat, and there was some tension present in her neck and shoulder. Laboratory findings were inconclusive, with a chest X-ray showing normal heart and lungs, and the stool was negative for occult blood.

The patient was closely followed and examined again two days later. At that time the patient complained of epigastric pain as well as pain in her right shoulder. She was started on a bland diet and initiated homeopathic duodenal ulcer therapy. In the meantime, the patient was scheduled for a G-I series. On July 7, 1982, the upper G-I series was carried out and a typical 6 mm active, benign duodenal ulcer was discovered. The patient has since been treated with the usual duodenal ulcer remedies. Her symptoms subsided after two weeks of this treatment. She has continued with a proper diet and periodic visits to the physician's office.

(8). E.H. — This 77-year-old male presented initially for this illness on January 24, 1981, complaining of rectal bleeding that morning. EAV examination showed indicator drops on the duodenal region of the G-I tract and a match with the homeopathic preparation ulcus duodeni. The patient, however, had no history of peptic ulcer. His hemoglobin was 12 gm%ml, and the white blood count was within normal limits. The RBC equaled 3.79 million per cu/mm.

The patient was treated by injecting vitamin B_{12} into acupuncture points Liver 9 bilateral, Small intestine 4 bilateral, and Stomach 36 bilateral. He was administered ice chips and instructed not to ingest anything else and was observed in the physician's office.

On the following day the patient returned. At that time, the hemoglobin test was repeated and reported to be 12.5 mg%ml, while the RBC was 3.82 million per cu/mm. Vitamin B_{12} was injected again into LV-9, ST-36, PC-7, and CV-12. Although the patient passed black tarry stools, his vital signs were stable.

The hemoglobin results were compared with a complete blood count on the patient which had been obtained on January 19, 1982—five days prior to his presenting with the current complaint. On that date, the patient's hemoglobin was recorded at 15.2 gm%ml, RBC at 5.16 million per cu/mm, and 4 grams of dropping.

He came back to the office on January 26. His hemoglobin was steady at 12.3 gm%ml of hematocrit 35 percent. Since the patient's symptoms had subsided, he was put back on a normal diet at that time. Regular peptic ulcer treatment was carried out.

X-rays taken at St. Francis Hospital revealed an approximately 1 cm crater, probably in the posterior wall of the duodenal bulb. There was a moderately-sized diverticulum of the second portion of the duodenum.

(9). W.Y.—This 52-year-old female first visited the physician's office on January 10, 1981, with the complaint of tarry stool noticed that morning. EAV examination indicated that she had a duodenal ulcer, showing abnormalities on the duodenal point, small intestine control point, and small intestine peritoneum. The patient's hemoglobin was 10.5 gm%ml, RBC equaled 3.67 million per cu/mm, and the white blood count was normal. She was treated with the peptic ulcer diet and homeopathic preparation.

The next office visit took place two days later, on January 12, and the patient reported feeling better. The occult blood in the stool

was found to be negative. She was put on a soft diet and was seen again five days hence. At that time, her physical findings were normal. The hemoglobin test was repeated and found to have remained at 10.4 gm%ml, while the RBC count read 3.63 million per cu/mm. Since she was feeling well, she was returned to a regular diet.

On January 29, a G-I series was carried out which revealed a 3-4 mm prepyloric antral ulcer as well as marked deformities and spasticity of the duodenum. This patient has been continuously treated with homeopathic preparation and a dietary iron supplement. She was sent back to work on January 29th.

The patient remained asymptomatic through the follow-up visit on February 2, 1981. On that date, the hemoglobin had returned to 11.4 gm%ml. Since then, she has been followed up periodically and there has been no recurrence of the peptic ulcer symptoms. The monthly check-up recordings of duodenal points were normal as of her most recent visit to the physician's office on May 8, 1982.

The above three cases share a similar medical condition. They had no past history of peptic ulcer and the presenting chief complaint was either expectorated blood, noticed tarry stool or rectal bleeding. EAV measurements in each case detected duodenal ulcer prior to the G-I series. Based on EAV findings, the correct medical treatment could be immediately initiated, even during the occurrence of active bleeding. Because of the early treatment, the duration of the course of the disease was relatively shortened. With a patient's follow-up monitored by EAV, the patient could be assured of his or her well-being.

(10). A.A. — This 57-year-old male first presented on April 3, 1979, complaining of a dull pain over the right lower quadrant of the abdomen. A physical examination revealed that the abdomen was tender on the right lower quadrant; a mild rebound tenderness and minimal amount of muscle guard were detected. Otherwise, the patient's abdomen was soft and flat. EAV examination, however, registered abnormal readings on the point of the appendix, indicating a subacute inflammatory process in that organ. It matched with the nosode Appendicitis 3x. The complete blood count showed the white cell count at 9,900 with the lymphs at 36, polys at 61 and mono 1 EOS at 2. The hemoglobin was recorded at 13.3 gm%ml.

The patient was admitted to the hospital on the same day. Due to the relatively atypical nature of the symptoms, the flat plate of the abdomen was done. An appendectomy was performed on April 4, 1979. The pathological report identified acute appendicitis.

(11). J.C.—This 50-year-old female was first seen in the family practitioner's office on November 13, 1981, complaining of severe tremor of both hands of over twenty year's duration. EAV findings indicated nerve degeneration and changes of the meninges. It matched with the homeopathic preparation of nerve degeneration combination 4x, meningitis, encephalic degeneration 4x, tetanus 10x, and mentha piperita 3x. This patient's condition fit the tissue diagnosis of the chronic, hereditary neurological disease, chorea.

She was given courses of homeopathic preparations and was followed by EAV measurements weekly, and then monthly. The first signs of improvement were felt in only one week's time, and within two weeks the patient felt that she could accomplish many tasks that the tremor had previously prevented her from doing. She was last seen in the office on July 30, 1982. At that time she reported that she was able to perform tasks without being hampered by the tremor.

The preceding two cases indicate that EAV could not only detect very acute inflammatory processes, but extremely chronic illnesses as well. Based on these diagnoses, the correct homeopathic preparation could be identified, the dosage adjusted appropriately, and the status of patient improvement measured. EAV, as a diagnostic aid, can be feasibly integrated into the current Western medical treatment of a family practitioner's office.