The Treatment of Menopausal Symptoms by Traditional East Asian Medicines: Review and Perspectives

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Abstract

This article provides an overview and critical evaluation of the management of menopausal symptoms by traditional East Asian medicines (TEAMs). For this purpose we utilise an interdisciplinary perspective that draws on social history, medical anthropology, and clinical research. Our goal is threefold. First, we examine the research literature regarding evidence for the effectiveness of TEAMs in the management of menopausal symptoms. The failure of all studies reviewed to address the problematic articulation between tradition and modernity in the case of menopausal syndrome leads us to examine more closely how this connection has been constructed. In the second part of this review we explain how during the late 20th century various TEAM currents such as traditional Chinese medicine (TCM), Japanese Kampō, and Korean medicine, explored different responses to a biomedically defined disorder, namely menopause, that was until then not discussed in these traditions. Third, based on the findings of the previous sections we make a number of recommendations as to how research in this field might be improved. We argue that while robust evidence for the efficacy of TEAM in treating menopausal symptoms is currently lacking, existing studies provide sufficient evidence to warrant further research. A new interdisciplinary research framework that takes account of the actual realities of TEAM practice will be required however for meaningful answers regarding the two most urgent problems in the field to emerge. These are, first the issue of actual treatment effects, and second the more general problem of how TEAMs might be integrated into personalised health care.
1 Introduction

As the use of hormone replacement therapy (HRT) in the management of menopausal symptoms is becoming ever more problematic (1) and women increasingly look for alternative solutions (2), the potential role of traditional East Asian medicines (TEAMs) seems particularly worth investigating (3). TEAMs are popular alternatives to biomedical care throughout East Asia and the various East Asian diasporas, but increasingly also among non-Asians throughout the world (4-8). Claims that TEAMs have successfully treated menopausal problems for hundreds or even thousands of years abound not only in texts and websites aimed at possible consumers but also the professional and research literatures (9-11). This review will examine the validity of these claims in an attempt to provide guidance in a field that is difficult to evaluate without specialist expertise in a number of different domains. Accordingly, we employ an interdisciplinary perspective that draws on the humanities and social sciences as well as clinical medicine. If the latter allows us to critically examine current research, history and anthropology are essential in order to understand how in the course of the 20th century various strands of TEAM configured different responses to the problem of menopause as part of a wider effort to define for themselves new niches in local contexts of practice.

For the purposes of this review the term TEAMs will be used to refer to the literary medical traditions of China, Taiwan, Japan, and Korea that trace their common roots to a small number of foundational texts composed in Han dynasty China. Although, over time, the various strands of TEAM developed along diverse historical trajectories, they continue to draw on a shared corpus of texts, concepts, diagnostic technologies and therapeutic techniques. Today, institutionalised and state supported TEAMs - traditional Chinese medicine (TCM), Japanese Kampō, and Korean medicine – exist side-by-side and in continuous interaction with smaller idiosyncratic currents in a vibrant plural medical field both in their respective home countries and increasingly the rest of the world. Focusing on this group of related practices as a set rather than examining each on its own allows for a more dynamic comparative perspective. This is capable of understanding diversity as a response to local contexts of practice (12) without the risk of hindering their ongoing development by misreading TEAMs as unchanging and bounded national medical traditions.

We begin with a review of studies that seek to evaluate the effectiveness of TEAMs in treating menopausal symptoms. This has been organised into four sub-sections according to countries/regions and medical traditions examined: Chinese studies of TCM, Western
studies of TCM, Japanese studies of Kampô, and Korean studies of Korean or Oriental medicine. If this review throws up multiple questions regarding research design, methods, and validity of the studies examined, an even more important issue to us appears to be the rationales that underpin these studies and frame their hypothesis. Specifically, researchers do not situate their research questions in the context of extensive literature reviews; they do not generally provide convincing arguments as to why their chosen intervention deserves to be studied in preference to available alternatives from the TEAMs archives; and they do not engage with the problem of how traditions that did not historically perceive of menopause as a medical problem can simultaneously claim to make available effective treatments for managing menopausal symptoms. The second part of this review therefore provides a brief cultural history of how the articulation between various currents of TEAM and menopause was established in the course of the 20th century, and how this is shaping current TEAMs practice. In the concluding section we put forward concrete suggestions for how the problems outlined in part one may be overcome through a novel multidisciplinary research framework. We suggest that this research framework may be relevant not only to the problem of menopause but to other biomedically defined disorders whose treatment by TEAMs we wish to scrutinise.

2 Review of Clinical Research on TEAMs in the Treatment of Menopausal Symptoms

Until recently, most available publications on TEAMs in both East Asian and western languages consisted of commentaries on the relevance of older medical texts and formulas, of single case studies, or of case series reports seeking to explicate individual physicians' idiosyncratic treatment strategies. From an emic perspective (i.e. one that accepts the perspective of these authors on their own terms) this was entirely appropriate in as much as the audience of these publications were other physicians, and the problem to be solved which of the many possible approaches from within TEAM for those that might be most suited to a particular context.

It has only been with the rise of evidence-based medicine and the change of audience this has implied that proof of effectiveness and efficacy has become an acknowledged goal. However, older agendas persist. TEAM as a whole is only beginning to build an internationally acceptable research infrastructure and agenda. Our literature review has revealed that evidence that might allow us to draw definite conclusions about the effectiveness of TEAMs in general or any of the currents outlined below in managing menopausal symptoms is currently unavailable. Properly conducted randomised-controlled
trials (RCTs) in the field are still rare, as almost all suffer from multiple methodological problems as discussed in this section. Therefore from the current evidence one cannot reach any definitive conclusions regarding the effectiveness of TEAMs in treating menopausal symptoms. This review outlines general problems regarding research in this field and makes suggestions as to how these might be resolved for future research. Our search criteria were tailored to each country (e.g. Kampō was used in Japan rather than Chinese medicine), and with very few exceptions only RCTs that compared herbal treatment with placebo or usual treatment of menopausal symptoms were reviewed. The search strategies are detailed in the footnote below. Please refer to Tables 1 – 4 for methodological details of the studies reviewed.

2.1 Studies of Traditional Chinese Medicine from Mainland China
Our search of TCM databases resulted in 19 relevant RCTs running from 4 weeks to 2 years (13-32). Due to space restrictions, rather than detailing all, we have presented a representative sample of five of these studies in Table 1, whereby readers may judge their quality. There were various methodological flaws such as not mentioning the duration of the study to poor randomisation procedures (26). The studies reviewed used a wide variety of interventions including ten different kinds of patent medicines and four different decoctions. Two studies used plant extracts, and one used herbal pills designed specifically for the trial. The comparison groups varied between placebo controls, various types of HRT, Vitamin E, and Oryzanol. Outcome measures were diverse including standardised instruments such as the Kupperman index, MENQOL, and serum hormone levels, but also informal calculations of effectiveness (14, 26), informal TCM symptom scores (13, 23, 24, 27, 31), cumulative symptom scores, ultrasound examination of the pelvis and breasts, and memory scale testing (16). The value of some of these outcome measures was not always clear.

None of the paper reviewed provided a systematic literature review to support treatment choice. None of the papers provided trial flow charts or principles for how patients were allocated to treatment and control groups. These problems in the design of the RCTs reviewed means that at present these do not comply with standards expected of internationally acceptable research. Furthermore, in as much as all of the studies reviewed use a single formula to treat all patients, these trials neither represent Chinese medicine as
practised in contemporary China, nor as outlined in TCM textbooks or national standards discussed in more detail in section 3 below.

2.2 Western Studies and Taiwanese Studies of TCM and Chinese Medicine

Altogether we found five studies conducted in the West\(^1\) (10, 33-36). The characteristics of these studies are detailed in Table 4. All used standardised outcome measures such as the Greene climacteric scale, hot flush diaries and/or the Kupperman index. Baseline characteristics were matched between groups and all ran for 12-16 weeks.

The results are variable. However, first it should be noted that each tested different Chinese herbs; ranging from an extract through three different standardised formulae to individualised formulae. It is important therefore to not generalise the findings to judge the practise of CHM. Three found no difference between placebo and treatment (34-36); the one pragmatic trial found no difference between treatments – herb or hormone therapy (33); and only in the individualised herbal treatment were the effects significantly better than placebo (10).

The rationale for choosing treatments varied and was often glossed over; they comprise a mixture of following “tradition” and replicating previous research. For example the single herb extract was chosen to strengthen the blood as “the symptoms of ‘deficient blood energy’ listed in Chinese texts are similar to those that Western medicine associates with menopause” (35). Whereas others state that all women at menopause suffer from a kidney-yin-deficiency problem for which an 18th century formula *Phellodendron, and Rehmannia Pill* (*zhī bò dì huáng wán*) is used as the basis of treatment (10), however in this trial further herbs were added according to other clinical patterns found on an individual basis. Another formula, *Augmented Rambling Powder* (*jiā wèi xiāo yāo sān*) is selected as the authors state that it is used for various menopause related symptoms, though these are not specified (37).

One trial tests what it calls an ‘industry-designed eight-herb formula’ which comprises two Chinese herbal formulae, *Two-Immortal Decoction* (*èr xiān tāng*) and *Anemarrhena, Phellodendron, and Rehmannia Pill* (*zhī bò dì huáng wán*) plus Cimicifuga chosen on the basis of previous inconclusive trials (36). One study explicitly states that they do not take the diagnostic and therapeutic principles of Chinese medicine into account; they are simple

\(^1\) Note that one English language study carried out in Taiwan was included in this group.
testing the efficacy of the herbs. Yet in using one of the most important Chinese medicine formulas for Kidney deficiency, i.e. Six-Ingredient Pill with Rehmannia (liù wèi dì huáng wán), they nevertheless selected herbs based on modern TCM interpretations of what menopause is.

2.3 Japanese Studies of Kampō Medicine

Our literature search revealed seven studies examining the effectiveness/efficacy of Japanese Kampō in relation to menopausal symptoms. These are detailed in Table 2. The studies reviewed included one RCT that compared different commercial products based on the same Kampō formula (38); two RCTs that examined the effectiveness of two Kampō formulas for depressive symptoms in post-menopausal women (39, 40); one quasi-RCT that compared the effects of three Kampō formulas both to each other and to HRT treatment Takamatsu (41); one RCT that compared the effect of a Kampō formula for the treatment of depression in postmenopausal women with those of antidepressants (42); one RCT that compared the effect of a Kampō formula to Vitamin E (43); and one RCT that attempted to compared pattern or shō-based Kampō treatment to HRT (44).

Trials ran from eight weeks to six months but insufficient information is provided as to how patients were allocated to groups or baseline comparisons. While all studies show improvement of symptoms or positive changes in biomarkers in the Kampō treatment groups various other design flaws impair analysis of the data provided. For instance, only some of the studies used standardised outcome measures such as the Greene climacteric scale, or the Kupperman index, while others relied on in-house symptom questionnaires. Most importantly, the rationale provided for the selection of treatment methods examined is frequently opaque. Thus only one single study attempted to compare biomedical treatment with shō or pattern-based Kampō treatment (41), even though treatment according to shō or patterns is otherwise defined as the identifying feature of Kampō medicine. The authors of this study found that whereas HRT treatment showed effects after only one month, Kampō formulas took up to six months for such effects to manifest. They also concluded that in relation to specific symptoms the therapeutic effect of HRT is superior for hot flashes, excessive perspiration, depression, and insomnia, whereas Kampō therapy is superior for general malaise and chill.
2.4 Studies of Korean Medicine from Korea
The situation is similar with respect to Korean medicine. We found only five studies that evaluated the use of specific herbal medicine formulas for relieving symptoms associated with the menopausal transition, specifically hot flushes (45-48), and vaginal dryness (49). Only one of these compared effects against a non-treatment control group (47). All others simply observed treatment effects by a variety of means ranging from unspecified questionnaires administered by phone (48), to standardised outcome measures such as the Menopause Rating Scale (MRS), Greene climacteric scale, or the Kupperman index (45, 46). The Korean studies are detailed in Table 3.

Few reasons, if any, as to why one formula rather than another was chosen are given, and no attempt at matching subjects to formula patterns seem to have been made in any of these studies. The four studies examined indicate that the chosen formulae improve symptoms associated with menopausal transition in relative short treatment periods (10-56 days). As in the Japanese study outlined above, the effect of specific formulas was more pronounced with respect to some symptoms where this was investigated. The formula daejo huan (Great Creation Pill, Chin. dà zào wán), for instance, was reported to be particularly effective in reducing the symptoms of fatigue, shoulder pain, anxiety, headache, hot flushes, and sexual problems on the Kupperman’s index and MRS after 8 weeks of using 12g/day (47). This suggests that focusing on patterns rather than diseases may be a more realistic approach in evaluating the effect of TEAM treatments and formulas.

3 East Asian Medical Traditions and the Problem of Menopause
The first chapter of the Inner Canon of the Yellow Lord: Simple Questions, one of the foundational texts of all TEAMs, discusses the development, growth, and decline of human life in terms of seven-year cycles for females and eight-year cycles for males. At age 49, i.e. 7x7 years, a woman’s fertility is said to be exhausted and her periods cease (50). While this implied a distinctive decline of vitality, it was not however considered a problem requiring specific medical attention in any premodern East Asian society. Rather, as the medical historian Charlotte Furth explains for the specific case of China:

“What moderns would understand as menopause is identified [in ancient Chinese medicine] in the same way as menarche, simply as an event in the life passage, similar in character if
not in timing for males and females alike. Just as females cease to menstruate, males' 'semen becomes scanty', and these changes are not seen as a 'pathology' but 'part and parcel of the ungendered feebleness of old age (51).”

It was only after the penetration of biomedicine into China, Korea and Japan that menopause and symptoms specifically associated with the menopausal transition came to be considered medical problems in Asian countries. In fact, the Japanese term for menopause, kōnenki, is a translation of the German “Klimakterium,” coined in the early part of the 20th century as part of a wider effort of introducing Western science into Japan (52). Its ideographic writing 更年期 was then rendered into Chinese as gengniánqì, and into Korean as gaengnyengi 개년기중후군 (53, 54). It took another half century for these concepts to penetrate traditional medical practice. This occurred on the back of efforts at medical modernization, as well as in response to changing patient demands (55-58). Different answers emerged as a result of these encounters reflecting various possible accommodations between traditional and biomedical understandings of female ageing and the socio-cultural contexts in which these were enacted.

3.1 The Treatment of Menopause by TCM in Mainland China and the West

Beginning in the 1950s the state-directed modernization of traditional medicine in China has been driven by two apparently contradictory goals: to align traditional practice ever more closely with biomedicine while, at the same time, maintaining an independent space for the thus modernized tradition within the overall health care system (12, 59). Many historians therefore distinguish this new hybrid, known today throughout the world as “traditional Chinese medicine” or “TCM, from older forms of practice that continue to exist at its margins (59-61). They also have shown that this alignment is held in place by a practice known as “pattern differentiation” (辨證 biànzhèng), which allows TCM physicians to treat biomedically defined disorders such as menopausal syndrome by breaking them down into so-called Chinese medicine patterns (12, 59). TCM patterns (證 zhèng) are defined as recurrent combinations of symptoms and signs whose presence can be explained in terms of TCM theory and that can be treated with formulas or acupuncture prescriptions from the TCM archives (62). While in theory a biomedical disorder may present with an unlimited number of such patterns, TCM textbooks and national standards generally
narrow these down to between 2-6 patterns or types (xing) said to define the typical presentations of most disorders (See Table 5).

Table 5: The pattern differentiation of menopausal syndrome as defined by National Standards for Diagnosis and Treatment (63)

In TCM textbooks these patterns or types are usually traced back to discussions in ancient medical texts establishing continuity between TCM and the commentatorial practices through which Chinese medicine developed in the course of the imperial era (64-66). They would make us believe that even as TCM succeeds in grasping biomedical disease, it is able to do so without its essential nature being changed by this encounter. The saying, “Western medicine treats diseases, Chinese medicine treats patterns,” succinctly sums up this apparent essential difference. In fact, biomedical theories have penetrated far deeper into the very tissues of TCM than even most of its own practitioners realize, throwing into relief many of the assumptions on which TCM practice and research is based. The TCM understanding and treatment of menopause is a typical example. Lacking any indigenous concepts of menopause as a “disease”, this was “invented” in the early 1960s by a group of TCM physicians in Chengdu. Educated in both Chinese and western medicine these physicians translated the biomedical concept of oestrogen deficiency into the Chinese medicine pattern of “kidney deficiency” (shèn xû). Through a process of skilful bricolage they then attached this new theory to ancient medical texts, creating an artificial lineage that moved its origins back to the earliest days of the Chinese medical tradition. Enshrined in national standards for diagnosis and treatment and globalised through TCM textbooks, this bricolage of the ancient and the new, the Western and Chinese, has since become the dominant framework through which menopause is comprehended, diagnosed and treated by TCM practitioners in both China and the West (67, 68).

Many clinicians and clinical researchers will argue that as long as it works in practice the history of this invention is fairly irrelevant. However, it is precisely because TCM textbooks do not acknowledge this invention for what it is – only one possible solution to a complex problem for which alternative solutions have also been put forward – that it has become an extremely problematic event. First, by systematically erasing the memory of its own origins, the TCM understanding of menopause has tied itself to what is, in essence, biomedical
theory ca 1950. If, and that is the great risk of all inventions, the claims its proponents make can not be verified, then a two thousand year old tradition risks to be judged in its entirety as a result of this erasure. Second, because it was hidden as soon as it was accomplished, the TCM translation surreptitiously moved into the domain of Chinese medicine a number of ideas not previously present. These include assumptions about gender differences between men and women at mid-life, and about female menopause as a problem of biology that manifests globally in essentially the same manner. As a result, TCM has so far refused to engage with the literature on cultural or regional difference in women’s experience of the menopausal transition even where these are related directly to China (57, 58, 69-75), and TCM textbooks continue to insist that menopause manifests globally through the same basic symptom patterns, even if their numerical distribution may vary from place to place (66, 76, 77).

3.2 Alternative Chinese Medicine Approaches to Treating Menopausal Symptoms in China and Taiwan

The TCM approach to the treatment of menopausal syndrome is thrown into relief by comparing it with Chinese medical practice in Taiwan where tradition has modernised along a very different trajectory. Lacking government support older modes of diagnosis and treatment survived, while new consumer demands, technological innovation, and the enduring influence of Japanese interpretations of Chinese medicine assimilated since the 1930s, fundamentally changed treatment delivery. Hence, whereas in mainland China patients are still treated predominantly with herbal decoctions, Taiwanese practitioners tend to prescribe concentrated herbal powders that are more easily prepared, and increasingly combine ready-made formulas rather than formulate individualised prescriptions (78).

Interestingly, too, the most widely used formula to treat menopausal complaints in Taiwan is Augmented Rambling Powder (jiā wēi xiāo yáo sān) (78). Dating back to the Song dynasty, it treats heat symptoms due to imbalances that reflect an older and less biomedicalised understanding of the menopausal transition.iii In mainland China, non-mainstream approaches to treating menopausal symptoms also exist outside of institutionalised practice, and are easily accessible in the case history literature published in Chinese medical journals and the collected experiences of famous senior physicians (老中醫 laozhongyi). It is
impossible to detail the diversity of these approaches in the space of this review. Suffice to say that some, like the various streams of the “classical formula current” (經方派 jīngfāngpài) that is currently undergoing a revival in China, operate with reference to the same ancient formulas used in Japanese Kampō medicine. Others draw from a wider range of traditional approaches similar to contemporary TEAM practice in Korea or Taiwan discussed below. This makes it impossible to define in a meaningful manner “the” Chinese medicine treatment of menopause. A more appropriate understanding should be that the Chinese medical tradition has over time developed a range of approaches for dealing with menopausal symptoms, and that understanding their origins can help clinical researchers, practitioners and patients to put them into perspective.

2.3 The Treatment of Menopausal Symptoms by Kampō Medicine in Japan

Japanese Kampō 漢方 medicine differs from TCM in China along three important dimensions. First, it is practiced exclusively by biomedically-trained physicians, often as an adjunct to biomedical care. Currently, more than 70% of Japanese physicians including nearly 100% of Japanese obstetricians and gynaecology specialists prescribe Kampō formulas. Second, the dominant school of Kampō in Japan today derives from a 17th century reinterpretation of Chinese medical texts dating from the late 2nd century. It emphasises experience and observation over theory and limits itself to a small range of 148 standardized herbal formulas composed from a pool of around 160 individual pharmaceutical substances. Daily dosages used tend to be significantly lower than those of comparable TCM formulas, and the relative dosages of individual ingredients are also often changed. Formulas are administered in the form of concentrated herbal granulates whose production is tightly controlled by government regulations concerning quality and safety controls (81-83).

As in China, Kampō physicians only “discovered” menopause as a distinctive medical problem only in the 1950s. A specific term for menopausal syndrome (更年期症候 kōnenki-shōgai) as opposed to menopause as a mere life event was introduced as late as 1953 by Kusumaya (84). He reported that this syndrome was characterized by “indefinite complaints” caused by an imbalance of the autonomic nervous system. For reasons unique to Japanese culture this theory was supported by numerous researchers for many years and has been replaced only more recently by a focus on female sex hormones (85). Kampō, like TCM,
focuses on symptom patterns, known as shō 調 in Japanese, through which menopause manifests in individual women. Unlike TCM, the determination of these patterns is, at least in principle, entirely experience based. This means that it could utilise only sensory data provided by means of the four examinations (asking, feeling, seeing, touching) without seeking to explain the presence of such data by means of theory (86).

In clinical practice, however, Kampō physicians often prescribe formulas for biomedical diseases rather than shō, or change the definition of shō to include not merely sense data but also biomedically defined pathologies such as "vasomotor symptoms" or “autonomic nervous disorders.” In that sense, the practice of Kampō in contemporary Japan, as that of TCM in China, is both heterogeneous and embodies Kampō’s very own cultural history (83). Table 6 lists commonly prescribed formulas for menopausal symptoms in contemporary Japan and their associated patterns.

Table 6: Common Formulas for the Treatment of Menopausal Symptoms in Traditional East Asian Medicines

3.4 The Treatment of Menopausal Symptoms by Korean Medicine

Koreans often employ the term Oriental medicine (東方醫學, 동방의학) for their country’s traditional medical system with reference to the Mirror of Oriental Medicine 東醫寶鑑, the 17th century medical text that defined the development of a distinctive medical tradition in Korea. In 1987 this name was officially changed into Korean medicine (韓醫學, 한의학) by the Korean National Congress bestowing a new degree of authenticity while also, like in China, recruiting traditional medicine to the cause of nation building. Traditional medicine in Korea is a high-status profession on par and in competition with biomedicine. It possesses its own institutional infrastructure and research institutions, and has historically been shaped by influences from both China (during the late imperial period) and Japan (as colonial power in the 20th century).

The relatively late entrance of the Korean state into the domain of traditional medicine means that in Korea one does not, as yet, find a split between an institutionalised official version of tradition and regional, local, or idiosyncratic variants. Accordingly, there exists no single dominant perspective as to how menopause should be treated. Instead, one finds an
assemblage of competing approaches that depend on an individual physician’s skills and background in matching patient presentations with treatment strategies and formulas from the medical archive. Compared to Japan Korean physicians draw on a much wider range of formulas from all eras and areas of the East Asian medical tradition, including modern formulas for the treatment of menopause from mainland China. As in China, attempts are made to trace back the use of these formulas to traditional precepts, though such linkages are established via the presence of significant symptoms (such as facial flushing, sweating, insomnia, or palpitations) and the disease patterns they imply rather than seeking to backdate a hormonal understanding of menopause to the premodern era (87, 88).

Table 6 lists the most commonly used formulas for the treatment of menopausal symptoms in Korean medicine and their associated patterns. Interestingly, the most popular formula *danchi soyo san* 丹梟遜散 (Augmented Rambling Powder, Chin. *jiā wēi xiāo yáo sān*), which is also the most often prescribed formula in both Japan and Taiwan but not in TCM textbooks and textbook derived practice (48, 89).

### 4 Traditional East Asian Medicines and Cultural Differences in the Experience of the Menopausal Transition

If the social history of TEAM accounts for how individual currents of the wider tradition have selectively adapted a shared box of tools (i.e. herbal formulas) to the treatment of a new problem (i.e. menopausal syndrome) by analysing different institutional arrangements of medical practice, a second important factor that may be shaping these adaptations are local differences in women’s own experience of the menopausal transition. These were first described by Lock for Japan (52) and have since been corroborated by a wide range of comparative studies (90).

If we compare how different TEAMs take account of such differences we can distinguish between two ideal-typical approaches. The first, embodied by Japanese Kampō, is extremely sensitive to local difference because its focus on symptom patterns (*shō*) is primarily phenomenological and, as much as that is possible, theory-free. This means that symptoms with low hormone dependence like general fatigue and shoulder stiffness, which are consistently reported as the two most frequent symptoms experienced by peri- and postmenopausal women in Japan, are as important to Kampō physicians in determining the *shō* of any given patient as symptoms with high hormone dependence such as hot flushes
and sweats (91). For instance, *keishi bukuryo gan* (Cinnamon Twig and Poria Pill, Chin. *gui zhī fú líng wán*) is one of the most often prescribed formulas for menopausal women in Japan precisely because it focuses on shoulder stiffness and backache as much as on hot flushes, but hardly features in either TCM textbooks or the case history literature. Another example is the *shō* for the formula, *toki shakuyaku san* (Tangkuei and Peony Powder, Chin. *dāng guì sháo yào sān*), which contains chills as a key symptom. Not only do such chills constitute an important and recurrent feature in the Japanese experience of menopause but the inclusion of chills into the *shō* of this formula is also typically Japanese. Again, as shown in Table 6, the formula is not widely associated with menopausal symptoms in either China or Korea.

TCM treatment, on the other hand, starts from an understanding of ageing as one of a universal decline in Kidney essence. Hence, TCM physicians in China and the West consistently focus on Kidney deficiency as the most important problem in menopausal women irrespective of documented differences in symptom prevalence not only between China and the West, but also between different regions within China (10, 93-95). In order to create a closer match between recommended formulas and patient presentations, TCM physicians, however, regularly modify formulas by adding or subtracting different ingredients, and it is this skill that is often seen to be the true reflection of a physician’s skill (62).

We have less knowledge about the processes through which Korean and Taiwanese physicians have constructed their treatments of menopausal symptoms. That the same formula dominates prescribing in both of these countries as well as Japan is an interesting observation that has not yet been commented upon in the literature. It may reflect similarities in women’s experience in these countries; it may be a sign of lingering Japanese influence on traditional medical practice dating from the colonial period; or it may indicate a homing in on the “essence” of a menopausal syndrome from the perspective of TEAMs that deserves to be further investigated both in relationship to biomarkers that might match the typical Augmented Rambling Powder (*jià wèi xiāo yáo sān*) pattern, and with respect to the TCM interpretation of menopause as Kidney deficiency that leads to quite different treatment priorities. It should be noted in this context that a study evaluating the effectiveness of Augmented Rambling Powder (*jià wèi xiāo yáo sān*) in treating menopausal symptoms without following a pattern based style of prescribing showed limited effectiveness compared to HRT that was not above that of other commonly used formulas.
At the same time, the extremely wide overall range of formulas employed by physicians in Korea, Taiwan and also China reflects the plurality of TEAMs beyond more narrowly defined institutionalised practices. This can be explained sociologically as a result of a lack of institutional control but also hints at local and individual differences in how women experience the menopausal transition, and at the potential sensitivity to such difference of TEAMs.

5 Conclusions

In this article we have attempted to place the various approaches developed by TEAM for managing menopausal symptoms in the context of local clinical practice. We used a multidisciplinary approach drawing on social history, medical anthropology and clinical research to examine how these approaches emerged and how clinical practice may be evaluated against this background. From this we draw three conclusions.

First, TEAMs constitute living traditions that have adapted to the changing contexts in which they need to operate today by pursuing three strategies of modernization:

i. The translation of biomedical ideas of menopause as hormone deficiency into the Chinese medical idiom of Kidney deficiency. This has generated a coherent and universally applicable model of menopause dominating TCM practice in China and the West.

ii. A phenomenological approach that seeks to match individual presentations of menopausal symptoms (patterns, shō) to a range of standardized formulas as in (idealized) Kampō medicine, or in the resurgent classical formula current in Chinese medicine. This generates a highly individualized practice in which each patient constitutes his or her own control.

iii. The adaptation of traditional medicine to local contexts of practice as an emergent synthesis of classical learning, modern biomedicine, technological innovation, culturally specific experiences of the menopausal transition, and patient demand.

Given their historical contingency all three models may overlap to a greater or larger extent. For instance, the assumptions about the universality of menopause at the heart of the TCM approach is adapted to individual presentations by modifying Kidney tonifying formulas in line with presenting symptoms and signs. Vice versa, in the absence of any external
pressures to systematize and standardize practice, *Augmented Rambling Powder* (*jiā wèi xiān yāo sūn*) has emerged as the most commonly used formula for treating menopausal symptoms among TEAM practitioners in Taiwan, Japan, and Korea indicating an overlap in terms of how patients in these countries present, and in how TEAM practitioners match presentations to formulas.

A second and equally important observation is that clinical research consistently fails to take into account the dynamic nature of TEAMs as living traditions and the diversity of practice that it generates. At present, there exists no coherent research agenda appropriate to a meaningful evaluation of TEAM practices in the treatment of menopausal symptoms and their potential integration into contemporary health care. Rather, in terms of research questions asked, methodologies used, and the understanding of what TEAMs are and should be, research seems to be driven largely by subjective interests, and the opportunity frameworks in which individual researchers or research teams operate. The following recurrent problems in the formulation of research questions are thus endemic in the literature we have surveyed:

i. Not distinguishing clearly between different TEAM approaches conflating, for instance, TCM and Kampō (96, 97)

ii. Selecting treatments for evaluation that do not represent actual TEAM practices, such as the use of single herbs, single formulas, or the prescribing of formulas not based on pattern diagnosis, but labelling them nevertheless as such.

iii. Justifying research questions by invoking spuriously defined or imaginary ‘traditions’, or previous research that is based on these rather than carrying out appropriate and critical literature reviews.

Avoiding these shortcomings in future studies will require integrating individual studies into a more comprehensive shared research framework. This framework, in turn, needs to be informed by a critical understanding of TEAMs history, including their complex articulation with biomedicine and diverse cultures, and their integration into specific contexts of medical practice. We also believe that this framework should be guided by the goal of rationally managing the integration of TEAMs into the personalised and integrated health care systems of the future rather than evaluate arbitrary chosen treatments whose relation to actual TEAM practice is spurious at best.
Our third conclusion is that at present evidence for the effectiveness of TEAMs approaches in the treatment of menopausal symptoms is inconclusive. Studies evaluating the use of specific formulas or treatment approaches provide sufficient evidence, however, that TEAMs may be able to help symptoms of menopause, especially when characteristics of everyday clinical practice are more closely taken into account. This is what the CONSORT guidelines for RCT’s involving herbal medicine recommend (98). It is part of the integrated research agenda we are proposing to create an environment in which such RCTs are seen as an essential part of defining in a rational manner the appropriate role of TEAMs in the treatment of menopausal symptoms.
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1 Electronic databases in Chinese, Japanese, Korean and English were searched using (in the relevant languages) key terms ‘climacteric or menopause’ for randomised controlled trials involving Chinese herbal medicine, Kampo, and Korean medicine versus placebo and/or biomedical treatment. We did not examine acupuncture studies because these are dealt with by a separate article in this volume. We searched the following databases: the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library); MEDLINE; AMED; AltHealthwatch; the portal infolinx at University of Westminster; the China National Knowledge Infrastructure (CNKI) at www.global.cnki.net; CQVIP Chinese Scientific Journals Fulltext Database at (http://www.cqvip.com; the Special Committee for

ii TCM physicians, today, also employ the terms manifestation patterns associated with the cessation of menstruation” (jingduan qianhou zhuzheng 經斷前後諸證) or “symptoms and signs associated with the cessation of menstruation” (jingduan qianhou zhenghou 經斷前後症候). These were coined in the 1960s in an effort to differentiate the TCM understanding of menopause from that of biomedicine, even if (or rather precisely because) it was a translation from biomedicine (18). The same can be said for the term gyeongpyegi 経閉期 used by Korean physicians in their writings.

iii Rambling Powder (xiao yáo sǎn 逍遙散) and its derivative Augmented Rambling Powder (jiā wèi xiāo yáo sǎn 加味逍遙散) are extremely important formulas in the history of Chinese medicine whose usage and range of indications has changed considerably over time (55). It must be assumed that the contemporary usage of the formula in Taiwan is influenced by Japanese Kampo usage as well assimilated during the era of Japanese occupation.


v This is the case not only for Chinese medicine in contemporary or late imperial China but for all medical traditions at any place and any time (79, 80).

vi Compare for instance the description of the pattern/sho for this formula in Scheid, Bensky, Ellis et al. (92) with that in Shibata (86).

vii Compare for instance the description of the pattern/sho for this formula in Scheid, Bensky, Ellis et al. (92) with that in Shibata (86).