Journal of Advancement in Medicine
Volume 1, Number 1, Spring 1988

On the Evolution of Electrodermal Diagnostic Instruments

William A. Tiller, PhD

ABSTRACT: A review is given of key skin electrical measurements using both large and small electrodes. Such measurements lead to an electrical equivalent circuit of the skin that contains both a high–frequency portion (microsecond time response) and a low–frequency portion (second time response). Commercial instruments based on one or the other of these circuits are described and evaluated as to what they actually measure in terms of skin parameters versus organ function. Some connection between acupuncture point electrical properties and internal organ function is noted as is the use of such devices as early warning cancer detection instruments. Some theoretical deductions concerning organ/acupuncture point linkage is also given.

Introduction

Expenditure on health services in the U.S. is currently at the rate of $1 billion per day. As a percentage of gross national product (GNP), medical care expenditures have risen from 5% in 1960 to 10.5% in 1984. Because of this, in recent years government officials have predicted that the present rate of escalating costs will bankrupt the Medicare system by 1990. Many difficult health policy decisions obviously lie ahead and it is clear that fundamental reform of the US health care system, and not just a minor adjustment of its parts, must become a national priority.

Within this context, I would like to propose that electrodermal diagnosis of human body systems holds the promise of being a much faster, much cheaper and perhaps a more accurate early method of body diagnosis than the present chemical analytic methods. Of

Dr. William A. Tiller is Professor, Department of Materials Science and Engineering, Stanford University, Stanford, California.

course, at the moment, much research needs to be carried out to provide the mapping transforms between the electrical signatures determined by electrodermal measurements and the chemical patterns associated with various medical syndromes or health pathologies.

At this point one might well ask, "What do I mean by electrodermal diagnostic measurements?" In response, I would say that this involves placing electrodes at various locations on the skin of the body, applying a fixed voltage or electrical current between electrode pairs for a specific amount of time and recording the response of the body to this stimulus in the form of a current or voltage, respectively, as a function of time. Analysis of these response magnitudes and patterns is thought to be directly related to the state of function of the various organs and body systems. Electrodermal studies of human skin have been carried out since the turn of the century with the view to learning more about the body's electrical characteristics and patterns of function, and some of this early work culminated in the invention of the ECG, EEG and EMG technologies, important "linchpins" in modern medical technology.

From one vantage point, the body can be looked at as a complex interconnected electrical power generation, power distribution and power use system much like that found in a modern state or province. Thus, the circuit theory concepts of electrical engineering are relevant here. One imagines a type of internal "wiring" into which organs feed a variety of current and out of which other body systems act as electrical loads and draw current. The energy streams from a number of organs appear to flow into one of the many internal conducting channels and appear to flow either to or "through" a set of surface points. It is the degree and character of energy flow that is correlated with the functioning condition of that set of organs and that degree of energy flow is thought to generate the difference in electrical conductance between these special surface points and the surrounding tissue. Thus, these points become *information access windows* to the functioning state of specific organ and body systems.

In this paper, I wish to trace the modern development of electrodermal instruments so that we will have a better understanding of its origins. Unfortunately, this sketchy historical review cannot be complete partially because many of the instruments in use have little written documentation, nor have they been written up in the professional literature. The available information can be divided into two domains of electrodermal studies involving either macro– or micro–

size electrodes. The large electrode (diameter ≤ 1 cm) results, which became the background terrain for modern galvanic skin response (GSR) studies, were well defined by the work of Rosendal, which was carried out prior to World War II and published during the early 40's[1]. The small electrode (diameter ≤ 0.1 cm) results, beginning in the late 1940's, revealed an interesting heterogeneity to the electrical properties of skin on living mammals.

In part, with small electrodes, one discerns an array of high electrical conductivity points patterned over the body that can be discriminated to lie along a number of discrete high conductivity lines. Although no histological difference can be discerned at present between a high conductance point region and the adjacent tissue, it has been shown that a direct correlation exists between (a) the difference in electrical conductance at the point versus the surrounding skin and (b) the hypnogogic state of the individual; i.e., waking, sleeping, depressed, elated, hypnotized, etc. Thus, they are, at least in part, neurally influenced.

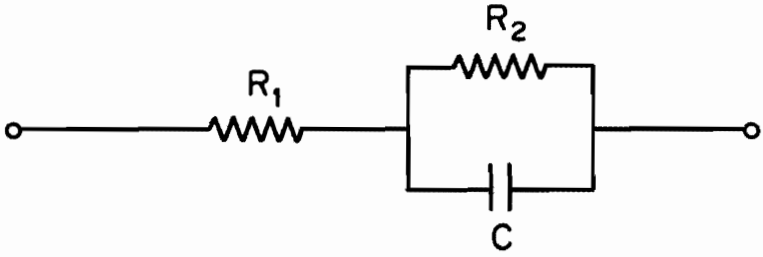
Large Electrode Studies

The skin consists of two main layers, an outer thin layer called the epidermis and a thick inner layer called the dermis. The outermost 0.001 to 0.01 cm of the epidermis is called the stratum corneum, which consists of flattened dead cells and constitutes a large contribution to the electrical impedance of the skin. Although somewhat squashed, the stratum corneum cells still contain electrolyte, are separated from each other by narrow channels of electrolyte and are cation (+ ve ion) permeable. The moisture content of the inner layers of cells in the stratum corneum is much higher than that of the outer layers so that moisture steadily percolates from the inner to the outer layers depending upon the external humidity. The electrical impedance of the stratum corneum is primarily capacitive in nature but is short-circuited by resistive channels between the cells. Its capacitance arises from the 10-100 layers of cells connected in parallel with the single cell capacitance arising from the polar nature of the two membrane layers plus the adjacent space charge in the interior cell medium.

The simplest electrical equivalent circuit for the case of zero applied voltage is that shown in Fig. 1. Here, C is the capacitance of these layers of cells connected in parallel, R_2 is the short-circuiting

FIGURE 1

The simplest frequency independent electrical equivalent circuit used for skin measurements.



resistance across the cells and $R_1 << R_2$ is the resistance of the deep tissues. If this was a true, fixed parameter, electric circuit, the application of a constant voltage V_o would lead to a current response. I(t), like that shown in Fig. 2 where:

$$i_\infty = V_o/R_1 \quad (1a)$$

$$i_\infty = V_o/(R_1 + R_2) \quad (1b)$$

and

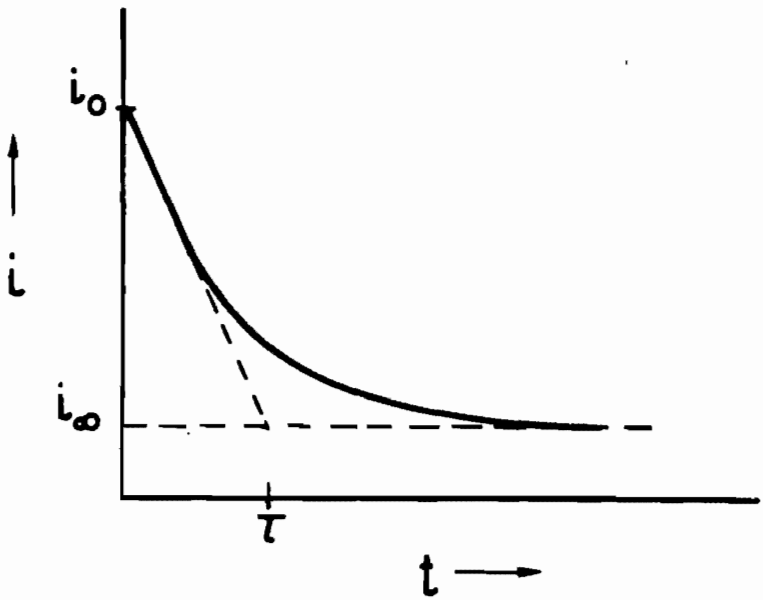
$$\tau = R_1R_2C/(R_1 + R_2) \approx R_1C \text{ for } R_1 << R_2 \quad (1c)$$

Thus i_o relates to deep tissue effects while i_∞ relates to stratum corneum effects.

Rosendal [1] showed that, when a negative DC surface voltage is applied such that a steady current is moved outwards through the skin (cathodal current), the D.C. resistance falls, as shown in Fig. 3, and vice versa for current moving inwards through the skin (anodal current). The ratio of the two saturation levels of resistance can be as large as 10:1 and the time constant for the process is many seconds long. When the applied voltage is AC at ~ 1000 Hz, the impedance slowly increases with time, but to a smaller degree than shown in Fig. 3. Such an effect is attributed to the selective permeability nature of the cell membranes (they pass + ve ions more easily than − ve ions) and the short-circuit channels between the cells. At very high frequencies, this effect will be absent because there is insufficient time in a half cycle for ion transport between the cell bound-

FIGURE 2

Current waveform arising from the application of a constant DC voltage to the circuit of Fig. 1.

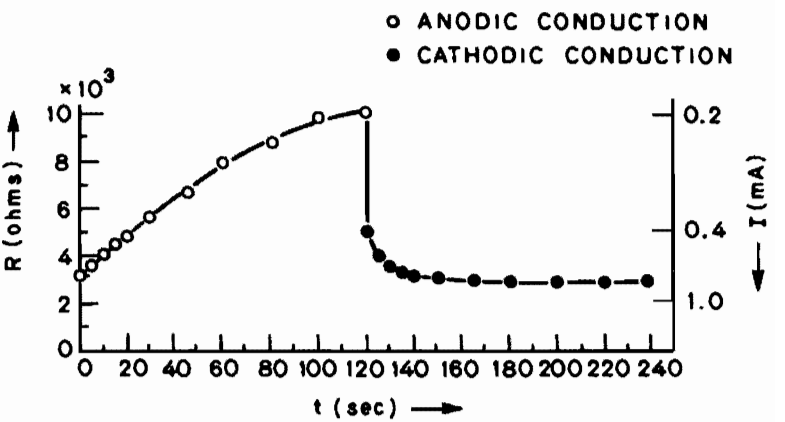


aries, and the current passes instead through the body of the cells. Thus, a frequency dependent resistance is expected at low frequencies.

Rosendal also found that moistening the stratum corneum with electrolyte revealed a marked decrease of DC resistance that became constant in about 30 minutes at a value 5 to 10 times lower than the initial value. This indicates electrolyte enhancement in the stratum corneum by a diffusion process just as occurred with cathodal current flow. When a voltage between 2 and 4 volts was applied after this constant resistance had been reached, a further decrease in resistance was noted so that the resistance approached that of the internal epidermal tissue. This decrease of resistance at $V_o > 2$ volts was

FIGURE 3

Time dependence of the electrical resistance, R, of the skin for a 2 volt applied DC potential (7 cm^2 of skin moistened for 20 min with saturated KC1 solution). (Courtesy of T. Rosendal)



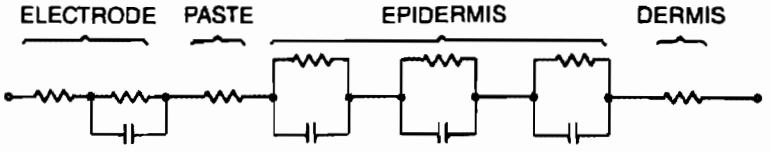
accompanied by a marked feeling of tingling in the skin which became stronger with increasing voltage and which is due to electrolyte dissociation of the water molecules in the stratum corneum and the ultimate generation of H_2 gas at very high dissociation levels.

Assuming the equivalent circuit model of Fig. 1, Lykken[2] applied 100 m sec voltage pulses of $V_o = 0.5$ volts to the skin and studied the relative contributions of the various skin layers to the parameters in Fig. 1. By abrading the skin, he found that C was reduced to undetectable values and that $R_1 + R_2$ was reduced by two-thirds. Therefore, the capacitance resides in the stratum corneum for this long time-constant process (see Fig. 3), while the major resistance is fairly evenly divided between the stratum corneum and the deeper epidermal tissue. He also found that, for voltages above 2V, the resistance was nonlinear with voltage and continued to decrease as the voltage was increased.

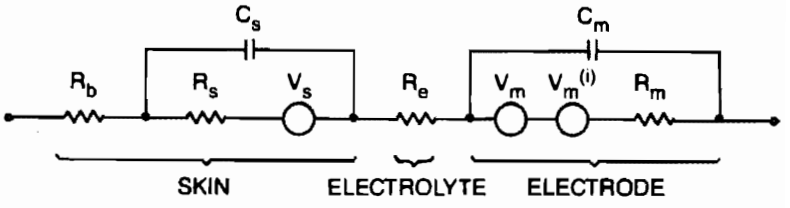
Swanson and Webster[3] obtained similar findings to Lykken by progressively scraping away layers of the stratum corneum and found that the electrical equivalent circuit model of Fig. 4a gave good

FIGURE 4

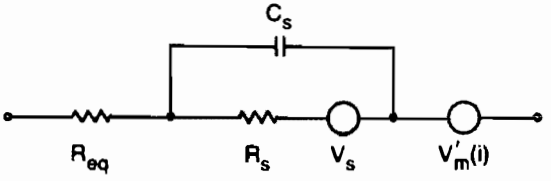
(a) Form of the electrical equivalent circuit of the skin and electrode system which matches the experimental data without assuming frequency dependent parameters.
(b) Alternate systems viewpoint circuit.
(c) Important circuit elements after neglect of the electrodes.



(a)



(b)



match to the experimental data when they gave specific values to the circuit parameters. Gatzke[4] used the model of Fig. 4b and showed that, especially if Ag/AgCl electrodes are used, the electrode parameters are insignificant and the model reduces to that of Fig. 4c which is essentially Lykken's[2] model except for the addition of interface ($V_m(i)$) and skin (V_S) potentials. He found the electrolyte characteristics to be quite important; with a high concentration (5-10%) NaCl electrolyte, the typical resistance values will decay by a factor of 25 in about one hour; with a low concentration (0.5%) NaCl electrolyte, very little resistance decline was noted with time.

Nagel and Tiller[5] found via a frequency-dependent study wherein the real and imaginary parts of the skin impedance were plotted (Cole-Cole plots), that skin exhibits both a high frequency ($\tau_I \sim$ 1-10 μsec) and a low frequency ($\tau_{II} \sim$ 10-100 sec) electrical equivalent circuit in series (See Fig. 5), with the Z_I and Z_{II} parameters in Fig. 5 being diffusional admittances which are functions of frequency.

In a study of electrocutaneous stimulation, Kume and Ohzu[6] used bipolar constant voltage pulse trains with ring type electrodes located on the forearm and observed the response of the high frequency circuit as illustrated in Fig. 6. We note that $\tau_I \sim 5$ μsec in this case.

The studies of Lykken[2], Swanson and Webster[3] and Gatzke[4] all

FIGURE 5

Electrical equivalent circuit generated from skin measurements using AC conductance techniques and complex plane analysis.

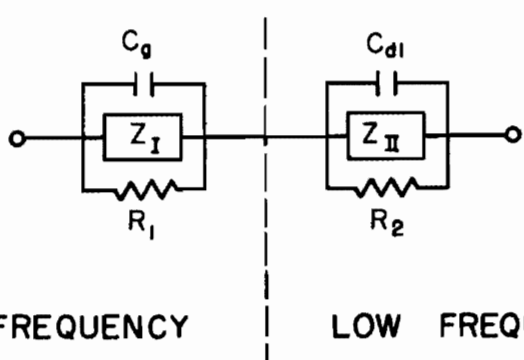
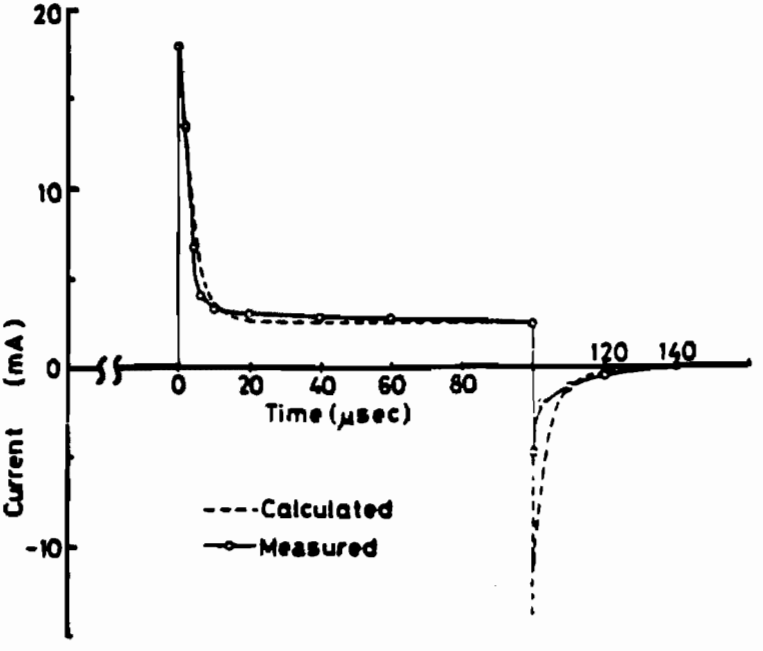


FIGURE 6

Stimulus current corresponding to a constant voltage pulse applied to the skin through a concentric electrode.

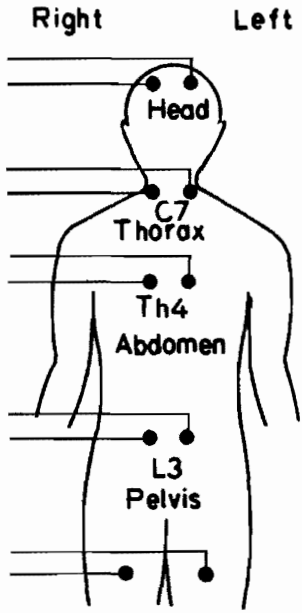


relate to the low frequency circuit (τ_{II}), where the diffusional admittance is primarily related to ion transport processes through the membrane. For the high frequency circuit, electrical dipole oscillations of the membrane fixed charge sites are expected to be responsible for τ_I.

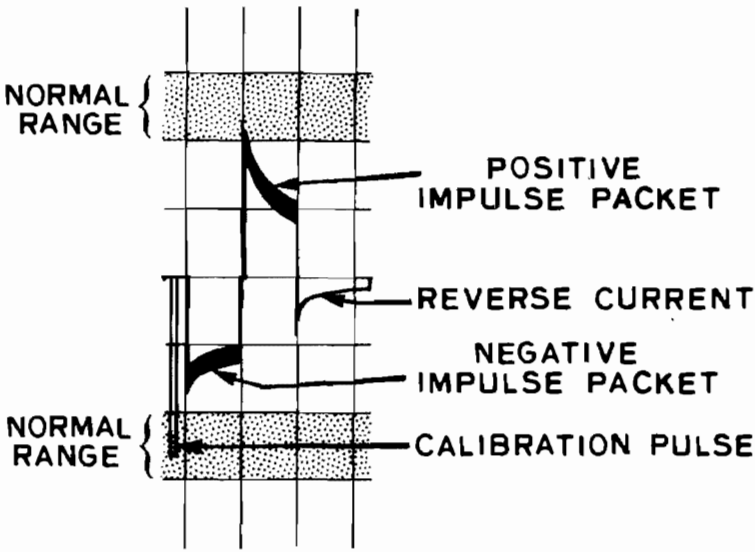
Schimmel[7] appears to be one of the first to develop a medical diagnostic instrument based upon this large electrode information. In the Schimmel Segment Electrogram, the body is divided into horizontal sections and a pair of electrodes is placed in each section on the anterior surface, as indicated in Fig. 7. Each electrode pair is stimulated with a sequence of: 1) a 13 Hz negative voltage sawtooth im-

FIGURE 7

(a) Body placement of electrodes in the Segment Electrograph technique.
(b) Illustration of electrical pulse cycle on recording paper.



pulse of 18 second duration, 2) a similar positive-going wave and, finally, 3) a 26 second quiescent period at zero volts. The current is recorded during each of the three phases and indicated in Fig. 7b. Schimmel indicates that diagnostic information is implicit in the following features: 1) the magnitude of the current pulse in the stimulation phase can fall in either (a) the normal region, (b) above the normal region (hyperfunction) or below the normal region (subfunction); 2) the shape of the current trace in the stimulation phase and 3) the magnitude and shape of the response current phase. The normal shape of the current trace in the stimulation phase is a slightly curved trace at about 35 degrees to the horizontal with drop



in amplitude and clear cut border line (see Fig. 8a). The subfunctioning energy condition is illustrated by a shortening or almost total absence of current amplitude and a transformation of the sloping shape towards a rectangular shape (see Fig. 8b). This is interpreted by Schimmel as increased energy rigidity combined with decreased energy flow. The hyperfunctioning energy condition is indicated by increased current amplitude and an increase in trace angle above 35 degrees (see Fig. 8c). This is interpreted as an indication of rising energy flow, of increasing degree of inflammation and of oxidation. Similar interpretations are also given to the features of the response current waveform (see Fig. 9).

From the basic information given earlier[1-6], we note that this technique deals with the low frequency portion of the skin circuit and thus involves ion transport across selective permeability membranes. The driving voltage sees the sum of the resistances from the left and right electrodes so the generated current is cathodal from one and anodal from the other (see Fig. 2). The net resistance increases with time due to ion transport effects so the current trace in the stimulation phase decays with time, as noted in Fig. 8. The subnormal functioning condition is thus due to high skin impedance which comes

FIGURE 8

Illustration of the general types of current trace resulting from the stimulation voltage wave: (a) normal body function, (b) sub-normal body function and (c) hyper body function.

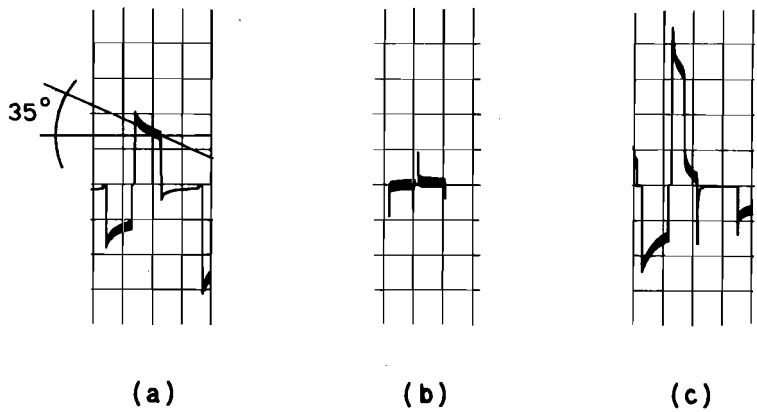
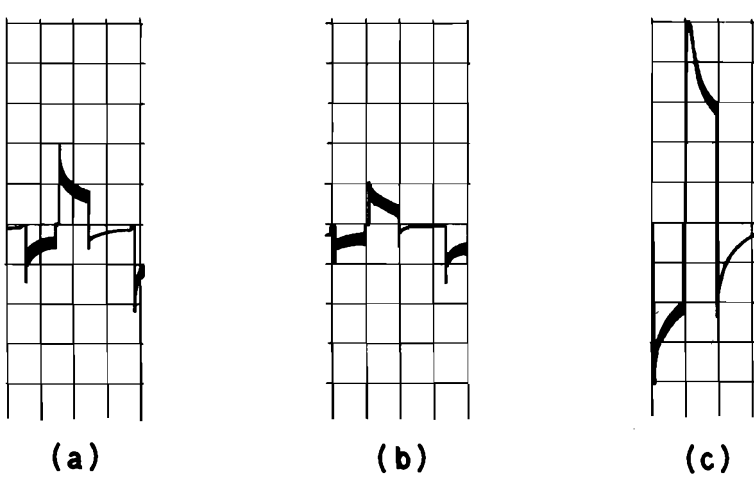


FIGURE 9

Illustration of the response current trace: (a) normal body function, (b) sub-normal body function and (c) hyper body function.



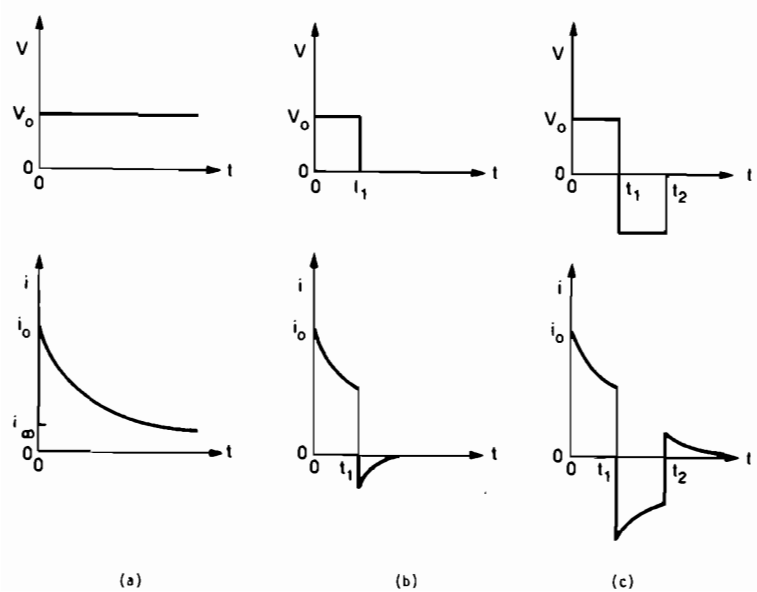
from a combination of low electrolyte content and/or low tissue fluid content. The hyperfunctioning condition is thus due to low skin impedance which comes from a combination of high electrolyte content and/or high tissue fluid content.

The stimulation and response current waveforms can be predicted from first principles just as Fig. 2 and eqs. 1 apply to a constant applied voltage. The qualitative results for a positive impulse voltage and for a positive followed by a negative impulse voltage are given in Fig. 10. In each case, there is a calculated response current, as shown in Fig. 10 (b) and (c), depending upon R_1, R_2 and C of Fig. 1 and the periods t_1 and t_2 in Fig. 10.

From the foregoing, we see that the Schimmel technique measures the basic ion concentration, the mobility of these carriers and the

FIGURE 10

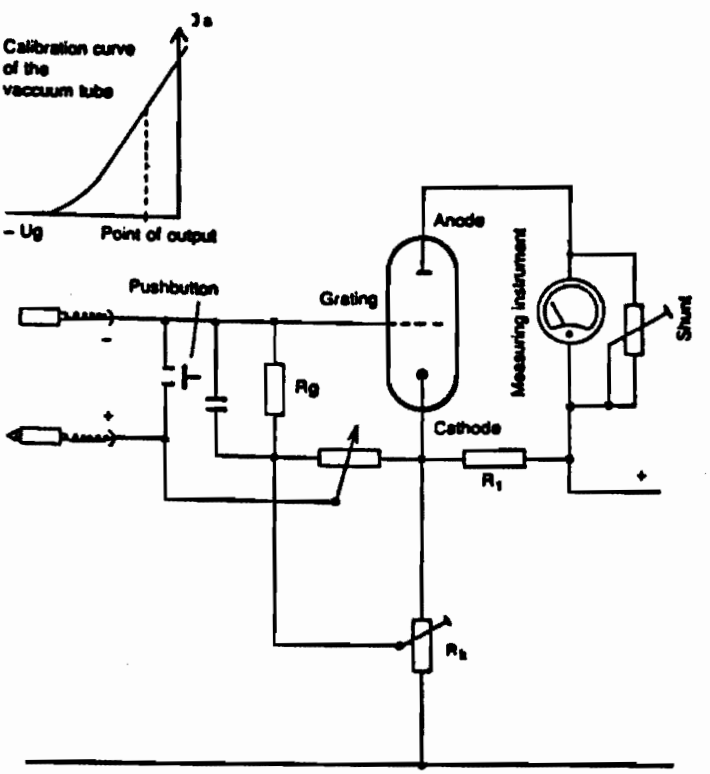
Response current waveforms to various voltage waveforms being applied to the circuit of Fig. 1.



permeability selective character of the cell membranes in the skin in various sectors of the body. The direct connection between these skin parameters and the body's state of health is not immediately obvious. However, the skin is one of the body's major waste disposal systems and it is a linkage medium to various nerve endings. It is reasonable

FIGURE 11

(a) Diagram of connections for the diagnostic part of the K+F− Diatherapuncteur apparatus.
(b) Calibration curve for the above apparatus.

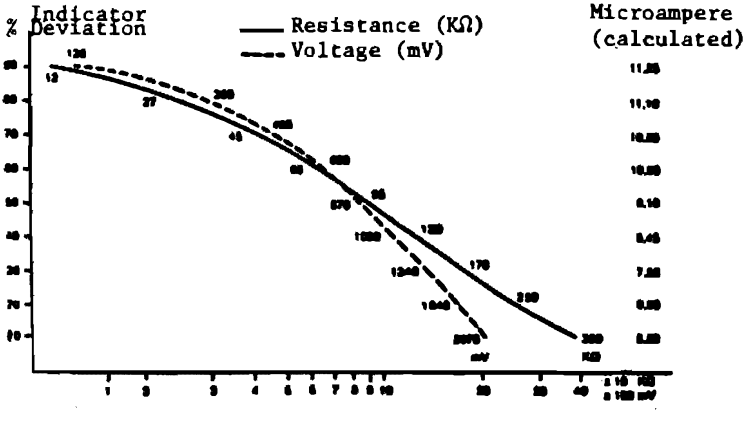


(a)

to deduce that a shift of the skin conductance parameters from the normal range signals either a local waste disposal problem or a local neural problem connected to some organ or body system malfunction. Or it is possible that the local skin conductance parameters, all by themselves, indicate the state of local body health or pathology in ways we do not yet understand. Finally, it is possible that we are kidding ourselves and the local skin conductance parameter values only indicate the local state of hydration, ion content and membrane permeability.

Small Electrode Studies

In the early 1950's, Y. Nakatani [8] used a 12 volt DC source and passed current through the skin of a patient discovering, thereby, that some points had a much higher electrical conductance than the surrounding sites. He named these "good conductivity points" and linked them up with an imaginary line known as a "good conductivity line" (Ryodoraku). This became known as the "Ryodoraku" technique and the measurement device was called the "Neurometer." Here, the patient holds in his/her hand the mass electrode, and the good conductivity points are tested with the tip of a search electrode. Because of the large voltage used, this response current is largely due to electrolytic dissociation of H_2O. In Europe, Niboyet[9], Bratu[10] and



(b)

Brunet[11] also studied the properties of these high conductivity points. In China, many similar studies were conducted[12-14]. They found that the location of these high conductivity points and lines coincided amazingly well with the points and meridians of Chinese classical acupuncture. Using a Nakatani neurometer, Matsumoto[15] showed that 80% of acupuncture points could be detected.

According to Nakatani[16], acupuncture points have a low resistance due to the fact that excitation of sympathetic nerves had caused enlargement and opening of the sweat and sebaceous glands at these sites. However, others[14] failed to substantiate this proposal. Ishikawa[17] claimed that the high conductivity was due to reflex changes in subcutaneous blood vessels. However, Niboyet[18] found that acupuncture points on cadavers also had the characteristic of highest local conductivity. Others[14] substantiated this finding and Shenberger[19] demonstrated the high conductivity characteristic on a human subject in life, after death and after embalming.

In an attempt to quantify the conductance observations a little better, Reichmanis, et al.[20] used a rolling-type probe in a 2 volt bridge circuit and found that conductance maxima could be found within a 1 cm^2 area surrounding the large intestine meridian on the forearms and that more prominent maxima were located at the acupuncture points. Wulfson[21] investigated 27 points and obtained an average resistance of 794 ± 197 K ohms when bilaterally compared with control points 0.25 inches away from them. The average resistance of the control points was 1404 ± 306 K ohms. Using a miniature array of 36 electrodes, Reichmanis, et al.[22] were able to compare both acupuncture point and control point regions without the need to search for the local conductance maxima. Most of the points on the lung and triple heater meridians were shown to be statistically different from the control point. Using a special ring electrode design, Hyvarinen and Karlsson[23] studied conductance maxima on the ear and found them to be a factor of 10-30 higher than the surrounding skin. Further, assuming a skin impedance model like Fig. 1, Reichmanis, et al.[24] used Laplace transform techniques to evaluate R_1, R_2 and C for points H_2 and H_4 of the heart meridian relative to adjacent control points. They found R_1, R_2 and C to be about 3-6 times lower, 1.5 to 2.5 times lower and 1 to 2 times higher, respectively, for the acupuncture points.

All of the foregoing has dealt with electrical conductance properties of these special points and it is perhaps not surprising to learn that these points also have higher electrical potentials than the surround-

ing tissue[14,25]. Becker, et al.[26] determined the skin electrical potential and found that some acupuncture points on the body showed positive electrical potential in contrast to surrounding areas. Brown, et al.[27] reported that most of the high potential points were present bilaterally on the body and were in corresponding positions with those of classical acupuncture points. Dumitrescu, et al.[28] reported that acupuncture points had electrical potentials 2-6 millivolts higher than that of the surrounding areas. Of course, this is just what one would expect if the skin cell membranes were cation permeable and the acupuncture points had a higher conductivity via a higher electrolyte content. Diffusion of positive ions to the surface of the skin would be enhanced at the acupuncture points leading to the excess positive potential at these points.

Fraden and Gelman[29] and Fraden[30] used a constant current source to investigate nonlinear effects at acupuncture points. A bipolar current source was employed in order to pass a 10 μA square wave current at frequencies from zero to 1000 Hz through certain acupuncture points. The skin impedance was investigated and it was found to be larger when positive current flowed (anodal) than when negative current flowed (cathodal) in accordance with the large electrode results in Fig. 2. This nonlinearity, defined as the ratio of positive impedance to negative impedance, is reduced as the frequency is increased above 1 Hz. The time constant for the resistance changes was found to be ~ 1-5 seconds for the positive polarity and ~ 0.5-3 seconds for the negative polarity. This is much shorter than τ_{II} in Fig. 2; however, here the current density is much higher. In fact, the current density is sufficiently high that the local voltage across the skin exceeds 2 volts so that H_2O dissociation is occurring at all times. They found that the skin impedance was suddenly reduced by 5-10 times when the negative current was applied for several seconds. This phenomenon, which has been called "point breakdown" is accompanied by a change of all point properties and is thought to be associated with the destruction of the cell membranes.

Besides the Nakatani neurometer[8], two major pieces of diagnostic equipment have been developed based upon the small electrode skin conductance findings and we shall now discuss these. No commercial diagnostic equipment has yet been developed which exploits the electrical potential properties of acupuncture points or which utilizes the constant current source technique.

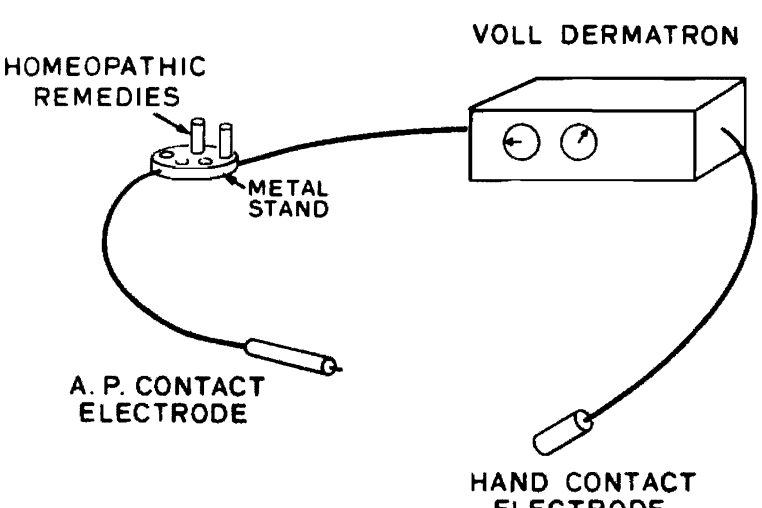
In the low frequency domain, the Voll dermatron[31] has been the most popular instrument. Its predecessor was the K&F Diather-

apuncteur unit which is no longer being manufactured; however, it forms the basis of all the other EAV (Voll instruments) and its functioning is described in Appendix A.

With the Voll dermatron, shown in Fig. 12, in the diagnostic mode, the AP is charged with ~ 8-10 μA at a DC voltage of ~ 1 volt. The method of doing this is via a ball electrode contacting the skin at an applied pressure of ~ 500-1400 psi, while a large cylindrical electrode is held in the patient's off-side hand to complete the electrical circuit. The meter on the instrument is designed to record the skin's electrical conductance rather than the electrical resistance. The scale of the meter has been adjusted so that a reading of 50 indicates "normal" while a reading of >50 is defined as indicating an irritated situation with the degree of irritation increasing as the reading increases. A reading of <50 is defined as a degenerative condition with the degree of degeneration increasing as the reading drops.

FIGURE 12

Schematic illustration of the Voll dermatron with electrodes.



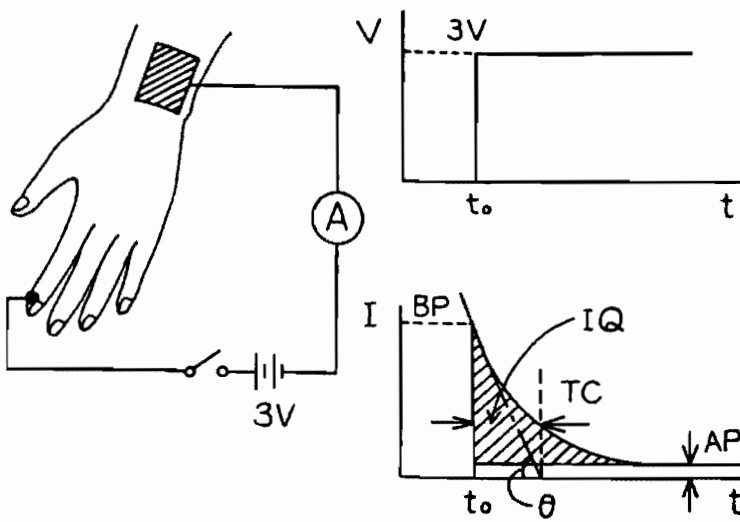
A second and perhaps more important diagnostic indicator is the indicator drop (I.D.); i.e., the reading decreases from its maximum initial value to a final value with time. As a rule, the I.D. occurs within 1 to 3 seconds. In a retarded I.D., suggestive of an incipient functional disturbance, the period is thought to depend upon the intensity and scope of the pathologic process in the organ being measured. The interval of the I.D. is usually 10-20 seconds when the initial measurement value is about 50; it is 20-30 seconds when the measurement value drops to 30 and it is greater than 30-60 seconds when the reading drops to 20 or less. This is basically the same type of behavior as noted earlier with the Schimmel device. Here, when the initial skin conductance is smaller (resistance higher), the anodal current flowing through the skin for fixed applied voltage is smaller so it takes longer for the ion transport to occur through the membrane walls. Thus, the resistance rises more slowly with time and the I.D. is slower. This device also measures skin conductance levels (combined electrolyte content and water content) and permeability selectivity of the membranes. Even for the same value of conductance, an increase of I.D. value by a factor of $\sim$ 5-10 in a pathologic versus a healthy case indicates less permeability selectivity for the membranes involved. Once again, it is not readily seen how the electrical conductance and permeability selectivity values of the A.P.'s are directly connected to specific organ or body system functioning.

The Motoyama AMI instrument[12] applies a DC potential of 3 volts between a number of meridian terminal points and a large indifferent electrode on the wrist, as indicated in Fig. 13. It utilizes a skin electrical equivalent circuit like that shown in Fig. 1 and samples the very short time domain (high frequency domain). A current waveform like that shown in Fig. 2 is sampled by the instrument. He defines 4 parameters (supposedly independent) for describing this current response: 1) BP (before polarization), the current value before ionic polarization in the skin proceeds against the externally applied electric potential ($i(t = 0)$); 2) AP (after polarization), the current value which still flows even after the completion of this short time polarization ($i(t = 10^{-3}$ sec)); 3) IQ (integrated polarization charge), the total transferred electric charge of ions incurred during this short time polarization and 4) TC (time constant), the intercept point of the initial current slope with the AP level.

One should not confuse the current waveform and circuit parameters involved in Fig. 13 with the current waveform and circuit param-

FIGURE 13

Single electrode arrangement in the Motoyama technique, applied voltage impulse and response current waveform for the system.



eters involved in Fig. 3, because the time domains are completely different. If one could assume constant circuit parameters for both the low frequency (Fig. 3) circuit and the high frequency (Fig. 13) circuit, then the value of i_∞ from the high frequency circuit is approximately the value of i_o for the low frequency circuit. In analogy with eqs. 1, let us use primed values to denote the value of R_1, R_2 and C for the high frequency circuit and unprimed values for the low frequency circuit. Then, we have

$$BP = V_o/R_1' \tag{2a}$$

$$AP' = V_o/(R_1' + R_2') \tag{2b}$$

$$\tau_I = R_1'R_2'C'/(R_1' + R_2') \approx R_1'C' \qquad \text{for } R_1' << R_2' \tag{2c}$$

$$i_o = AP' = V_o/R_1 = V_o/(R_1' + R_2') \tag{2d}$$

$$i_\infty = V_o/(R_1 + R_2) \tag{2e}$$

$$\tau_{II} = R_1R_2C/(R_1 + R_2) \approx R_1C \qquad \text{for } R_1 << R_2 \tag{2f}$$

If $V_o < 2$ volts, then the current is given as a function of time in the following way:

$$i(t) = V_o\{Ae^{-t/\tau_1} + Be^{-t/\tau_{II}} + C^*\} \quad (3a)$$

where

$$C^* = V_o/(R_1' + R_2' + R_2) \quad (3b)$$

$$B = V_o/(R_1' + R_2') \quad (3c)$$

and

$$A = V_o/R_1' \quad (3d)$$

Motoyama has shown[32] that the BP current travels primarily in the dermis with only a 30% influence coming from the epidermal layer. He has also shown that the seat of the C′ capacitance involves charge transfer across the basal membrane barrier between the epidermis and dermis, as illustrated in Fig. 14. It is tempting to identify R_2 with the stratum corneum resistance, R_2' with the epidermis and R_1' with the dermis; however, there is no completely valid justification for this. In Fig. 15, log [ln $(i - i_\infty)$] is plotted versus log [time] to show these two processes on the same time scale for the $V_o < 2$ volt case where no electrolysis occurs and for the $V_o = 3$ and 4 volt cases where some electrolysis occurs. The current drops by about a factor of 20-50 over the first 10^{-4} seconds and by about another factor of 10 over the next 10^3 seconds. In actuality, we cannot use constant parameters for these low and high frequency circuits but must use the approach of Fig. 5. If the parameters were constant in the high frequency circuit, the mathematics requires that $\alpha = 1$ in the following defining equation:

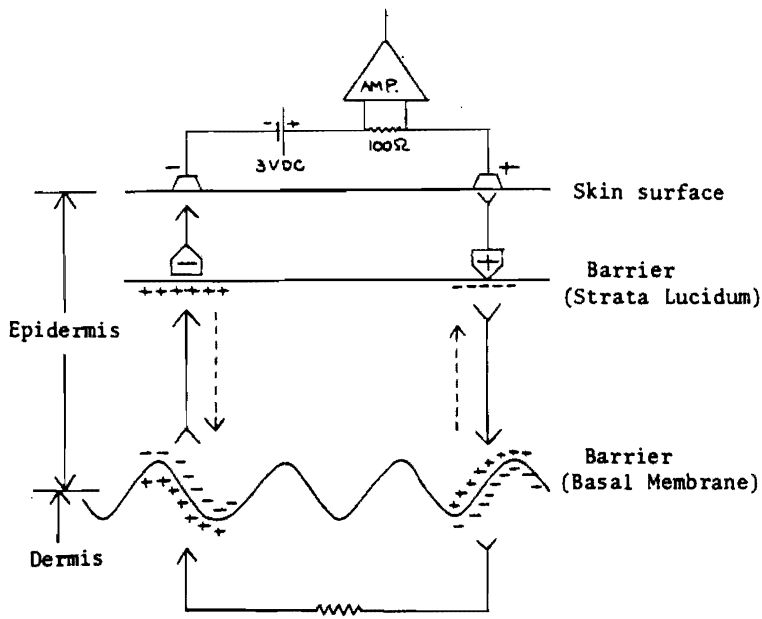
$$IQ = \tfrac{\alpha}{2}\,TC\,[BP - AP] \quad (4)$$

This author checked the data sheets for 30 patients studied via the AMI[37] and found that α was not unity but ranged from 0.3 to 0.5 to fit the data. Either the important circuit parameters are time varying in this small time domain or the AMI machine is not responding rapidly enough to accurately measure in the initial 10μsecs, or both. Although the AMI utilizes a 1 MHz clock, this only guarantees accurate time sampling in 10 μsec blocks, not 1 μsec blocks. A 10 MHz clock would be needed to accurately sample the initial few μsecs.

Motoyama's technique is to attach electrodes to the distal points of all meridians on the hands and feet and measure each point in turn, à la Fig. 13, automatically with a computerized system. In the

FIGURE 14

Generalized diagram of the ionic accumulations in the dermis and epidermis.



Chinese system of notation, the 12 Jing distal points indicated in Fig. 16 have been used for acupuncture point treatment for centuries and quantitatively by Akabane since 1952[33,34], and more recently by Ionescu-Tirgoviste[35]. These points are thought to play an important role in the "six energy axes"[36], as illustrated in Fig. 17. In the Motoyama notation, these are called the Sei points and there are 14 of them, as indicated in Fig. 18. After the electrode placement stage, which may take ~ 20 minutes, the measurement stage of the 28 electrodes begins. The automated measurement process of all the BP, AP, TC and IQ requires only a few minutes and the computer prints out these values for each of the points. The computer also prints out the

FIGURE 15

Schematic representation of the current vs. time plot over the entire time domain (9 decades).

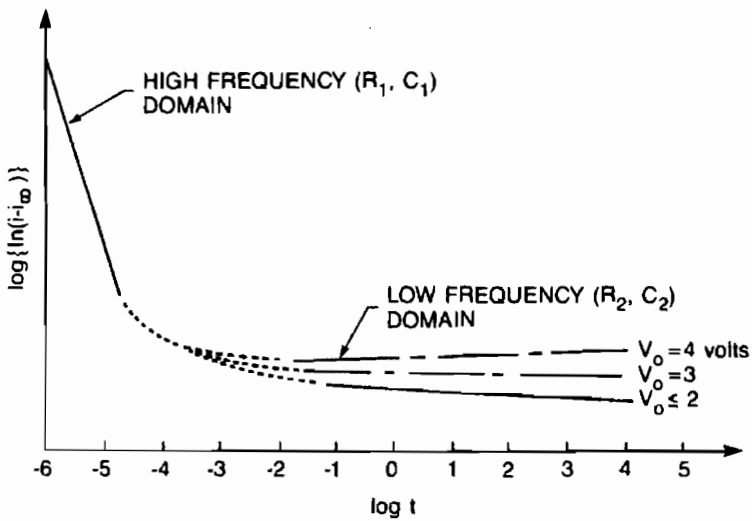


FIGURE 16

The location of the 12 Jing distal points.

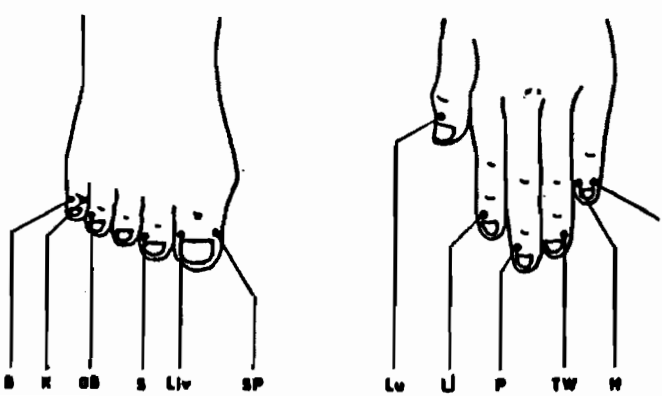


FIGURE 17

Schematic illustration of the six energy axes.

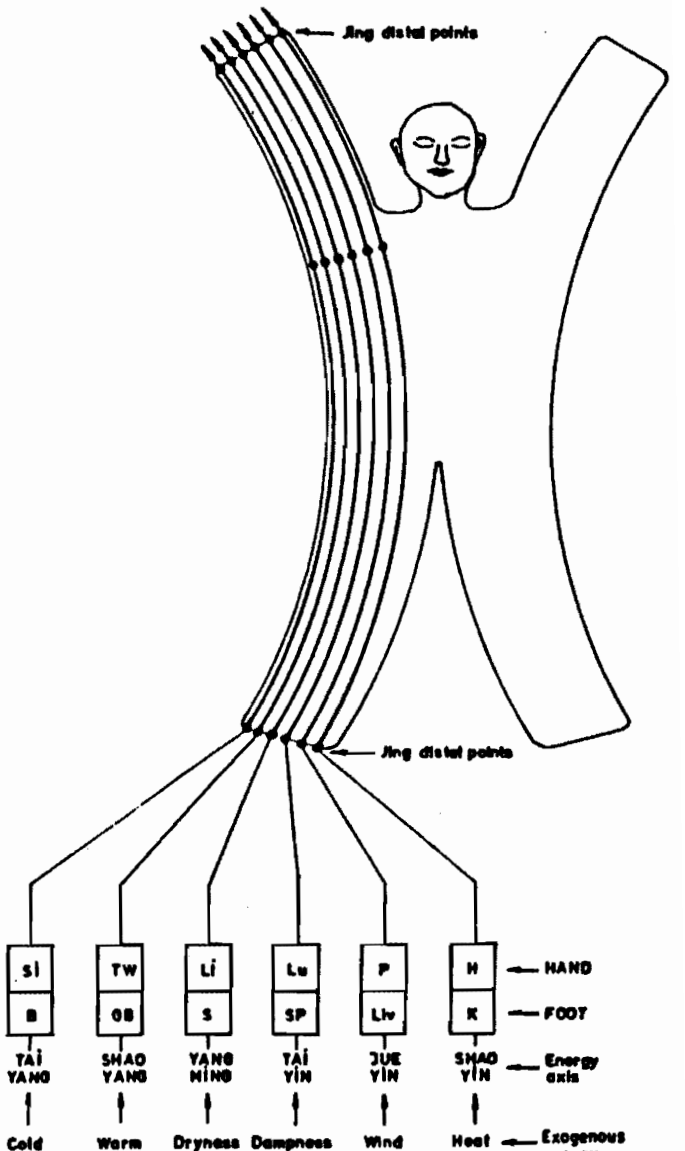
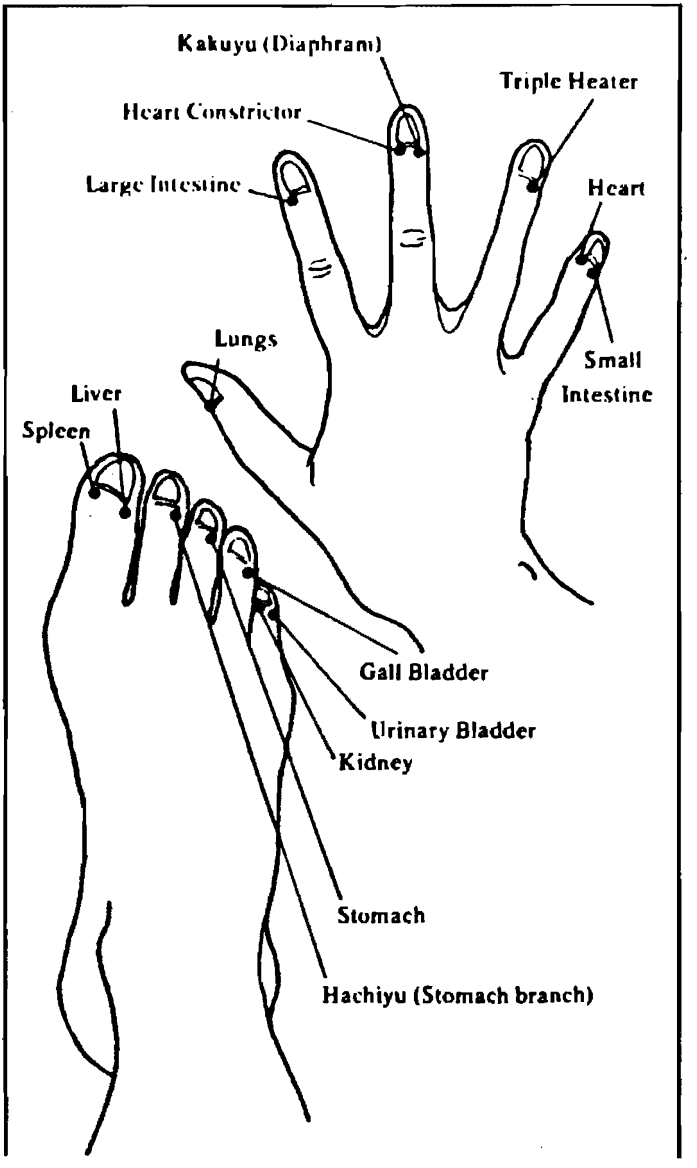


FIGURE 18

The location of the 14 Sei points.



standard deviations for each of these points and the changes between the left and right side values relative to the sum of the values for the 28 points. It also prints out the body averages, left-right differences on average, hand-feet differences on average and the average standard deviation. When the values fall outside of the expected range for a healthy person, they are "flagged" for the viewer. In a general sense, values that are too high are interpreted to mean that the body is in an excited state—often signalling the beginning of disease. Values that are too low are interpreted to mean that the whole autonomic nervous function is reduced generally through a chronic disease.

In a more specific vein, the following are average values in adults for the Phoenix area[37].

$$\begin{aligned} BP_{Avg} &= 1600\text{-}2000 \\ AP_{Avg} &= 20\text{-}30 \\ TC_{Avg} &= 8.5\text{-}12 \\ IQ_{Avg} &= 3500\text{-}4000 \end{aligned} \tag{5}$$

If the patient's IQ value is high, it is thought to indicate congestion or blockage and the higher it is, the more toxic is the condition. When the value is low, a weakness is thought to exist in the whole reaction of the individual. When the TC is high, the individual is thought to be armored, stressed, chronic tightness; if it is low, the indication is weakness, apathy, given up. If the AP is high, this is thought to indicate an overstressed sympathetic nervous system (sweaty palms, tight individual); if it is low, the indication is for weak defenses and poor recoverability (meditators fall here, but this is normal for them). Finally, if the BP is high (>2100), the indications are for a mildly toxic to a very ill condition (depends on the IQ value), perhaps an allergy; if low (<1600), the individual is weak in overall energy and complains of severe fatigue[37].

Reflecting on both the Voll and the Motoyama devices, the measurements appear to reflect classical resistance and capacitance values and no direct electrical connection yet appears to specific inner organs or body system. The field is in great need of such connection delineation.

Before leaving this section, it is important to note a major difference between these two techniques that has not yet been brought to light. In the Motoyama technique the electrodes may be attached by a nurse and the data gathered in the automatic mode to be examined by the doctor later; i.e., the doctor need not be present when the data

is gathered. In the Voll technique and any other hand-held electrode technique, the doctor is in the psychic loop "patient/machine/practitioner" and can unconsciously influence the readings by subtle tilts of the electrodes, subtle changes in pressure, etc. Thus, it may begin to be used unconsciously in a radiesthetic mode. This is an important factor that needs to be carefully studied before electrodermal devices become a commonplace tool for the health practitioner.

Some Connections

Rosenblatt[38] attempted to investigate: 1) changes in functioning of an internal organ (heart rate) correlations with selected acupuncture points which are related to the internal organ, 2) changes in functioning of that organ correlations with acupuncture points that are unrelated to the organ even though these points will be in close anatomical proximity to a point that *is* related to the organ function, and 3) correlations in skin conductance changes at a selected acupuncture point versus an unrelated AP with the functioning of an internal organ (heart rate).

Rosenblatt[38] found that when subjects attempted to alter their heart rate via biofeedback using a tone generator, there was a significant correlation ($P = 0.01$) with changes in the skin conductance at a preselected heart meridian AP (both for raising and lowering the heart rate). The conductance increased as the heart rate increased. No corresponding correlations were found at other AP's or in localized areas of skin near but not on the selected AP's. Conversely, when the subjects used biofeedback to change the conductance of a preselected heart point (H-7), there was a significant correlation in the actual change in heart rate. Using points unrelated to heart functions, as the conductance was changed, no corresponding changes occurred in the heart rate. This is a very important result and it will be very valuable to obtain similar checks with the functioning criteria of other organs.

Early Warning Cancer Detection

Kobayashi[39] used a Nakatani neurometer and found simultaneous abnormalities in the bilateral readings of six specific meridians identified as the "signature of cancer." These were the pericardium,

heart, triple heater, spleen-pancreas, kidney and gall bladder meridians. He divides cancer into seven stages by weight: cancer-free, microgram (μ), small milligram (M^1), large milligram (M^2) and gram level or clinical cancer (early gram, G^1, median gram, G^2, and terminal gram, G^3). He observed a statistically significant difference between the μ gram cancer and the non-cancer groups ($P < 0.001$). He also found a significant difference between the M^1-level cancer and the non-cancer groups ($P < 0.1$). In general, he felt his electrodermal signature to be an effective early warning system for cancer detection.

Summary Deductions From the Data

Aside from conductivity effects (electrolyte concentration and ion mobility) and permeable membrane selectivity effects, which are all localized to the epidermis/dermis region, the one special feature that is unaccounted for is the battery-like effect of the AP's; i.e., they will supply current to a high impedance load. Another special feature is the enhanced positive potential of several millivolts at the AP skin compared to surrounding skin. If one just evaluated the surface potential based on simple diffusion of + ions from the inside of the cell to the surface, the potential would be only ~ several microvolts. Thus, for it to be as large as millivolts requires a driving field pushing the + ions out onto the skin.

If a magnetic vector potential field, $\bar{A}$, flowed along the meridians, an electric field, E, would exist given by

$$\bar{E} = -\nabla\varnothing - \frac{\partial\bar{A}}{\partial t} \qquad (6)$$

This additional negative field at the surface of the skin would require a larger transfer of positive ions and a correspondingly larger surface potential, $\varnothing$, such as has been measured. The induced field indicates that this is probably the source of the battery-like effect observed at the AP's and points to an internal body source which may be the organs. Interestingly enough, this same time-varying $\bar{A}$ field gives rise to a microwave EM field passing out through the AP's and this field could dissociate membrane-bound water molecules in the stratum corneum tissue to give the AP's their enhanced electrical conductivity compared to the surrounding tissue. This seems to be the connection that we need to understand better than we presently do. It

is perhaps this connection that will reveal the diagnostic efficacy of these new devices that monitor the skin and predict the state of organ pathology. Much more study is needed to test this hypothesis.

Conclusions

1. There are several effective electrodermal techniques in present use and we understand both how they work as well as what they actually measure.
2. There does appear to be some beginning experimental support for, and a possible theoretical model to explain, connectivity between the organs and their specific AP's.
3. There does appear to be important differences between the hand-held moving electrode modality of skin measurement and the fixed, multiple electrode, automatic switching modality of skin measurement.
4. Although we are just at the beginning of this new technology, it is likely that new and more effective devices will appear during the next decade that could significantly reduce health care costs.

Acknowledgements

The author would like to thank Drs. Harvey Bigelson, Peter Madill and Roger Wicke for very helpful discussions.

References

1. Rosendal T: Studies on the conductivity properties of human skin to direct current. *Acta Physiol Scand* 1943;5:130-151; Further studies on the conducting properties of human skin to direct and alternating current. *Acta Physiol Scand* 1944;8:183-202; 1945;9:39-49.
2. Lykken D: Square wave analysis of skin impedance. *Psycholphysiol* 1971;7: 262-275.
3. Swanson D, Webster J: A model for skin-electrode impedance, in Hood J, Purser P (eds): *Biomedical Electrode Technology*. New York, Academic Press, 1974, pp. 117-128.
4. Gatzke R: The electrode, a measurement systems viewpoint, in Hood J, Purser P (eds): *Biomedical Electrode Technology*. New York: Academic Press, 1974, pp 96-116.
5. Nagel L, Tiller WA: Dielectric response in human skin. (unpublished).
6. Kume Y, Ohzu H: Electrocutaneous stimulation for information transmission, I:

Optimum waveform eliciting stable sensation without discomfort. *Acupuncture and Electro-Therapeut Res Intl J* 1980;5:57-81.
7. Schimmel HW: *The Segment Electrogram*. Vega, Grieshaber KG, Postfach 10, D-7622 Schiltock (Schwarzwald).
8. Nakatani Y: An aspect of the study of ryodoraku. *Clinic of Chinese Medicine* 1956;3:54; and Skin electric resistance and ryodoraku. *J Autonomic Nerve* 1956;6: 52.
9. Niboyet JEH: Nouvelle constatations sur les propriétes électriques des points chinois. *Bull Soc Acup* 1958;30:7.
10. Bratu I: The value of electrical skin resistance in acupuncture. *Communic Dtsche Ztschr Akupunk* 1960;6:11.
11. Brunet R: Introduction a l'étude de l'acupuncture. *Bull Soc Acup* 1960;37:7.
12. Zhang X, et al.: The principle of diagnosis and the method of application of meridian detector. *Journal of the Institute of Traditional Chinese Medicine*. 1958;9:579.
13. Zheng Z, et al.: A study on the determination of the normal value of cutaneous conductance and temperature of acupuncture points. *Journal of Traditional Chinese Medicine and Pharmacology of Shanghai* 1958;12:33-37.
14. Zhu ZX: Research advances in the electrical specificity of meridians and acupuncture points. *Am J Acupuncture* 1981;9:203-216.
15. Matsumoto T: *Acupuncture for Physicians*. Springfield, Illinois, Charles C Thomas, 1974.
16. Manaka Y: Ryodoraku and clinic. *Gynecology and Obstectrics* 1978;32(12):893.
17. Sekigawatachio: *Journal of Kanazawa Juren Medical Society* 1959;63:182.
18. Niboyet JEH, et al.: Comptes rendu de recherches experimentales sur les meridiens. Chez le vivant et chez le cadavre. *Actes de Illiemes Journees Internationales d'Acupuncture* 1958:47-51.
19. Shenberger RM: Acupuncture meridians retain identity after death. *Am J Acupuncture* 1977;5:357-361.
20. Reichmanis M, Marino A, Becker R: Electrical correlates of acupuncture points. *IEEE Trans Biomed Eng* 1975;22:533-535.
21. Wulfson N, Yoo J, Gelineau J: Twenty-seven acupuncture points and their electrical resistance, in Warren F (ed): *Handbook of Medical Acupuncture*, New York, Van Nostrand, 1976.
22. Reichmanis M, Marino A, Becker R: DC skin conductance variation at acupuncture loci. *Am J Chinese Med* 1976;4:69-72.
23. Hyvarinen J, Karlsson M: Low resistance skin points that may coincide with acupuncture loci. *Med Biol* 1977;55:88-94.
24. Reichmanis M, Marino A, Becker R: Laplace plane analysis of impedance between acupuncture points H-3 and H-4. *Comp Med East and West* 1977;5:223-229 and 285-297.
25. Podshibiaky AK: Variations of electrical potential with respect to internal organs and their relation to 'active points' of the skin. *J Physiology USSR* 1955;44:357.
26. Becker RD, et al.: Electrophysiological correlates of acupuncture points and meridians. *Psychoenergetic Systems* 1976;1:105.
27. Brown M, Ulett G, Sterm J: Acupuncture loci: Techniques for location. *Am J Chinese Med* 1974;2:67-74.
28. Dumitrescu IF, et al.: Contribution to the electrophysiology of active points. International Acupuncture Conference (Bucharest) 1977:20.
29. Fraden J, Gelman S: Investigation of nonlinear effects in surface electroacupuncture. *Am J Acupuncture* 1979;7:21-30.
30. Fraden J: Active acupuncture point impedance and potential measurements. *Am J Acupuncture* 1979;7:137-144.
31. Voll R: Twenty years of electroacupuncture diagnosis in Germany, a progress report. *Am J Acupuncture* 1975;3:7-17.

32. Motoyama H: *How to Measure and Diagnose the Functions of Meridians*, International Association for Religious Psychology, 1975; and Electrophysiological and preliminary biochemical studies of skin properties in relation to the acupuncture meridian. *Intl Assoc for Religion and Parapsychology* 1980; 6:1-36.
33. Kajdos V: the Akabane method as applied to acupuncture. *Am J Acupuncture* 1974;2:266.
34. Dale RA: A new three-phase acupuncture law. *Am J Acupuncture* 1982;10:325.
35. Ionescu-Triboviste C, Bajenaru O, Zugarnescu D, et al.: Electric skin potential of the Jing distal points in diabetics with and without clinical neuropathy. *Communic USSM*, Bucharest, 1983.
36. Ionescu-Tirgoviste C, Bajenaru O: Electric diagnosis in acupuncture. *Am J Acupuncture* 1984;12:229-238.
37. Bigelson H (M.D.), Phoenix, Arizona, (private communication).
38. Rosenblatt SL: The electrodermal characteristics of acupuncture points. *Am J Acupuncture* 1982;10:131-137.
39. Kobayashi R: Early diagnosis of microcancer by cancer check of related acupuncture meridians. *Am J Acupuncture* 1985;13:63-68.

Appendix A

The K + F Diatherapuncture Functional Description

The circuit diagram for the diagnostic part is given in Fig. 11 where we note that it consists primarily of a vacuum tube voltmeter with the anode current being displayed on a meter. The measuring voltage, applied to the patient via the small diameter electrode pressed strongly against an AP, ranges between 0.135 and 2.070 volts and the current passing through the body ranges between 11.25 μA and 5.5 μA for a resistance change from 12 KΩ to 380 KΩ. The calibration curve for this instrument is also shown in Fig. 11.

The measurement instrument shows an indicator deviation of 50 (50% of full scale) as long as the AP and the corresponding organ are free from pathologic disturbances. If, instead of the human body, either a resistance of 95 KΩ or a voltage of 0.87 volts is connected between the two electrodes, the indicator deviation becomes 50. In addition, if a galvanometer of high ohmic resistance is connected to one hand-electrode and one stylis-electrode, a much higher reading is obtained from an AP than from a random skin point. Thus, although an AP must certainly be thought of as having an electrical impedance, it appears to act as a type of battery as well.

When the electrodes of Fig. 11 are applied to the body, the following sequence of events happens: 1) The skin resistance is placed in parallel with the cathode-grid resistance, Rg, set to produce a strong negative bias at the grid electrode; 2) this reduces the net resistance

of the loop causing the grid bias to become less negative so that the cathode-anode current increases and is registered on the meter (see the calibration curve of Fig. 11); 3) The smaller is the skin resistance, the lower will be the equivalent resistance of the cathode-grid circuit so the more positive will be the grid bias and the larger will be the anode current registered on the meter. Thus, the meter responds in proportion to the skin conductance so it is essentially a conductance meter; 4) The more positive is the grid bias, the greater will be the current flowing in the cathode-grid circuit, a part of which also flows through the skin resistor in such a way as to make the stylis-electrode have a positive potential relative to the hand-electrode; 5) This anodic potential applied to the skin causes ion flow through the skin in such a direction as to increase the skin resistance (see Fig. 3) and sets in motion a change in grid-bias such that the cathode-anode current in the tube decreases and an indicator drop (ID) occurs on the meter.

It is also important to note that the effective skin resistance depends upon the pressure applied to the stylis-electrode and the angle at which it is applied to the skin. In all cases, the stylis should be applied almost perpendicular to the skin to obtain a constant electrode contact area. As the axial force on the contact area is increased, the resistance decreases until a plateau is reached in the range of 0.6–1.6 Kg. Using a constant pressure electrode, when the spring pressure was such as to fall in this range, the normal value of the indicator meter (50 scale units) was registered for healthy subjects.