DOI：10.14148/j.issn.1672-0482.1999.02.003
南京中医药大学学报 1999 年 3 月第 15 卷第 2 期
JOURNAL OF NANJING UNIVERSITY OF TCM Vol.15 No.2 Mar.1999

·学术探讨·

内火病机论析

储全根　余越峰△　（安徽中医学院临床医学一系，合肥　230038　△安徽省潜山县中医院，安徽　246300）

摘　要　结合历代医家的有关论述，对内生火热病机加以探析，认为气火失调、阴虚火旺、阳虚火浮、瘀郁化火、五志化火 5 个方面可概括之，并对每种火热机理进行了具体分析。

关键词　内生火热　病机　分析
中图号　R228

火热病证临床极为常见，因而成为历代医家研究的重点，如金元四大医家中，刘完素、李东垣、朱丹溪 3 位均从不同方面重点探讨火热病机。火热病证形成有外感与内生之别，前者系感受外界六淫、戾气之邪而成，属外感热病之类，而内生火热系由于脏腑功能失调、情志过度变化、气血津液亏虚或代谢运行障碍等诸多因素造成。内火可单独亢烈为病（如内伤发热证即是），或可兼夹于它证之中。其形成机理非止一端，正确地认识病机对恰当施治有重要价值，根据历代医家的相关论述并结合临床，笔者认为可从以下几个方面进行概括和分析之。

1　气火失调

乃指元气或脏腑之气的虚衰而导致的内火亢盛。《素问·阴阳应象大论》有“壮火之气衰，少火之气壮。壮火食气，气食少火；壮火散气，少火生气”，此即论述气与火的生理、病理联系，“少火”，乃指温养人体脏腑组织肌肤百骸，使之发挥正常功能的“正火”，它与元气相互为用，相互制约，若这一关系失调，平衡打破，元气虚衰失去对少火的制约作用，“少火”亢逆则变成“壮火”，亦即“邪火”。李东垣在《内经》论述的基础上，对气火关系阐发颇多，李氏重点论述脾胃之气的虚衰而造成的内火炽盛。李氏认为，元气和“阴火”之间本来就存在着相互制约的关系，元气充沛，则阴火敛降；元气虚衰，则阴火内生，对此，他高度概括为“火与元气不两立，一胜则一负”[1]。而脾胃为元气之本，脾胃之气可以充养元气，故脾胃之气虚衰致元气无以充养，制约“阴火”的功能减退，故而阴火上冲。“脾胃之气既伤，而元气亦不能充，而诸病之所由生矣”[1]。元气一虚，则诸症蜂起，内伤热中证为其最常见证候，此乃在脾胃气虚的同时而见火热亢盛，症见气高而喘，身热而烦，口渴欲饮，脉象洪大等。若火热郁于肌肤，则表现为四肢困热、肌热、筋骨间热，表热如火燎于肌肤，扪之烙手。其证或以虚为主，或虚实夹杂，故治疗以甘温之药补中益气升阳，藉此而实现散火除热之目的，必要时配以寒凉或发散之药。

诸多论述气虚发热之病机，每每从气虚不能生阴血，阴血虚则进而导致火旺来解释的，笔者认为这种分析虽有道理但未必确切。诚如前述，气火之间本身就存在制约关系，一旦气虚，制约失衡，即可能出现内热，这正是李东垣竭力倡导的补脾胃之气，而不是通过滋阴或补血来消除阴火的道理所在。

2　阴虚火旺

由于阴液的虚衰导致其对阳热的制约功能障碍，阳气相对偏盛，而变生火热。阴虚而致火旺有以下几种情形：一为肝肾阴虚。此乃元代朱丹溪所着力阐发的内容。朱氏认为，人体的阴精难成而易亏，而人的情欲无涯，嗜欲繁多。由于五志过极、色欲过度、饮食不洁等诸多因素均可引起相火的妄动，导致肝肾之阴（尤其是肾精）的消耗，阴精虚衰即失其对相火的制约进而加剧相火亢逆妄动而表现出阴虚火旺之象。“阴虚则发热，夫阳在外为阴之卫，阴在内为阳之守，精神外弛，嗜欲无节，阴液耗散，阳无所附，遂致浮散于肌表之间而恶热也”[3]。阴虚和火旺互为因果，阴伤愈致火旺，火旺更致阴伤，从而形成不良的病理循环。朱氏将阴虚分为阴精不足和阴血不足，而相火妄动则涉及肝、肾、心、心包络、三焦、胆、膀胱等脏腑，其中尤指肝肾。二为叶天士所倡的胃阴学说。认为胃阴亏乏者可致“胃有燥火”，表现为舌绛、咽干、烦渴、不寐、肌燥、火高热、便不通爽等。三是绮石的论阴虚成劳。认为阴虚成劳之病统之于肺，病机主要责之肺阴虚，伏火刑金。“伏逆之火，出于阴虚阳亢，火乘金位，谓之贼邪，以其火在肺叶之下，故名伏。以其火只星星，便能使金令捍格，故名逆”[3]。凡若此者，症见骨蒸、潮热、劳嗽、干咳、脉细数，甚至吐血等，故治疗急当清金保肺。四为血虚发

热，它往往与脾胃、肝肾等多脏腑相涉，丹溪、东垣等对此也均有所论及，丹溪主张用四物汤加知柏，东垣创制当归补血汤均针对血虚发热而设。

3　阳虚火浮

乃指阳气虚衰，阴寒内盛，虚衰之阳气失其依附，被逼迫浮越于外而变生火热之象。阳虚而致的火热主要责之于肾阳。张介宾对此认识深刻，认为“阳虚者亦能发热，此以元阳败竭，火不归原也”[4]。而其表现则有以下形式：一是下焦阴寒太盛，虚惫之阳气被格拒于外而表现为内寒外热之象，《伤寒论》少阴篇之通脉四逆汤证的手足厥冷，脉微欲绝，或下利清谷，但“身反不恶寒”为其典型表现，此种身热乃阳浮于外而发于皮肤肌肉之间，张介宾称其为“格阳之火”；二是虚阳被格拒于上，浮越于头面咽喉而表现为下寒上热之象，症见颧红面赤，咽痛，烦躁，口渴。但口虽渴而不欲饮，或饮而不多，或喜热饮；苔虽有而舌必滑润；小便清长，足冷过膝，脉象沉小而迟，或浮大无根，此乃阳戴于上而见头面咽喉之间，张介宾称其为“无根之火”。无论何处之热象，其本质仍为真寒，故从舌脉、肢体凉热、饮水等诸多方面可循及内真寒之见证。总之，元阳虚衰为火浮的根本。

4　瘀郁化火

乃指瘀血或气血痰食等的郁滞而产生之内火。瘀血不仅阻滞经络血脉而见诸多瘀血症状，亦可因瘀阻而化热。如《金匮要略·惊悸吐衄下血》篇所言的“病者如热状，烦满，口干燥而渴”，另《妇人杂病》篇的“暮即发热”、“手掌烦热，唇口干燥”等皆为瘀血化热之象。唐容川对瘀血化热深有研究，认为“瘀血在肌肉，则翕翕发热，证象白虎；……瘀血在肌腠，则寒热往来，以肌腠为半表半里，内阴外阳，互相胜复也；……瘀血在府，则血室主之，证见日晡潮热……瘀血在脏，则肝主之，以肝司血故也，证见骨蒸潮热，手足心烧……”[3]。究其机理，《灵枢·痈疽篇》所说的“营卫稽留于经脉之中，则血涩而不行，不行则卫气从之而不通，壅遏不得行，故热”乃为最好注释。另一方面，瘀血不去，新血不生，营血衰少，亦为产生内热之因素。

气机的郁滞而化火，即朱丹溪所言的“气有余便是火”，朱氏弟子王履更明确提出“气郁成热”之说。刘完素认为其机理在于玄府（指气升降出入之道路门户）闭塞。气机郁滞广涉脏腑经络，而以肝郁化火最为多见，可见胁痛吞酸，烦躁易怒，口苦目赤，大便秘结，舌红，苔黄，脉弦数等。又如心气不舒，郁而化火，可见口糜，舌尖疼痛，小便热赤等症。气郁化火与气火失调不同，前者多为实证，而气火失调以虚为主，或虚中夹实。其它如痰湿、宿食的停积郁滞，均可化生火热，其理相同。

5　五志化火

指由于情志的过度变化导致脏腑功能失调而产生的内火，如大怒、大喜、过思、过悲等。刘完素的“五志过极皆为热甚”说即是。刘氏非常重视五志过极产生内伤火热，“五脏之志者，怒喜悲思恐也。若五志过度则劳，劳则伤本脏，凡五志所伤皆热也”[6]。究其机理，刘氏多从五行生克关系进行论述，如“恐则伤肾而水衰，心火自甚”[6]，“将息失宜而心火暴甚，肾水虚衰不能制之，则阴虚阳实而热气沸腾”[6]。而朱丹溪认为“五脏各有火，五志激之，其火随起”[7]，即五志的过度变化可直接激起五脏之火。然而无论如何，五志化火还与气血的郁滞有密切关系。

总之，内火病机不外人体阴阳气血虚衰、内部平衡失调以及瘀、郁、五志化生火热几个方面，病涉多个脏腑。然而上述病机不是孤立的，每每有两种或两种以上的病机同时存在，如既有气虚，又有阳虚；或既有气郁，又有阴虚；或气血痰均郁滞；或阴阳两虚而火浮等等。内伤火热证虚实均见，气火失调、阴虚火旺、阳虚火浮等均以虚证为多，而瘀郁化火、五志化火则以实证多见，或虚实夹杂。另外，诸病机之间亦可相互转化，如气郁化火日久伤阴而成阴虚火旺，五志化火可转变成瘀郁化火等，临证之时，均宜仔细辨识。

参考文献

1　湖南中医药研究院·脾胃论注释·北京：人民卫生出版社，1976.150

2　朱震亨·格致余论·南京：江苏科技出版社，1985.47

3　汪绮石·理虚元鉴·北京：人民卫生出版社，1988.35

4　张介宾·景岳全书·北京：中国中医药出版社，1994.188

5　唐容川·血证论·北京：中国中医药出版社，1996.137

6　刘完素·素问玄机原病式·北京：人民卫生出版社，1956.7，9，19

7　朱震亨·局方发挥·北京：人民卫生出版社，1956.22

（收稿日期：1998－10－23）

南京中医药大学学报 1999 年 1 月第 15 卷第 2 期
JOURNAL OF NANJING UNIVERSITY OF TCM Vol. 15 No. 2 Mar. 1999

Abstracts of Major Papers in This Issue

Pathogenesis of Interior Fire

Chu Quangen, *Yu Yuefeng*△
(*First Clinical Medicine Department, Anhui TCM College, Hefie*, 230038;
△*Qianshan County TCM Hospital, Anhui*, 246300)

ABSTRACT This paper presents analysis of pathogenesis of interior fire based on the opinions of physicians of various dynasties. The authors believe that this falls into five aspects, namely incoordination between qi and fire, hyperactivity of fire due to deficiency of yin, floating of fire due to deficiency of yang, accumulation of depression turning into fire and fire arising from the five emotions.

KEY WORDS: Interior heat turning into fire, pathogenesis, analysis

(Page 71)

Clinical Research on Plasma ANP and TXA_2/PGI_2 of Symptomless Myocardial Ischemia Patients

Li Song, *Mu Weidong*△, *Chen Jinghe*
(*Emergency Centre of First Affiliated Hospital of Guangzhou TCM University, Guangzhou*, 510407;
△*Cardiovascular Department of Central Hospital of Huizhou City, Guangdong*, 516001)

ABSTRACT **OBJECTIVE**: To investigate into the relationship between changes in ANP, TXA_2 and PGI_2 and TCM syndrome types in symptomless myocardial ischemia patients. **METHOD**: 57 patients were divided into 20 with syndrome of deficiency type and 37 with syndrome of excess type, compared with a control group of 22 persons, and the levels of ANP, TZA_2 and PGI_2 were detected. **RESULT**: In patients with syndromes of deficency type, the plasma ANP (185.54 ± 13.34 pg/ml) was significantly higher than that in the control group (101.53 ± 32.77 pg/ml) ($P < 0.01$), whereas in patients with syndromes of excess type, plasma ANP (79.45 ± 20.20 pg/ml) was lower than in the control group ($P < 0.05$). TXA_2 and TXA_2/PGI_2 rose ($P < 0.01$) as compared with the control group, but no marked difference in plasma PGI_2 was detected. Plasma ANP of patients with deficency syndromes was markedly higher than those with excess syndromes ($P < 0.01$). The TXA_2, TXA_2/PGI_2 in the latter is higher than in the former with no marked significance. **CONCLUSION**: The marked disorder in TXA_2/PGI_2 in symptomless myocardial ischemia patients and the compensatory changes in ANP are related to the TCM sydromes of the disease. Changes in TXA_2 and TXA_2/PGI_2 are not related to the TCM syndromes..

KEY WORDS: Symptomless myocardial ischemia, TCM syndrome division, ANP, prostacyclin, thromboxane

(Page 79)

Effect of Combined Use of Large-aperture Resin adsorption and Ultrafiltration on Salviol and Loganin in Liuwei dihuang Bolus

Guo Liwei, *Peng Guoping*, *Wang Tianshan*, *Xu Nanping*△, *Xing Weihong*△
(*Nanjing TCM University, Nanjing*, 210029; *Nanjing Chemistry University, Nanjing*, 210009)

ABSTRACT **OBJECTIVE**: To investigate into the effect of the combined use of large-aperture resin adsorption and ultrafiltration on salviol and loganin in Liuwei dihuang Bolus. **METHOD**: HPLC method was used. **RESULT**: The weight of the refined extract is only 4.6% that of the original medicinal meterial and meanwhile 98% of salviol and 86% of loganin were retained. **CONCLUSION**: This combined use technique can effectively reduce the administration dosage and retain the micromolecule effective constitutents.

KEY WORDS: Ultrafiltration, large-aperture resin, Liuwei dihuang Bolus, Salviol, Loganin

(Page 86)

Research on Preparation of Nebulized Liquid for Asthma and Its Quality Standard

Di Liuqing, *Fan Xinsheng*, *Fan Biting*, *Wang Yongjie*△, *Tong Xiaodong*△
(*Pharmacology College, Nanjing TCM University*; △*interns in Pharmacology College of Nanjing TCM University, Nanjing*, 210029)

ABSTRACT **OBJECTIVE**: To optimize the preparation process of Nebulized Liquid for Asthma and establish standard for quality control. **METHOD**: Orthogonal test was employed to decide on the best drug material processing techniques and the most suitable pH value for the dosage of solubilizing agent. TLC and TLCS methods were used to establish methods for determining quantity and quality. **RESULT**: The best processing techniques were found to be thd following procedures: add 10 times of water to the drug materiaes and soak for 1 day, decoct for 3 times, each time lasting 1.5