Academy of PHYSICAL MEDICINE

Getting Totally Hip

with Simeon Niel-Asher

9th December 2020

TRANSCRIPT

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Steven Bruce
So today I have Simeon Niel-Asher joining us from Tel Aviv to talk to us about the hip and trigger points in particular. Simeon, you're behind the screen somewhere. There you are.

Simeon Niel-Asher
Hello, everyone. Hi, there. Thank you for having me back. Thank you. I'm surprised that you had me back actually.

Steven Bruce
The 10th time is it this year, I think?

Simeon Niel-Asher
Isn't it? Yeah, something like that. We did the eight, didn't we? And then we had Professor Gerwin, which I think that went really well actually. Now he has got an encyclopedia. Wow, that guy's knowledge is...

Steven Bruce
And if you didn't watch Dr. Bob Gerwin, his video has been recorded, it is up on the website under the recordings tab, and the title is Myogenic Headaches, but it's a mine of information. So do watch that. And that was a funny screen. Simeon, we're getting totally hip today. I take no blame for that, that's entirely you're doing that title, Simeon.

Simeon Niel-Asher
I thought, I was thinking of something around hippie and then I don't know, time to get hip. Too much time indoors, I think. Moving on. Yeah. So, I thought what we do is, look, the hip is quite a difficult area to treat, actually. So, I thought I'd share a couple of pearls of things that I'm finding useful. You know, always with these lectures, what I try and do is just to share stuff that I find clinically helpful. Because I think if we can, if there's a couple of take homes, I guess, if there's one take home, Steve, for that for the hip it is the adducters. I'll leave it, I'm just throwing you a bone.

Steven Bruce
We'll throw that one in. I promised people that you're going to tell them about that horrible technique you used on me, which not many people know about, but which is very good for groin strains.

Simeon Niel-Asher
Well, I think we're going to cover that on our next course, as well. Hopefully, one day. You know, in Israel, we're very happy the British are starting with the injections, apart from it's good for your ego, if people grow an extra tail, it couldn't happen to a nicer race. I'm joking.

Steven Bruce
You say an extra tail, as though we've already got one.

Simeon Niel-Asher
Adventitious, as they say. So yeah, so I thought we'd cover some hip stuff. So I thought, yeah, I don't know, shall we bring up some slides?

Steven Bruce
Yeah. Do you wanna talk about what it is we're gonna do today?

Simeon Niel-Asher
Yeah, I think what we're gonna talk about is osteoarthritis of the hip. Again, I don't want to spend too much time in it, because you guys know this stuff as well. One thing you might not know about is FAI, or femoral acetabular impingement, impingement syndromes, much like the shoulder we can get impingement syndromes in the hip, the Thomas test, which is something useful, and then I thought we'd talked about some trigger points that I've found really helpful, personally, for treating hip problems. I've got a really nasty hip technique that I work with, which is really similar to my frozen shoulder technique. In fact, if we start with the first slide, the one with hip and the shoulder,

Steven Bruce
Hip and shoulder relationship, I can't control the slides. So, Justin's, on top of those.

Simeon Niel-Asher
Yeah, so I think we might have used this one for my lumbo pelvic lecture, but what I've found is that the hip and the shoulder clearly are related. One is the front leg, one is the back leg. And they do show an intimate relationship. Now, there's some very reliable sources, Schlepp and also Myers, that have done a lot of fascial dissection. And they're showing that there's this kind of sling or posterior oblique sling mechanism, where you get this rotation force from the glute maximus on one side to the lat dorsi on the other. And that sort of moves the energy from one side to another. Now, of course, makes sense when you're on four legs, as Claire would tell us on the horses, you want to have your front left leg and your back right leg at any one point, it's not good to have both legs on the same side up in the air, although you can of course do it. The other thing was that in terms of ambulation, okay, go back to that slide. Okay, so in terms of locomotion and ambulation, we have this pattern where we swing one arm and we swing the opposite hip at the same time. So, there's clearly a kind of rhythmic gait, postural and biomechanical relationship between the shoulder and the hip. And as you know, my passion really is the shoulder I mean, I treat everything but I love the shoulder. And what's really interesting is that the technique, the nasty technique, that sort of hip technique that we did with you, uses the same kind of algorithm, almost, as the frozen shoulder technique, but instead of the lateral fascia on the side of the arm, we use the adductors. And that's because, just getting hip, if we can, when you think about it, the upper extremities kind of come out and forwards like this, they externally rotate, whereas the lower extremities kind of internally rotate. So, they bring all the fascia with them in the opposite direction. So, what will be on the outside of the shoulder is on the inside of the hip. So that's why. So, we talked about this sling effect, the sling mechanism.

Steven Bruce
It's interesting what it says on the bottom of that slide, Simeon. And I know it'll be difficult for people to read if they're on small screens, but the slides will be made available afterwards, as always. It says that, I think, the forces are on the same side below 0.75 kilometres per hour of walking, which, of course, is only half a mile an hour, I don't know how many people walk at that speed but it's very slow, and then it switches over to diagonal.

Simeon Niel-Asher
That's right. And again, if you think about it, really, there's a kind of stabilisation, the hips, the whole gait mechanism, of course, you know, very complex, we'll cover some of it. But yes, so let's move on. So, I thought perhaps we'd start now with osteoarthritis, I think that's the first one. Did we miss one? Yeah, that's good. Yeah, that's it. So, I thought we're going to start, so this what we're going to cover briefly, osteoarthritis or post-operative arthritis or stiffness, some of these impingement syndromes. We're not going to cover the other ones. We'll cover those on the course the live course. But I thought we've only got the time now to do a little bit, but hopefully, it will be insightful. And here we've got the Thomas test, which we're going to look at as well. So, let's just move to the next slide. Okay, thanks. Okay, so in terms of impingement itself, there are four real kind of sites of impingement. So, one of the things is get the patient lying on their back. And this is a really useful slide, looking at internal and external rotation or internal rotation, actually, of the hip. And as we internally rotate, the first thing, the first place you'll get some impingement is on the TFL, tensor fascia lata. In terms of trigger points, there's a lot of evidence that taut bands in the tensor fascia lata is related to hip pain. We can do needling, we can do inhibition, compression there to relieve hip pain, especially things like trochanteric bursitis. The deep, external rotators of the hip, we can see that they're kind of more as you start to look at the next thing. So this is kind of an order of merit as you've got internally rotating the hip. C, is the adductors. And then the final one is you take into full internal rotation, is the iliacus and the psoas. So just a useful little slide there.

Steven Bruce
Do you have any, this is almost impossible to answer, I imagine, have you got any sort of degrees of rotation at which each one of those might become more...?

Simeon Niel-Asher
Yeah, I mean, I guess like 0 - 15 would be the TFL. I think I'd say 15 - 20, I guess they're in sort of grades of 15 to 20 degrees each time. Really to get ilacus and psoas, you need to be quite internally rotated. And again, if someone's got OA hip, you're not really going to be able to get it that far anyway. Some of these tests are limited by the mechanical factors in terms of the pathology as well. Same with the shoulder. If someone's got osteoarthritis of the shoulder, you're not gonna do a hornblower's test because they just can't do it. So, I think we're going to start with OA hip. Of course, osteoarthritis of the hip, fairly common. Interesting, they talk about osteoarthritis, don't know if the slide's coming, as being like for weight bearing joints. But of course, the ankle doesn't really get osteoarthritis often at all and the shoulder does. So, there's not really a clear evidence with weight bearing. Also, there was some good papers published recently about

OA in the knee, how running of the knee actually reduces the chances of OA, so it's not just all about as simple as overloading. But we talked about either primary or secondary OA of the hip. There are two stages, the first is this degenerative, where we get this articular cartilage change that tends to be associated with sort of a dull aching. Now, generally speaking, if there's a problem with the hip, we're going to feel it in the groin, not in the outer part of the hip. In terms of the outer part of the hip, you're going to be looking more trochanteric bursitis. And that's obviously because you're looking at, so patient's often, sort of, say the hip and they point to the greater trochanter. But of course, that's not really the hip is it, that's the kind of thigh but we're talking about in the groin. So usually, it starts with a nonspecific and sometimes actually in the early stages of OA you can get hyper mobility or slight laxity of the ligaments around the hip. But then you get this subsequent thickening, subchondral bony changes, and if nasty, you can get these osteophytes around the joint margin, and they can be fairly tricky. Again, in my own experience, when a person has gone really far down the line with an OA hip, I would look at some kind of operative changes. There's some new minimally invasive anterior approach hip things. But in a lot of cases, people don't want to do that or they're on medication or they're at high risk. So, there are techniques that I use to look at symptom modification. So, like we said, it's either idiopathic primary or secondary. In terms of secondary, we've got this like slipped upper femoral epiphysis, Legg-Calves, Perthes' syndrome, osteonecrosis, slipped upper femoral epiphysis, RA, sceptic. But in terms of, again, secondary, one really interesting one is called hemochromatosis. I don't know, have you guys, have you ever come across that, Steven, your clinic? Hemochromatosis?

Steven Bruce
I've never come across it in the clinic, no. I can remember it from college days.

Simeon Niel-Asher
Well, I've come across it a few times, especially in the elbow and sometimes in the hip. And it's basically an excessive amount of iron in the blood and it manifests as joint pain. So, it does happen, it does happen clinically. I had a patient who had it and she used to go and get blood taken like every six months and all her joint pain would go. Really weird.

Steven Bruce
Remind us, Simeon, is it the result of over supplementation? Or is it never that?

Simeon Niel-Asher
I think it's genetic? I think it's a protein genetic thing. Leeches, that's what I say. Keep a jar in the clinic. Moving on. Some of the other things that will precipitate an OA hip, I'm going to come to the next slide. This is my segue.

Steven Bruce
The next one is the labrum.

Simeon Niel-Asher

Yeah: are things like the labrum, for example. And the labral tears, again, this is something I didn't really, it took me a while to pick these up clinically. But actually, labral tears are far more common than we think. In fact, about 12% of people over the age of 40 have them, usually associated with clicking. So, clicking, people that do yoga, and they bring their hip down, it clicks, that's not necessarily, that might be snapping psoas tendon, but it's clicking on walking, normally on weight bearing. And it can happen, I see it mainly in women, actually, I think it's something to do with the shape of the pelvis. When we have a gynecoidpelvis, we have an acute angle of the hip and all these things. So, it tends to be a little bit more in females over the age of 40. And associated with ligamentous laxity, we call it Ehers Danloss Trait, I know Gerwin talks a lot about that, and some kind of impingement. But that's, as we will remember, the hip itself, the ball and socket is fairly sort of solid. But if we look at B, we can see there's other things called CAM impingement and pincer impingement and femoral retroversion. So, we're going to look at those now. So, the labrum is this kind of just sort of cup, the top of the cup of the hip, and it's the cartilage that helps keep this kind of passive stability. So, moving on.

Steven Bruce
You were going to tell us about the symptoms of a labral tear, I think.

Simeon Niel-Asher
So yeah, in terms of symptoms of labral tear, it's pain. It can be groin pain, but it's normally clicking and painful click and associated usually with activity. So, I'm just thinking off the top of my head, I had someone in a couple of weeks ago, was not really a kind of active person, she just did walking, and she came in with this painful click. So here we go: 92% of people complain with anterior groin pain, 33% do recall a traumatic onset, 2/3 of people that we think it's degenerative in nature, that's why it's mainly over the age of 40. Night pain is a common feature, clicking is a common feature, limping is a common feature, and catching or locking. So, if you've got someone that's coming in, they've got this click in the hip, night pain, limping, they've hear it clicking and it catches, then you might want to think about the labrum. Not necessarily to go to surgery and again, this nasty hip technique that I kind of developed, that we worked with you on, actually really works well for this. But again, it's going to be sort of symptomatic relief rather than sort of full fixing it because there's a tear in the cartilage. That doesn't really heal. So, with the next slide, I think we're going to be looking at this other thing, which is FAI or femoroacetabular impingement. Again, these are things that I've seen clinically that I didn't necessarily, I probably did study them at college, but they weren't, that's the thing, isn't it? When you when you study things at college, it's really isn't, often until they come in, they're a bit abstract. And then when they come in, you're like, oh, wow. And the cam and the pincer lesions, we do see those with athletes. So, I did quite a lot of work with the British Olympic badminton team and quite a few of them got these FAIs, pincer, cam. The cam lesion, we're looking at the normal anatomy and the FAI, and if you look at the femur, the neck of the femur there, you'll see that cam lesion, that's a kind of bump. And the other thing is a pincer, and what the pincer is where the shape of the labrum and the ball and the socket is angled, thus, that it actually creates a kind of pincer movement. So, every time that person is going to abduct the hip or move it into internal rotation, you're going to get a pinching effect. So, all of those things can happen. We carry on with the, that's called FAI or femoroacetabular impingement. I guess it's anomalous to the impingement of the shoulder a little bit. So again, FAI, people usually come in with a dull

ache in the inguinal groin area or sometimes a little bit more towards the outside of the hip. But usually, it's a sharp stabbing pain when they're turning, twisting or squatting. So that is your differential diagnosis, not necessarily night pain, it's normally on twisting the hip or when you're standing and twisting the body or passively or the hip and the squatting and they'll feel this horrible pain. 3 types of FAI, we talked about this cam deformity, the cameras is this extra sort of bit of bone that occurs on the proximal neck of the femur, the pincer, and again, we said this is due to this excessively deep socket or abnormal tilt of the acetabulum itself, and then we've got this mixture of the two of them together. So these are some of the causes of hip pain that we might want to differentially diagnose, osteoarthritis of the hip, FAI, and I think did we cover groin strain? I can't remember. Maybe we didn't.

Steven Bruce
We didn't cover it. You mentioned it earlier on. But no.

Simeon Niel-Asher
I took that slide out. But again, the other one is groin strain, just quickly. Something we do see fairly commonly, I'm sure you've seen it clinically, football players, soccer players, commonly get groin strains, athletes. The other group, and a really interesting kind of subgroup of people, I don't know if you ever seen them, is acrobats, people that do acrobatics. And it's not necessarily professionals now, because now you've got these classes where people are kind of on these parachute things and they're putting their legs out and they're upside down. Have you not seen these?

Steven Bruce
No, I haven't.

Simeon Niel-Asher
Oh, yeah. You're not watching the right videos. Moving on. Or people that are doing pole exercises. And I'm not talking about pole dancing, there are obviously classes now using poles. And we tend, I see quite a few more of these groin hip injuries from these kinds of excessive, kind of hyperextension, hyperflexion, hyperabduction injuries around the hip as well. Yeah, so there the kind of three categories that really would give you hip pain, which is the osteoarthritis of the hip, the FAI, the impingements, and the groin strains.

Steven Bruce
Okay. The famous Thomas test is next on your list.

Simeon Niel-Asher
Well, again, this actually is a really, really, really helpful test. And again, what I didn't mention with the OA hip, is that when it presents, depending how sort of chronic it is, how long it's been there, it normally presents with fixed flexion of the hip. So that is a kind of positive Thomas test. So that gives you an idea of what the Thomas is. Fixed flexion of the hip. So, I'm just thinking I had a guy recently that came in with back pain. And the doctor said to him, you've got a disc problem at L4 L5. Had a look at him and it was an osteoarthritic hip and everyone missed it, everyone, physios, doctors, everyone missed it. And it was because

he had this fixed flexion of the hip, he couldn't extend his lumbar spine. So, we've got this sort of progressive breakdown, where you have this fixed flexion of the hip, overloaded flexors and of course the flexors of the hip are? Come on. The psoas and the quads. And of course, the quads is the big flexor of the hip. So, what happens with a Thomas test is you lie someone their back, you get them to bring the good knee up, and you sort of put them on the edge of the couch, bring the good knee up into flexion towards the chest, and it's the bad leg on the other side will not be able to hyperextend, it just won't flatten down. In fact, it usually stays up. And that can be either from psoas hyperactivity or from some kind of joint issue, like osteoarthritis of the hip.

Steven Bruce
And how are you gonna distinguish between the two?

Simeon Niel-Asher
Well, if it's psoas, what can happen is you can generally get them to gradually lower the kind of affected side or you can passively gradually lower it. If it's OA hip it's fixed, it's a fixed flexion deformity. And usually, it's fixed because they've got these osteophytes around the hip and these other sort of joint, kind of bone on bone, nasty cartilage bits.

Steven Bruce
I'll tell you what, Simeon, you've raised some interest already because, and I'm really glad that you and I are not in the studio together for this, it's the only time I've ever said this, because Joanna Bird has said, what's this nasty hip technique? And I know what would happen if you were in here with me, you'd make me endure it.

Simeon Niel-Asher
Well, they'd have to see your underwear, the union jack. Look, the technique it's nasty, because only because it involves looking at pectineus, which is one of the muscles we're going to talk about shortly, and a bit of the hip flexors. And like all these techniques, it's really a function of how bad the hip is, you know, if there's no problem with the hip, the technique's not that bad. But again, you're working on chronic shortened compensated tissues. But the technique I believe, hopefully next year when I come and do my shoulder, we're going to do a Totally Let's Get Hip workshop as well, right? Funky shoulder and happy hip. We'll come up with an idea. All right. Moving on.

Steven Bruce
I'll leave the marketing to Simeon.

Simeon Niel-Asher
Thank you. Any other questions?

Steven Bruce

No, not at the moment. I remember though, as you said, you said it's a nasty technique as though it's horrible. But actually, it's not really nastier than any other say trigger point technique, where you do get that sort of, as you like to describe it, exquisite pain when you're inhibiting.

Simeon Niel-Asher

I think again, with the trigger points in the hip, it's important to say that often you have to hold them a long time, especially the quads, pectineus. In fact, any trigger points that are sort of protective around arthritis or anything like that, they don't want to give up. So, you know, sometimes I'll be 15 minutes, just on that one spot, obviously, I'm moving slightly around. And that's why it's nasty is because you just don't let it go. Not wanting to compress the femoral artery or anything, but you literally hold it there, sometimes for 15 minutes, until you feel it give. So, I think that's probably why it can be a bit nasty. But again, you know, these trigger point techniques are, I think of it as therapeutic pain. In other words, it's not kind of pain for no reason, it's got this quality of it. I think we've talked about it before, it's like when we get a massage and someone's like two millimetres away from that bit, and you just think, oh, please move two millimetres to the left. It's because there's something fundamental about these trigger points that is a yearning to be treated. In fact, without wanting to get too philosophical, in some ways, we've talked about this before, pain is a gift in some ways, because it tells us where the problem is, what the tissues are, and really, it's an invitation to change. Of course, it isn't always a gift. And I'm not going to generalise, not trying to make light of it. But there is this sense of protection and sort of that feedback resonance within the pain that is very helpful.

Steven Bruce

Maury has asked whether the chronic compensation issues can lead to tendinopathies in the groin area.

Simeon Niel-Asher

Yes, certainly, I think tendinopathy definitely is one of the cofactors that happens with, again, if you're thinking flexion of the hip or fixed flexion deformity over time, and you're going to get sort of obviously the hip extensors going to be over overloaded, which is the glute maximus, the hamstring sometimes. So, you're going to get some tendinopathies around there. It's all part of this pathology isn't it?

Steven Bruce

So apparently context is important in this.

Simeon Niel-Asher

Well, it is again, we talked about, remember we talked about with the shoulder, we talked about this idea. I didn't put the slide in here but from Kibler, where pitchers that are throwing with the shoulder, if they have a hip problem, they have to use like 20%, 30%, 40% more effort with the shoulder to throw the same amount of force. So, the idea is that anywhere in the body and again, not that we need it, but this is confirmation of this kind of osteopathic holism, that if you're going to have a problem anywhere in the body, it's going to affect these chains, myofascial chains. And so, you're going to want to look at not just the hip, you're going to want to look at the ankle, at the knee and at the lumbar spine. In fact, in my nasty hip

technique, as you remember, part of it is looking at the lumbar spine. And if you imagine the effect of flexion of the hip all the time, it's going to have an effect on the lumbar mechanics as well.

Steven Bruce
Simeon, you make a lot of holding patterns as well, don't you? And you've got this slide of the fluffy puppy and the horse that says or indicates-

Simeon Niel-Asher
Yes, so I like holding patterns. And I think holding patterns, why? Because again, we talked about these with the frozen shoulder, with the shoulders, this is a kind of primary default of what the nervous system wants to do to protect us. So here we have the fluffy puppy on the left, bless him, and he's hurt his leg. And this is a kind of default position of his nervous system. And of course, we do the same thing. It's this kind of flexion of the bicep, internal rotation. So, with the front hip, flexion, internal rotation, which is subscapularis. And that is kind of what the body wants to do. And again, with the horses, I don't know if we've got Claire here. Again, we see with the fetlock and things like that. There is this kind of flexion, internal rotation of the hip.

Steven Bruce
Horses haven't got much choice, have they? They want to take the weight off it.

Simeon Niel-Asher
Yeah. But again, taking the weight off it, I think the whole idea about a holding pattern is that it's actually wired into the ancient nervous system. It's not just about sort of unloading it. It's like a literally a protective shutdown mechanism. And certainly, we see that in the frozen shoulder where things just lock and it stays there for a longer time than is needed. And again, you can imagine if this horse has got a problem with the fetlock and gets that treated, but it's been holding that leg there for too long, you're gonna have these secondary changes, these adaptive responses, this kind of sarcomere changes, recruitment changes. But the point is that these are holding patterns of the nervous system. They're not just in the human being, they're throughout the kind of mammal mammalian world, possibly even reptiles, I'm not quite sure, I haven't looked at that. But certainly, in mammals, it's this kind of holding pattern. And the point is that it's unconscious and its sort of preconscious. So, it's something that we're fighting against as a therapist, you're going to always be trying to fight against it, because it's going to want to do that naturally. And you're going to sort of have to look at how you work with the body rather than against it. Forcing it down isn't really going to help, is it, because it's just going to want to go there again.

Steven Bruce
Yeah. Which takes us up to trigger points, I guess, and perhaps you need to remind us on what the trigger points are.

Simeon Niel-Asher

Yeah, again, trigger points are, it's pretty simple really, trigger points are exquisitely sensitive areas within tight bands of muscles. So, we'll feel a muscle and we'll feel this tight band in the muscle or taut band in the muscle. The truth is, you can treat anywhere within that taut band, but usually, there is an exquisitely sensitive or hypersensitive area within that taut band and it's normally in the belly of the muscle, which is where most of the sarcomeres are for various reasons. And the thing about trigger points is that they're very specific, in terms of when you hold them for more than 5 to 10 seconds, they cause a very specific referred map of pain. And again, the final picture there from Myers is to show that actually, as we've said before, you've got to look at them in context because they're part of the myofascial continuum. So, there's reasons for that as well. So tight band, hypersensitive spots, hold it for more than 15-20 seconds and it causes this reproducible, referred pain. And it's nociceptive pain, it's pain not from sort of neurogenic pain, it's from another source. And these maps often are distal to the actual area of where the trigger point is. And that's what makes them complex. And that's why it's good to be able to visualise them in more interesting ways. And they're not always intuitive. I mean, they can be, some of them aren't.

Steven Bruce
Some questions for you, Simeon. Maury has come back on that question about tendinopathies in the groin region, saying how would you differentiate between the compensation issues and the tendinopathies?

Simeon Niel-Asher
Well, I think I would treat the tendinopathy as well. I guess how you differentiate is if it's going to be in a bony end feel or if it's a soft tissue end feel. As the thing is going into a kind of dysfunctional pattern, you're going to go through that tendinopathy stage and then you're going to get to a bony stage. So, I'm guessing you'll looking at how chronic it is. You'll look at the symptom picture, night pain, if there's any kind of inflammatory stuff about it. For example, if there's a tendinopathy, is there any sort of pain on rest, pain in the morning? And again, osteoarthritis is classic, it's morning stiffness, that's one of the classics OA back, OA hip. So yeah, you'll differentiate it from the history, the end feels of the tissues, and if you feel there's any kind of inflammatory other sort of things around it.

Steven Bruce
Camillia has asked about checking for anterior posterior ilia. Do you do that, do you check the ilium?

Simeon Niel-Asher
Look, again, that's a good question. Okay. Is the question would a posterior anterior ilia kind of predispose to an OA hip? Maybe that's the question. In which case, it is possible. You know, any biomechanics is possible. But again, in my experience, with OA hip, it tends to be after, in terms of monostotic or single hip arthritis, after a trauma or after sometimes years later after a trauma, or after a fracture, or after someone's been limping, you know, they've had the other leg in a cast or that leg in a cast or genetic, you know, that's the main thing I see. Often, you'll ask someone and they say, yeah, my mom had a hip replacement and my brother's got osteoarthritic hips as well.

Steven Bruce

I'm guessing that Camillia's thinking back to it, well, I'm thinking back to my college days, when we would always check for the orientation of the ilia and, if one was anterior, then we'd straighten it and then we'd do our test. Would that affect your findings, in terms of internal rotation of the hip and how you might diagnose certain problems?

Simeon Niel-Asher

The answer is possibly. Yeah, possibly. It depends how far gone they've gone. I mean, that's the point, isn't it? How far down the line they are?

Steven Bruce

Lori Hartman talks a lot about primary lesions, doesn't he? About this being this in the lumbar spine is actually the lesion which is affecting that thing in the cervical spine. If you don't fix this one, then that won't get better. And again, I'm guessing maybe Camillia's saying, well, could that be the primary thing which has got to be fixed if everything else has to work?

Simeon Niel-Asher

I think there's truth in that. I think there's truth in that. It's a good observation.

Steven Bruce

And Nick says, have you found many issues with chronic psoas problems relating to hip dysfunction or OA?

Simeon Niel-Asher

Yeah. I think there's a little misconception of the psoas as a hip flexor, it's a very, very weak hip flexor. By far the big hip flexor is the quads, vastus, you know, the big rectus femoris. So that really is all the power in the hip. The psoas is a weak hip flexor. But the psoas is really interesting. Obviously, it's a hugely interesting and important muscle, there's The Vital Psoas, that book that was written, the emotional psoas, it's one muscle that connects the lumbar spine to the hip. So certainly, I'm not ruling out psoas issues, in terms of hip pain, but it's rare. I'm just trying to think clinically, I do see it, I do see it clinically. Certainly, I'll see it with people that have had discopathic pain, where the psoas seems to be, you know, you get a loss of lumbar lordosis, clearly the psoas is working extra hard. Tend to also see it in yoga people that are doing a lot of psoas stretches, you can get this kind of reactive psoas afterwards. And again, I think that group of, definitely see it in that group of people that are on these kinds of hoops and parachutes and sort of pole dancey things. Yeah, I see it in that group as well. So, I think there is something about this kind of hyperextension of the hip, that will irritate it.

Steven Bruce

Better leave you some time to finish off, Simeon, because we've got quite a few slides to get through.

Simeon Niel-Asher

Yeah, I just thought we'd cover some of the key muscles. And I think let's have a look at some of those slides. So I think we start with pectineus, I think I've put a slide up with the key muscles.

Steven Bruce
Okay, well let's start with pectineus then.

Simeon Niel-Asher
Okay, so yeah, so in terms of trigger points, this is talking about the effect of trigger points: they have nociceptive drive to the local spinal response, they can cause Dorsal Horn Wind-up. So, if a trigger points there and it's not treated, then it can perpetuate a condition and it can be part of this peripheral and central sensitization. And we talk about that in the other lectures, which I highly recommend you download and watch again, at least once a week. So, the key muscles that we're going to look at now are on the next slide, there we go. So, the adductors. So again, I started with this tantalising, the adductors. And again, the adductors are not muscles that I used to really think about, but they're absolutely brilliant for treating hip and actually pelvic floor issues as well. So, I'm not going to cover all of these, but we're going to cover some of them. So, I think, what are we doing first? Are we looking at the pectineus first? Okay, so let's have a look at that slide. So, what I thought we would do is, oh, before we do, yeah, so this is the adductors. So, let's just look at what the adductors do. So as part of this locomotion, in terms of gait, they help bring the leg forward from the backward position, so they assist hip flexion, so they're very much involved in locomotion and gait and stabilisation. In the same way, glute medius is a stabiliser of the hip on the opposite side. The adductor is on the side that's not sort of being used. You can see as you as you load one side, the adductor on the opposite side is being loaded. Right. So, pectineus. So that's the area where I usually spend a lot of time on holding that trigger point. And pectineus is an interesting muscle, takes its origin from the pubis, between the iliopubic bone and the pubic tubercle, and inserts into this linear aspera of the femur, lesser trochanter pectineal line. And it's a very strong adductor of the hip, it's sort of slightly internally rotated adduction. And there's a trigger point in there, which is so useful for osteoarthritis of the hip. So that's just one of them. Again, I might, if I can, can I just share my screen? Let's see if we've got pectineus.

Steven Bruce
Dear old Boris in his underpants again?

Simeon Niel-Asher
Boris, yeah, I'm not gonna take his underwear off. I'm working on it. I told you, I've got this new model, but we can see there's this radiating map of pain. And again, this is where you're going to try and you'll find out, look, there's the ball and socket joint. So it's just slightly inferior and medial to the hip joint itself. And there's usually a trigger point in there that if you hold it, it really, really has fabulous, fabulous work to do with the hip.

Steven Bruce
Just so people know, Simeon, that little graphic that you have there is taken from the Trigger point 3d software, isn't it?

Simeon Niel-Asher

Yeah, absolutely. Thanks for saying that. Sorry, I should have mentioned that, yeah.

Steven Bruce
Well, we're not here to do, we don't do marketing for people on this show but I'll mention anything that's good value and this is extremely good value.

Simeon Niel-Asher
Well, thank you very much. Yeah, we've been working really hard on it. Since we're there, we can look at the other adductors as well. Look, the adductor group. And it's really interesting, actually, generally speaking, with OA hip, when you hit the adductors, it's one of the three, it's normally just one of them. So, the brevis, which is obviously the smaller, shorter, let's just have a look in here, so in terms of the brevis, it sort of comes from the ischial tuberosity, as they all do, and it's the upper sort of part of the femur and it's just sort of the upper third of the femur. Again, that strong adductor of the hip. And then we've got the longus and that sort of sits on top of the brevis. And then we've got the magnus and the magnus is much bigger, it goes all the way down, it actually has slip into the pubis as well, into the pubic ramus, into the linear aspera all the way down. Huge muscle. And generally speaking, it's really weird, with OA hip you either have a trigger point in the brevis longus or the magnus, it's usually one or the other. So, you'll have to sort of work to feel where that tight band is. So, these are the adductors and again, just looking at the pain maps, you can see the pain is all the way into the medial knee here. So again, with a magnus differential diagnosis with things like pes anserine, bursa problems and stuff like that. So, let me just stop there. I don't know, what slides did we have next?

Steven Bruce
We were looking at the hip adductor group.

Simeon Niel-Asher
We covered the adductors. Yeah, so in terms of the adductors, actually I will just show you what I would do in terms of treatment, because that's probably what people want to know, what does it mean? What does he mean adductors? So, let's come back here. So, adductors, what we would do is we would start by having the patient lying on their bad side. So, if they've got an OA hip here on the right, have them on the right, we flex the left knee up, so the right leg is straight and back and the left knee is sort of over here. And we will, we're going to start with a deep stroking message. And we start here at the knee and we're going to work slowly up the adductor until we actually sit right here. And we finish and we hold right here in the groin. And it's going to be one of these adductors. So magnus is going to be here, longus here, brevis here. And as we sort of work our way up, we're gonna hold those trigger points, either here, sort of here or here. And we're going to finish here. Now, deep stroking massage in one direction only. And this is something we talked about in the frozen shoulder technique. Seems to be, and I haven't read this in the literature, this is my own thing, but I'm sure it's there. And probably someone will send it, that would be great. If you go from insertion to origin, it tends to sort of stimulate the muscle. Whereas if you go from origin to insertion,

it tends to relax the muscle. That's what I've found in terms of soft tissue work. That make sense? Anyway, so that's what we would do for the adductors. So we would start by doing some inhibition through pectineus. So, we're going to sit there have the patient on their back, lying supine, gonna bring our, usually elbow for me, but you can use reinforced fingers. Remember that you've got the femoral artery, vein and nerve slightly medial, it's quite interesting. And then you've got psoas as well, the psoas is on the outside, pectineus on the inside, and in between, we've got the VAN, vein, artery and nerve, but it's quite easy to miss it, because you can feel that femoral artery and then you're going to go medial to that.

Steven Bruce
Also, it's pretty hard to completely block the femoral artery, isn't it?

Simeon Niel-Asher
Yeah. And again, but you don't really want to be in it, because it you can use it as an anatomical guide. So, going sort of medial, so once you find the femoral artery you just slip medial and that's where your pectineus, and then laterally, if you want to, is where you feel the psoas insertion, sort of laterally here. So yeah, so let's carry back on. So that's pectineus and the adductors.

Steven Bruce
Simeon, you know we're out of time? Already! I don't want to stop you quite there. I'd like you to sort of finish off, I mean, because what we wanted was your clinical points and so on. But I'm very conscious that some people will have planned to leave for a patient at two o'clock and we're already there.

Simeon Niel-Asher
Okay, so if you're planning to leave now, brilliant. I mean, have a good clinical afternoon and do some good work. Have some fun. If you're going to stay, I thought, anyway, if you're going to leave down the adductors and pectineus are just two of the really important trigger points, I think. In fact, I think they're the main ones that I really wanted to cover today anyway.

Steven Bruce
Right. Okay. Well, you went through a hell of a lot there. And Camillia has come back to us to say she disagrees with you. So, there you go. She's very politely said that she's found that a lot of women have a problem with that anterior ileum due to carrying children on their hip and from childbirth itself.

Simeon Niel-Asher
I don't disagree with you. I don't disagree. I think it is a factor. I'm not saying it's not.

Steven Bruce
Simeon, can we get you back in again to finish off and do some more of this stuff?

Simeon Niel-Asher
At least once.

Steven Bruce
We've got your recorded commitment on camera to the world so you can't get out of it.

Simeon Niel-Asher
Everyone turns off when I turn up.

Steven Bruce
No, we have our biggest attendances. We had our biggest attendance, I think, of over 1200 on one occasion when you were on and I don't know what it is today but you're a popular chap.

Simeon Niel-Asher
Well, you know what? The truth is what you do for all of us is amazing as well. So, we're all very grateful.

Steven Bruce
Let's just, just so people know, let's bring up your last slide, which is your very kind offer to people watching and it says APM members, but if you're watching today, then you'll have the offer as well. Justin, can you bring up that slide?

Simeon Niel-Asher
Yeah. Trigger Points 3d is a project between myself and Dr. Gerwin. You know, trigger point maps are, trigger points are complicated. It's hard to remember where the maps are. And again, even for me, and I've been doing it for years and years, hard to remember. So, this software makes things really easy. It allows you to show your patient what's wrong with them, engage with the patient and there's a tonne of stuff. We got a little trigger point hub there with tonnes of videos about needling and about what to do with trigger points. So yeah, Trigger Points 3d. It's in all the app stores.

Steven Bruce
So, get your seven-day free trial. If you use this code APM25 then you get 25% off?

Simeon Niel-Asher
Correct. For the next few months.

Steven Bruce
Right, 25% off for two months. And then you said, don't forget to unlock the needling videos. To do that I discovered you have to also upload your certificate to say you're qualified to do needling. Which is good, because that means it's a safety issue in there.

Simeon Niel-Asher

Absolutely. Absolutely. You know, I spoke at length with Dr. Gerwin about it. It's not fair, also on the courses, it's not fair to unlock everything. These guys spend a lot of time training and before you put a needle, there are things like pneumothoraxes and things like that, you know, you want to be careful.

Steven Bruce
We were actually going to talk at length to a chap that you know very well, Phillip, about safety issues in acupuncture but maybe for another time. Anyway, Simeon, it's been great to have you on the show and I'm looking forward to getting you back, as always.

Simeon Niel-Asher
I look forward to seeing you in person, man.

Steven Bruce
Thank you.