



Case Studies Ref 175

with Pippa Cossens, Kerry Dowson and Anne Mamok

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TRANSCRIPT

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Steven Bruce

What we're going to do this evening, we're going to do something that we have done before, only once, where we had a number of practitioners, seasoned experienced practitioners bring to the table some cases, either current or historical that they have had in the past, which they thought were interesting, and they thought would be useful to share. Now, the cases themselves might be resolved, but it's the opportunity for you, particularly, to ask questions about why a particular approach was taken, why we think the results were achieved, what might have been done differently, all which of course counts towards your CPD, particularly if you're an osteopath, because we are required to do those things now. But as a chiropractor, you learn just as much from these case-based discussions, as effectively this is, as anyone else. So let me introduce my three osteopathic guests this evening. I have Anne Mamok. Anne, lovely to have you with us. You're going to go first, I believe in a second. And you've actually got two cases to talk about. And, Pippa, nice to have you with us as well.

Pippa Cossens

Nice to see you.

Steven Bruce

Kerry, Kerry, you've been on the show on a number of occasions as our star guest in the past, haven't you? So you're no stranger.

Kerry Dowson

No, no, no, just once.

Steven Bruce

Once is a number. You're one of our star guests. And it's great to have you back. As I've said, you are all osteopaths, but it's fascinating that actually, we're going to start with Anne, and Anne, the approach that I understand you took with the patients we're going to discuss was a chiropractic approach. So, can we start with you? Can we hear about your first case?

Anne Mamok

Yes, of course. So the first patient, was a patient, he has since died, sadly. But I saw him actually in 2010. And I was given permission to keep his notes because this was such an interesting case. He came to me age 67. He had had a hemiplegic stroke, five months, actually six months previously, and had seen a colleague of mine. The brother who was bringing him to my colleague had said, oh, Anne's doing cranial work, do you think that might help him? So the stroke was, I believe, as a direct result of having had chemotherapy for lung cancer. His speech was extremely poor, his stroke was on the left-hand side. They were querying that his right shoulder may even have been dislocated. He had spasticity of the flexors in his right hand. He also had osteoarthritis in actually both hips and shortening of the muscles in his right hip. And the approach that I used, because I knew I had my colleagues notes there, I knew that my colleague had done everything, conventionally osteopathic with him. And so what I used was an approach that was taught to me in 2006, by Michael Allen, he's a chiropractor from California. He came over and presented a whole weekend. And this is where, he had originally presented this at a conference in Vienna. And his lecture was heart attack starts in the brain. And Chris Smith from Metabolics at the time thought this is very interesting. Let's have him over. And basically, his premise was that in applied

kinesiology, which I use a lot in my practice, we have certain muscles connected with certain organs, and there is only one that is connected with the heart, which is subscapularis. It's an extensor and an abductor. And what he found was that when he provoked certain primitive reflexes in his patients, specifically the asymmetric tonic neck reflex, which many of you, I don't know if you can see that at all. Can you see that? Yeah. So it's, it's a reflex that we have as infants. But you can reproduce it in adults that if you were to test flexors extensors on the body, and you turn the head to the extreme right, what should happen is that as the arm reaches out in the infant, so does the extensor muscles should be switched on, but on the right side, but the flexor should be switched off. And contralateral on the other side, the flexor should be switched on and the extensor switched off. And what he found was that when you had aberrant switching or muscles that weren't behaving themselves, and he tests routinely, six muscles in the body, I can go through it if you like the details, but principally subscapularis, latissimus dorsi, pectoralis major, and then the lower extremity, gluteus medius, quadriceps and psoas or iliopsoas. And he was able to demonstrate that when people weren't switching on and off as they should, you could sometimes cover one eye, for instance, particularly the dominant eye and find that that normalised the tone of the muscles, so they would behave normally with the switching on, switching off, you could also get the patient to therapeutically localise their spinal levels. And again, identify those, sometimes palatine bones, parietals, temporals, you could find ones that would, again, normalise the response. And what he basically said was the eyes are the stalks of the brain. One of the problems with strokes, is that if you have a stroke on the left-hand side of the brain, as this patient did, that the brain, as you know, the eyes, you have the lateral fibres of the eye, sending signals to the ipsilateral thalamus, but the nasal fibres send the signals to the contralateral side. And so what he did was he found that when he used these goggles, okay, and these are by a company called Marc Pick Creations, M, A, R, C, P, I, C, K, the reason they are placed in this position or that position is that blue wavelength of light, as many of you probably know, is shorter wavelengths. Yeah. So when you look at the wavelength of light, you have the red light rays are longer, but they are weaker in their response. The blue waves are shorter in wavelength, they're 540 nanometers, but they have a higher energy. So if you want to stimulate the left side of the brain, you would actually place the goggles in this position over the patient's eyes. So you would be stimulating through the blue light to the left side of the brain. And with the ridge would be sedating, the mesencephalon, okay.

Steven Bruce

Anne, can you keep those on for the rest of the show? Because it's a really cool Elton John look you've got rocking there.

Anne Mamok

Okay, so, anyway, what we know with strokes is that what happens is that the side of the brain that is damaged, or compromised, basically becomes bullied by the side of the brain that is functioning more correctly. And what I did with this patient of 67 years of age, was that on his first visit to me, I placed the goggles over this side because his left side was so damaged, and then placed an eyepatch over the other eye. Okay, so that you had the sedating of the nasal fibres in the left eye. And you had the complete exclusion of light on the right side. And then what you do with that then is that you use the proprioceptors in the joints. If you think about our neurology, the proprioceptors of the joints in the right side of the body send signals to the contralateral thalamus or motor cortex, okay. But to stimulate the left eye through the muscles, you stimulate the spindle cells through the muscles of the extremities on the left side of the body. So what I did with him was, I placed the goggles, I patched the right eye, so that we were stimulating

and then I had a bright light shining into his left eye through the goggles. It's not uncomfortable because the goggles are so dark. And what I did was I then spent a good half hour, just literally articulating every single toe, every single foot joint, coming all the way out through the ankle, the knee, the hip, just mobilising, just gently moving the limbs, then the upper limb, you don't work on the spinal level, just the peripheral joints, and then to the left side of the body, doing something called Spindle Cell Technique, and what you're doing is you're taking the muscle belly of the spindle like quadriceps, and you're pushing the spindle cells together, so you putting a neural input into that left cerebellum. And he had a lot of tension through the quadriceps, particularly it was all quite spastic. And the second visit, just looking back through my notes, he had already achieved, so just reporting, speech is remarkably better. So he had been having speech therapy weekly, for the four to five months before I saw him. And there has been no recovery of speech, he could only manage the odd word, which was actually his greatest source of frustration. But his pronunciation was better, he had a greater vocabulary, his right hand was much less spastic, and his right foot was less spastic. So I did some more work with the goggles, and with the proprioceptors and, again, stimulating the left side. His right foot was also a better colour, interestingly enough, and then I finished with some cranial work, just very gently, sort of stimulating the left motor cortex, and just the whole left brain, just to try and awaken up that side. And on the third visit, when he and his wife came, they said the speech therapist was very impressed. And this had been the only intervention that had made any difference since his stroke. And she could only attribute it to what we had done. So it made a massive difference to his quality of life. And, sadly, he did, a couple of weeks later, go on to have another stroke. And that was the last time I saw him. But I did manage to persuade his wife to do some treatment at home. And basically, the recommendation was that they simply patch his right eye. And keep doing the articulating the proprioceptors on the right side, the muscle spindle cells on the left. And I've seen other stroke patients subsequently, who've also been pretty much written off by the doctors and, you know, said, well, we just keep a close eye on things, but there's not much we can do. And they've all made similar progress.

Steven Bruce

Anne, this is, you got to be making this up. Because this should be frontline, one of the frontline approaches in any therapy for a CVA, shouldn't it, if it's had some effect like this, they should be trying it throughout the ages. Sounds to me as though it's a really cheap approach, a pair of goggles and an eyepatch.

Anne Mamok

Yes, yes, absolutely.

Steven Bruce

Who else is using it?

Anne Mamok

Um, well, I think Michael Allen has trained a number of people. The last time I checked, he was doing a series of seminars in Italy, in Milan, but we all know what's happened in Milan. So let's just say the last couple of years that hasn't been happening, but there is a very big neuro chiropractic movement in the States.

Steven Bruce

Yes. And we've had some interesting speakers in that regard as well. How long has he been doing this particular approach for stroke victims, do you know?

Anne Mamok

I think he's been, I think he set up his clinic. I checked today online, and he's been running his clinic since 1991. And what he will do is, is work as any chiropractor would, but he uses the assessing of the head right, head left, the switching on, switching off, to evaluate every patient, which is why when he trained us all, I thought this is an interesting and useful approach to use.

Steven Bruce

Yeah. And that sounds to me, if he's been practising since 1991, he ought to have a reasonable body of credible evidence for what he does, hopefully evidence where he's not cherry picking just the ones who get better. But it sounds from what you've said that actually, this isn't cherry picking the ones who get better, actually, the only ones who are coming to you are the ones who are not getting better through conventional treatment anyway, so you've got the worst-case patient before you even start. Any theories into, you know, you said that there was better perfusion in the right foot and was this just a restoration of sympathetic responses, do you think, once the brain is rehabilitated, or?

Anne Mamok

Quite likely, I mean, I said my seminar with him was in 2006. So considering I only knew I was going to be speaking tonight, yesterday, lunchtime. I haven't had time to look through my...

Steven Bruce

I just wondered if you'd have a thought on that. It's quite amazing. I wish I had known about this a few years ago, because I haven't treated many stroke patients because we don't, I've never treated stroke. I've never considered myself to be a neurological practitioner. And I would have said go away and see a physiotherapist for that sort of thing. Until a few years back when, I forget which speaker it was, but they made it clear that the conventional approach that there's no recovery after about 18 months with a stroke is completely wrong. And actually, you can get a lot of recovery. And then we get to techniques like this where actually you might see something dramatic. And it's a shame, well, obviously it's a shame your patients suffered a second stroke. But it's particularly a shame, because of course, it would have been nice to see how much more progress he could have made. And I don't know if the next patient you're going to talk about goes further than that. Kim has asked whether the head was rotated to the left in this patient?

Anne Mamok

Gosh, considering it was 2010, I don't recall that. I would have normally made a note of that. Yeah, I can picture him lying straight. Yes.

Steven Bruce

Tell me, are you advertising your services to people who have suffered strokes? Or I suppose legally, we can't do that.

Anne Mamok

No, I mean, much of my work is, much of my referral is word of mouth. You know, like many, it was yellow pages when we first qualified and we could never advertise so. I do say I have a particular interest in neurological work, because I do a lot of work with children, with retained primitive reflexes and with dyslexia and dyspraxia. So it's an interesting field.

Steven Bruce

And actually, Emily, thank you for the comment you've sent in ,because Emily has just said that she'd love to know if we're able to talk about this in advertising because the ASA of course are particularly antsy about what we say. Emily thinks what you said is absolutely brilliant, as I'm sure everybody else watching is does. But I think personally, I think the regulations there are that the ASA stipulate very clearly what we osteopaths and chiropractors are allowed to say that we treat. And if you were to say that you treated something else, you would have to have good evidence for it. Now, you might well have good evidence for this. But actually, we also got to bear in mind that if you say you can treat something which the ASA disagrees with, they're only going to react if someone complains. And they're only going to say stop doing it. They're not going to strike you off, and it won't go back to the general counsel. Unless of course you ignore the ruling of the ASA because it would be wonderful to get some statistics. This is a perfect case for a practice audit, isn't it? Hopefully, Michael Allen in the States has done one, you know, because none of us want to do that sort of thing. But yeah. And somebody who's calling him or herself Hiall in the Vimeo team. Nice title. Does this reduce athetosis? We don't know, I think.

Anne Mamok

Yeah, I think would be the short answer.

Steven Bruce

Yeah. Simon has sent in an observation saying that when he was a nurse 30 odd years ago, the eyepatch approach for stroke sufferers was used by a couple of consultants, but it fell into disuse. He hasn't mentioned the goggles and imagine the goggles weren't used, but interesting to know how these things can go in fashions in the NHS, even when you can clearly get some interesting results with them.

Anne Mamok

If you go on to the website, Marc Pick Creations or MarcPick.co.uk, I think, I can give you those details later, Steven.

Steven Bruce

I can send an email, but that's Marc Pick, Marc with a C and Pick.

Anne Mamok

Yes, with C. MarcPick.com. And he's got some really interesting information on there about the hemisphere glasses. And again, looking today, it was interesting to see how he's got ones which are half red, and half clear, rather than the blue. But there is a, so the red is all about sedating. And these would be, because it's clear, I think these are spectacles that people actually could possibly walk around the house and still function with, so stroke patients could wear, they're a new thing. I've not seen those before. And, but he does write some warnings, it's worth looking at his stuff about how sometimes you can have

the overstimulation of the mesencephalon. And it can cause elevated blood pressure. So be careful. And Michael Allen also warned us, he said never do this work within the first two weeks after a stroke. It's too much sensory input to the brain, motor and sensory input.

Steven Bruce

That's useful because I would have probably made a rash assumption that there couldn't possibly be any adverse side effects from this but yeah, good warning. Just out of curiosity Marc Pick, what is Mark Picks background? Marc Pick Creations sounds like he's a graphic designer, which he clearly isn't.

Anne Mamok

No he's another chiropractor, and he's another of these neuro chiropractors, he does quite expensive courses from the last times I've looked. But there are some really good, there's another chap who's David Traster, he's another chiropractor who's come to Europe and to Britain, and has done some intense neuro courses. More within the field of applied kinesiology, it's very complex, he tried to cram in something like four weekends into one. And most of us were a bit punch drunk by the end of the weekend. But it's very exciting work. But it's very intense work.

Steven Bruce

Kim has come back in and said she asked because, about the neck rotation, just a moment ago. Because she wonders whether this treatment would help people with wry neck, her son has this and his neurological physio makes him use his eyes to the right before he does these exercises.

Anne Mamok

I have tried to use it, this approach with, trying to remember the name of the condition, it's not wry neck, but it is a neurological one where you get the spasm of the muscles. Perhaps someone would remind me in the chat box or something. But I haven't found it successful in all cases, but extremely helpful in stroke patients. And in the next case, which I was going to share with you, which was hemiplegic migraine, which is another thing that I had not come across until this patient walked through my door.

Steven Bruce

Thank you. We'll just come onto that in a second. I just want to update, Simon said that no goggles were used when he was a nurse 30 years ago. But he said the result he saw were astounding. There just wasn't enough research to back it up. I just I find it flabbergasting that no one's told the NHS about this. And if they have that they can't afford enough money to try a bunch of goggles and eye patches to see if this makes a difference. But Simon, thanks for the observation. Matthew has said he doesn't think there'll be a problem with the ASA if the practitioner said they were treating the symptoms and sequelae of a stroke, not the stroke itself. Personally, the ASA will get grumpy if someone complains and your advertising gives the impression that you are treating a stroke. And possibly the general counsels might weigh in at that point. But if I were doing what you've been doing with this, and I'd bloody well say it until somebody complained and I'd take it off the website. And by the time someone complains, you probably have a whole host of patients you can say, well here we are, these ones I treated, and these ones went well, these ones went badly. Sounds like pretty good evidence to me. But that's just my aggressive approach to Advertising Standards. Yeah, Pip's asked why we're not using it in the NHS. And as Simon said, Pip, it's because there's no research to back it up, and therefore, NICE guidelines aren't going to

reflect it. I know you want to get on Anne, but Lawrence has asked whether this treatment would work with head injury patients?

Anne Mamok

Yes. Yes, very much so. And I use it in a number of patients with just chronic spinal problems, because it enables me to actually do a much more full assessment of which levels are giving the highest hyper facilitation, for instance, you usually go to the hypertonic muscles and find out what's causing them to be so switched on all the time. And the thing is that once you do the work with that proprioception, and stimulating the side, because many, I'm interrupting myself there, but for many patients after the age of 40, we tend to express our dominant side of the brain or dominant high, quite distinctly. So that, what can happen is that we end up with this real one sidedness of the body, how many of our patients say, all my problems are down one side, for instance. So the weaknesses, the sprains, the injuries, and those are the real candidates for having a look at this. But it's a nice quick thing that you can assess somebody in one hour that you can really assess all the spinal levels. Once you start putting the input through the proprioceptors and spindle cells, you're going to lose the display of all of those levels. They will creep back. And that's why I did that with that stroke patient, was just go straight to that biggest neural input to make the biggest difference to his quality of life. I had no idea whether it would help his speech. And as we know that, yes, we have Broca's centre, but speech and fluency actually requires several different parts of the brain and the recognition of words, the recognition of objects. So it's a case of everything working together I think.

Steven Bruce

One quick question again from Simon, he says, would your approach work, would this approach work with myasthenia gravis?

Anne Mamok

I have absolutely no idea. But it would be worth trying. Certainly, when I've worked with, like, for instance, thinking about a patient I was working with Motor Neurone Disease. She had lost a lot of her early reflexes. And going back to, if you like wiring them in, made a big difference to the fluidness of her movement and her comfort.

Steven Bruce

Yeah, that's useful to know, because one of the questions that also has come in, was would this be useful in Parkinson's, MS or Motor Neurone Disease? So thank you for that one. And just before we move on, Henry has sent in an observation saying that a chiropractic neurologist in New Zealand has published peer reviewed research on the effectiveness of chiropractic care in the treatment of stroke. You know, that's great to hear, Henry. And hopefully, could you send us in the references if you know them? Otherwise, we'll look them up. Because I'd like to send those out for people to look at. But I always object when the research says the effectiveness of chiropractic care or osteopathic care because that doesn't tell you what it actually did. In this case, you know, we've got an osteopath using what was a chiropractic invented treatment perhaps. But actually, it's not whether you're a chiro or an osteo, is it? It's actually what you do with your hands and with your handling of the patient. But I am not criticising chiropractors at all there, at all. It's just the way that the research is often phrased. Anyway, shall we move on.

Anne Mamok

Okay. So patient number two was age 37 when she came, and she had three months previously spent a week in hospital, having CT scans, MRI scans. She had over the previous five months before coming to me. She had this gradual onset of a loss of function in the left side of her body. She had developed visual disturbances. She eventually, in the September, so this was six months before coming to me, she developed a weakness in the left leg, she couldn't see properly, she couldn't speak properly. She couldn't feel her arm. But all on the left side and she had left severe head pain. And they did full blood works in hospital. And after the end of the week, they were able to say, there was no brain damage, there was no evidence of any neurological problems. But she was diagnosed with a hemiplegic migraine, which was extraordinary the idea that something would still be affecting her six months on from initial onset. She had a similar episode three years previously and had been to an applied kinesiologist and that had helped. She had had some heavy metal detoxification, and had been taking omega three, six and nine and had done some tapping as well. She'd also had some acupuncture and Chinese medicine. The doctors that basically discharged her from the hospital said, there's nothing more we can do for you. All we can do is prescribe propranolol, and antidepressants. So she came to see me and she, literally, she came with a walking stick, she came with a friend by public transport. She did not trust that she could walk steadily or get off trains with any degree of steadiness. So balance was a real problem for her. She said that she couldn't make her arm and leg balance or move properly together. Her left side of her tongue and cheek were numb, and her speech was quite slurred. And her lateral vision was a problem. She said, it's like walking around with blinkers on. And even her hearing was a problem, she had developed tinnitus in both ear but the nature was different from each side. And differentiation of sounds was very difficult for her. Stress made things worse. The left side of her neck was numb and painful. She'd been having some EMDR in the previous year. She had also historically had Bell's Palsy when she was 19 years of age. And what I did with her was to immediately assess her more fully.

Steven Bruce

We've lost your microphone, I'm afraid, you're muted. You hit the mute button by mistake?

Anne Mamok

So sorry, at what point did you lose?

Steven Bruce

You examined her more fully, I think you were saying.

Anne Mamok

Right. Did I talk to you, say that her left side of her neck was painful?

Steven Bruce

Don't recall that bit.

Anne Mamok

Okay. Or that she had problems with hearing and lateral vision?

Steven Bruce

Yes, lateral vision. Yeah, you were only out for a couple of seconds.

Anne Mamok

Okay, sorry about that. I think that mouse got touched. So she'd also historically had an episode of Bell's Palsy when she was 19 years of age. So, so there's a bit of a history here.

Steven Bruce

So sorry, Victoria said, was there any head trauma?

Anne Mamok

No, no, that's nothing that, and in fact, she was in marketing. There was no history of any accidents. And she was a yoga teacher part time as well. So she was actually quite fit, very in tune with her body. So what I did was I assessed her with the full Michael Allen protocol. So head centre, testing the six groups of muscles each side, then head right, head left, what was switching off and switching on and she had a number of muscles that were hyper facilitated, so when I got her to turn her head to her left, the left pec major which should have switched off was switched on and would not switch off. And the right pec major, which was supposed to be switched on with her head to the left, was switched off. So there was this kind of contra thing going on. Also her, with her head to the left, psoas and quads on the right were weak, not strong. With her head to the right, she was weakening in the right upper extensors, weak in the right gluteus medius. And weak left pec major and weak psoas and quads. So all hell broke loose when she had her head to the right, she was really weak and wobbly. As soon as we covered her left eye, she became more normal. She was also left-handed, was her dominance, but also in terms of identifying which areas were, should we say, indicating that there was a problem. So in other words, when she touched, one of them was the left palatine bone. One was the left temporal, one was C2 on the left, and T4 and T5, were all abnormal. So I made a note of those, knowing that they would immediately disappear once I've done the proprioception and the goggles and the spindle cell technique. And that's what we did the first time, was simply what I've done with the stroke patient. Put the goggles on, patch the right eye. So in her case, the problem was all down her left side. That was the left side of the migraine, but it was like everything was just switched on. And it wouldn't calm down. And we needed to sedate it to calm it down and bring more balance to the brain again. So I do remember distinctly, she sat up at the end of the treatment. And she said, oh my gosh, she said, I can see the entire room now. She said, I can just sit here and I, all my peripheral vision has returned. And she'd been like that with blinkers for the best part of four and a half months, which was a dramatic result.

Steven Bruce

You'll be delighted to know, Anne, that I'm told that the viewers in both teams, Facebook and Vimeo are all busy turning their heads and palpating their pecs at the moment, I'll see what happens.

Anne Mamok

So, she came in the following five days later, because she'd already had the foresight to look ahead. And she, I remember she sat down, and she said, she came in independently, no friend, no walking stick. And she said the me that has walked in today is 80% better than the me that walked in last Thursday, which was like a wow moment. Her vision was much better. Interestingly enough, she said that in the mornings,

she was very aware of a lot of pressure around her sphenobasilar symphysis. And I'm guessing that that might have been possibly to do with the mesencephalon and possibly some extra pressure going on there. And she said that she felt as though she'd been banged over the left side of her head. But it was much easier for her to speak. So her tongue, everything felt quite much more normal. And I then did a follow-on treatment. It's quite complicated to explain but what we call gateway initialization procedure, it's a very advanced form of Kinesiology, which took her into what we call current trauma. It's almost as though, stirring of the, you know, throwing all the things up in the air as it were, it was almost like a slight trauma to her. Had I only had cranial skills, important as they are, I would probably have done just a very gently calming treatment on that day. But I was able to do a little bit more of in-depth treatment. And what I did was work on her cranial reflex centres, and these are ones that are part of neural organisation technique. These were developed by another chiropractor called Carl Ferreri. He died some years ago, wonderful chiropractor, and cranial reflex centres are where you actually look at the pterygoids and the palatine and the sensory processing between the inner ear and the eyes, the visual reflexes. And in her case, she had lost them with eyes closed and in the dark, she had them with eyes open. She also showed up that her left trochlear nerve was showing up, I have in my practice, a huge, what we call brain kit. And these are all tiny files made of 6X homeopathic potencies, of all different parts of the human brain. So it allows you to make distinctions whether you're doing trochlear, vestibular or ocular nerves on the right or the left or cerebral peduncles or middle peduncle. And very useful. And so we use this in muscle testing. So I did see her over a period of time, interesting enough with the second session, when we found that her left trochlear nerve was in trouble, should we say, I recommended that she wear an ear plug in her left ear and listen to music through the right ear only. And this was to balance. I need to look up all the, I've been investigating this at the time, was how we could balance the brain with sound. And you can use different pictures and different frequencies to help balance the brain as well. So I think I'd, yeah, I said that I hadn't treated the trochlear nerve. But I'd recommended wearing earplugs in the left ear. And there was a certain set of music that was particularly good with stimulating the right brain. And then I didn't see her for three years, she moved to Bristol. But she came back to see me. Well, no, sorry, after two sessions, she was 95% better. That's it. I saw her four sessions before she moved to Bristol. And I'd worked round the pallet and sphenoid lift, I'd found she had a torus palatinus. So, as most of you know, I'd suggested that she put her thumbs on the inside of the back teeth and do this inspiration and the spread of the palatines to do that five times twice a day when she's cleaning her teeth just to help open everything up. And so after that second session, she was 95% better. She still had the tinnitus. And that was when I recommended using the earplugs. She'd also interestingly enough, notice that her spelling had become ridiculous. She said, it's all become phonetic, and she was searching for words. So we did more of the proprioception, the spindle cell technique. And that helped with her vision and her hearing. So it was four sessions, and then she moved off to Bristol. And then she came back to see me when she developed some eczema problems. What she reported was that now and again, she would have a sort of shadow of.... So three years later, she had some slight hemiplegic symptoms again, all left side again, when she slept on the arm. And what I did was I taught her a particular exercise that Michael Allen had shown, which is where you work on stimulating the right brain. It's a real kinesthetic exercise, I wouldn't be able to show you on the screen. But it's where you actually, again, you cover the left eye or you patch the eye and you basically recreate the asymmetric tonic neck reflex to the right. And you do that quickly, you fly the arm out, you straighten the leg on the right side and you claw up the flexors of the left arm and the left leg and then you very slowly come out of that position. So you're firing off to the side that you want to stimulate, patching the eye and then bringing the arm back into the midline again, and letting the

arm relax and letting the leg relax, again. And you do that about 10 times, always firing to the side that you want to stimulate. And last time we spoke, she was moving up to Glasgow, so I found someone for her up there.

Steven Bruce

Anne, I suspect that people watching, I haven't had very many questions in about this, at all. And I suspect that because there's a lot of the same things that you've talked about with the first patient. But I suspect also there are some people just sitting there with their mouths open. Because one of the first things that occurred to me with both these patients is, well, yes, but these changes, these beneficial changes, could have happened spontaneously, but both of these patients are well into their normal treatment with no change. So it would be extremely unlikely. The other question, of course, is are you just picking the only two cases that have got any better through your treatment? And I suspect knowing you that that's not the case at all. And of course we got evidence from Michael. We did have some questions, ah, the questions are coming in now. We did have a question earlier on about where one can do training. And I presume it's with Michael Allen or through Michael Allen's services.

Anne Mamok

Yes. I mean, I did look into his training courses he was doing in Milan, I think they were 2018 and 2019. I mean, by the time you add the airfare and the hotel costs, it's an expensive...

Steven Bruce

But if you want to find out about Michael Allen, it's Michael, spelled conventionally, Allen, A, double L, E, N. If you stick in DC chiropractor, he will come up in the States. I think he's in California, isn't he?

Anne Mamok

Yes. He's MichaelAllen.com or Allen Chiropractic Functional Neurology. Yeah.

Steven Bruce

We need to move on soon because we've got two other people waiting in the wings. But just a quick question for you. Elsbeth has asked about the information about spreading the upper teeth, the palatines.

Anne Mamok

Torus palatinus. Yes, so, really interesting interventions. So, if you, and again, I'm going to credit Eric Pierotti, he's a lovely Aussie chiropractor. I do train with osteopaths honestly, and but he did a wonderful demonstration where if you've got to, especially sports people, if you have someone who has recurrent knee or hip injuries, just with them lying, relaxed on the couch supine, just take the leg into abduction and see how far you can reach before you meet resistance. And then, I mean, I would suggest, especially as we're all wearing gloves these days, it's just pop your finger on the palate or sometimes I ask the patient, if you stroke your tongue across the palate, do you feel it as a nice sort of dome like a copular of a cathedral? Or do you feel a ridge, and sometimes patients say well, there's a little bit of a ridge, and that definitely is torus palatinus. But what you can do is you can do the abduction, get the patient to witness how far their abduction is on each side, and then get their thumbs onto the inside of the back teeth. And just really pull and just hold it there. And then you as practitioner, just take the leg into abduction. And sometimes it extraordinary, how many, you can have sometimes 20, 30, 40 degrees extra abduction.

What Eric Pierotti found was that often these were patients who, if they were sporting patients, they were far more likely to get the groin injuries, knee problems, recurrent injuries. And when he got the patient to do this exercise, I would say to people, you clean your teeth at least twice a day. You're at the washbasin, you can wash your hands, nice clean hands and just do this big breath in and then relax. And then breathe in and do it no more than about five times twice a day. But already within a couple of weeks. And certainly within a month, you will see a massive change in their abduction. And patients like it. Lots of them say, ooo lots of fresh air in there, you know, so I've never yet met resistance. So very useful technique, nice little gem.

Steven Bruce

Anne, we could probably talk for a lot longer about this and I apologise, I'm going to have to cut you off, otherwise our next two osteopaths are gonna have no time at all. I did have an observation sent in by Victoria but I couldn't work out what it was because apparently she's got her fingers in her mouth, so, I'm teasing Victoria. Thank you, Anne, that was very helpful indeed. I'm going to turn now to Pippa. How are you going to follow that Pippa? Unmuting I think is a start. Pippa, are you with us?

Pippa Cossens

Yes, I'm sorry. Can you hear me now?

Steven Bruce

Yes, we've got you. Thank you.

Pippa Cossens

Perfect. Sorry about that. I couldn't get my microphone to unmute.

Steven Bruce

Oh, Don't you just love zoom and teams, they're wonderful, aren't they?

Pippa Cossens

Just love the technology.

Steven Bruce

Can you remember what real people used to look like?

Pippa Cossens

Well, thankfully yes, having been a practical year. So I was going to speak this evening about a patient of mine who came in earlier this year. And I apologise because I always get on the same soapbox, that I treat a lot of patients with chronic pain and fibromyalgia. And I do come from a sort of a mind body approach to these patients. And I'm very passionate about sharing that with everybody.

Steven Bruce

So you should be.

Pippa Cossens

So my patient came in this year, she's a lady who was 43 years old. And she came in with a sort of, as she described it, unbearable pain in her neck, with a huge amount of sort of muscle spasm as she described it, and then pain in across her shoulders, that did sometimes go down into her arms. But I wouldn't particularly describe it as radicular symptoms, there was no pins and needles or numbness or anything in her arms or her hands. And so this was February this year, we saw her and she'd had the pain since April last year. And there hadn't been no particular injury at the onset of this pain. It had just sort of appeared, if that makes sense. And over that time, it had progressively, I think it actually got bad quite quickly and stayed bad. It hadn't particularly got much, much worse, because it was pretty bad when it started. And there was nothing really that she was finding that would make it better. And she was a holistic therapist herself. So she tried massage, she tried exercising, she tried rest, she tried all sorts of things, but nothing was really making any change. And so because it was completely unbearable, she had actually managed to see a spinal specialist or spinal surgeon, I think at some point during last year, and she'd ended up having two lots of steroid injections into her neck that hadn't made any difference. And she'd also had an MRI scan. And the MRI scan had reported that she'd got a disc degeneration at C5 and C6 in her neck. And because the more conservative injection treatment hadn't worked, the sort of the place she was going, the place she was heading before she saw us was to have some sort of decompression surgery within her neck. So she was on gabapentin, but it wasn't really making a lot of difference. And life was, you know, fairly unbearable. So in other parts of her history, she was slightly hyper mobile, but it wasn't a massive amount of a problem. But something that we do and, in the practice here, because several of us are also SIRPA trained practitioners, which is the Stress Illness Recovery Practitioners Association. And we ask a lot of other sort of health questions, which I know many of us as osteopath do. But these are specific things that we are wanting to know about. So we want to know about kind of current stress and past stress, fatigue. And she had described that she had got high levels of anxiety, which hadn't been particularly a normal thing for her, prior to the onset of the pain. She was fairly exhausted. And actually, she was really quite struggling with, sort of, I think, really homeschooling her children and not having any time which was not an unusual thing for many, many people last year. So one of the key things we always want to know about is, what else was going on at onset. So we are always going to ask about, you know, what injury might have happened, what helped, what was happening in the preceding few weeks. And for her, both her and her daughters had had COVID in March last year, and I think for many people who had COVID in March last year before, as it kind of hit us here in the UK, it was incredibly frightening. And I think there were a lot of people, we didn't really understand it, you know, we've seen terrible stories coming out of, well, the rest of the world, but Italy, particularly, you know, in the forefront to us. And I think it was a very frightening time to have had it, there was obviously no hint of any sort of vaccination, there was no hint of any treatment. And it was, you know, it was overwhelming. And I think this had caused her, definitely caused her massive anxiety. So we, again, a part of our history, we will very much investigate what else is going on in the whole of her story, particularly when we've got pain, along chronic pain, alongside anxiety, and you know, reported high stress levels, disturbance in sleep, then we, you know, that's something we want to investigate. And so what turned up when we asked her about that was in the past, she had had, I think it was three or four whiplash injuries, she had had, as a child at age seven, she had had a major injury where she'd fallen onto a stick, that had gone through the floor of her mouth, and had actually gone up and and fractured her palate. So that was a massive injury, but actually, in some respects, had, it was the emotional and the traumatic aspect of that was almost as important as the physical aspects of that injury. Again, when

we have patients who have chronic pain, as I said, we often give them the SIRPA questionnaire that then asks them back through, you know, other life experiences. And she'd had 16 significant sort of previous relationship trauma, difficult delivery of a child, and her current stress, or at the time, along with homeschooling three children, was that her son was suffering with mental health issues. So she really felt she'd lost all her sort of space, and you know, personal space and time to do anything to nurture herself. So on that initial, what we then do, obviously, was to examine her and on that initial consultation, really, the impression I got is that her whole system was just completely fired up, she was really, really, really fizzy. The whole, it feels like the nervous system has been plugged into the mains, that's the best way of describing it really, there's a buzz in the tissues under your hands. And that will be completely what I would have expected to find with the history that she'd given me. The other thing that was going on was that she had a massive, massive sort of drag through the fascia through her throat, again, not unsurprising, because of the injury that she'd had previously. And that went down around the heart and onto the diaphragm as well. So it was really between the whole cranial base and down to the diaphragm was very, very tight. Interestingly enough, as I had my hands on that, what we do, or the approach we take is to then sort of ask questions about that. And she certainly wouldn't recommend that you do that unless you've had some extra training to be able to support that. But for her, it just felt like the impression was that, at some point she'd taken, you know, she'd had a massive, massive shock, and she sort of almost hadn't breathed since. And when I asked her, I said you know, when do you feel you last took a deep breath, or when did you have a really big shock? Bless her, it was quite an emotional question for her and she was quite upset by that, and it allowed that emotion out and actually she reported back about some of the incidents that had happened during her previous relationship history. And that was then something that we are able to, obviously to deal with our sort of extra training. But it's an important, sort of, it was an important factor within her story. So with putting all these sort of pieces together, we went with a working diagnosis of what we would call tension myoneural syndrome, which is a phrase or a syndrome that was coined by Dr. John Sarno, an American physician in the States who works in sort of Mind Body medicine. And with tension myoneural syndrome you have symptoms of chronic pain, often gastrointestinal issues, and fibromyalgia type signs, and often accompanied by anxiety and sleep disturbance insomnia. And what we find in these patients is there's no signs really on there's no there's no pathology, there's no changes in the pathology, there's no structural abnormality, and it hasn't really been explained by diagnostic testing. But there is a physical symptom as a result of a dysregulated sort of autonomic function that comes from the stress. Now, she had had an MRI, and she had been diagnosed with degenerative discs. But if you take asymptomatic patients in their 40s, so if you take a cohort of asymptomatic patients in their 40s, about 68% of them will have disc degeneration. But they don't have any symptoms.

Steven Bruce

I think we talked over that with the guys who've been on the show, Rob Shanks and Darren Chandler, haven't we, talking about reemphasizing what I think we all know that evidence on an MRI, unless it correlates very strongly with the symptoms, it's not necessarily something that needs treating.

Pippa Cossens

Absolutely, absolutely. So she was in this place at that time, where she'd been told obviously, that she'd got these degenerative discs, and she was going to have to have surgery to resolve her pain.

Steven Bruce

That probably didn't alleviate her stress at all, did it?

Pippa Cossens

Well completely. And that's the trouble, and then you're stuck in this cycle of fear. And you think that you're never going to get better, and then you think that you're going to have to have surgery. And essentially, what then happens is, of course is the muscles just tighten up more, you get more dysregulation through that autonomic nervous system. And essentially, you're in the perfect storm, ready for this to continue. So the way we approached it is, is really looking back to the nervous system, we want to calm that nervous system down in any way that we could. So from the first treatment, what we did was very much a sort of cranial based treatment, before kind of trying to allow her system to ground, established a good midline, we did look at releasing through the fascial structures too. But thinking from a mechanical aspect, of course, if you've got fascia tied to the diaphragm, then we're not going to breathe as easily. That's not going to help the, you know, the whole of that autonomic function. But the aim was very much to calm her system. And what we then did was we gave her exercises to do when she was at home between treatments. So anything initially that was really not challenging to her system. So deep belly breathing, sort of any grounding techniques, you know, taking her shoes off, getting her feet on the floor, growing roots. There's a havening technique or self-soothing havening technique where you get the patient to rub the outside of their arms, a bit like you would if you were soothing a child, but you can actually do it for yourself. And you just very gently rub down the arm. And actually, if you do that for a couple of minutes, it just starts to, again, calm that system. It's like that, you know, everything to settle down. So that was sort of where we started. We didn't want to challenge her particularly with any of the emotional stuff, but we wanted her to feel safe, because there's so much truth like you say with her being frightened about surgery, that danger, anything that produces danger, is more likely to create pain. Lorimer Moseley, the physio from Australia talks about dimes and sins, danger in me and safety in me, and the more dimes you have, so the more danger in me you have, the more likely you are in a chronic pain scenario to have, you know, to have persistent pain. And then so what we try and do is balance those out. So make her feel safe, make her feel, you know, do activities that make her feel calm, and they're not necessarily specific techniques, but they're techniques that will just allow that whole system to feel a little bit more relaxed and less under threat. And a part of that is very much the education of saying actually, you know, we've examined you, we know that there's nothing wrong, we know that even though you've got this showing on MRI, that that means that it doesn't necessarily mean that you need surgery. So the education aspect of it is really key. Anyway, over the next, I think we saw her nine times, sort of weekly. And through that process very much initially, it was very much the same thing, calming down the system. From a neurological perspective, talking about the emotional and stressors that had come up over those, you know, different things came up and at the second treatment, certainly, she felt more able to look at those a little bit more. So we actually recommended that she did some journaling. And then that was definitely in her neck. Because we use a combined obviously SIRPA and osteopathic approach, you know there was tension within her neck, the muscles were tight within her neck, there was decreased range of movement through the C5, C6. And so we're then looking at releasing those and improving the mobility but in a really, really gentle way, because I think you can work the system both ways. If that makes sense. You can work from the physical into the neurological in the sense of calming things down. But you can also then work on the emotional to calm it down from the inside out if that makes sense. So we take a sort of double pronged approach. I won't go through each treatment.

Steven Bruce

No, I was going to say so what is the SIRPA approach but of course, we did a broadcast on SIRPA with Georgie Oldfield sometime, didn't we, might even have been your suggestion, I'm not sure. And that might be a good reference for people who want to know about SIRPA itself. But of course, SIRPA, S, I, R, P, A is the organisation to go and look out for the treatment of chronic pain in this way. Again, I don't want to, I don't want to rush you. Because you know, it's a fascinating case. But we are running out of time all together, and I don't want Kerry to feel offended by us not being able to cover her patient properly. Would you like to sum up, then that particular patient and maybe some of the characteristics of your treatment approach to her?

Pippa Cossens

Well, absolutely. I mean, over the nine treatments that we did, we looked at various things, we gave her various things to do, we actually have a mind body toolkit on our website that has all these tools for patients to use, so that they can access them and they've got all that information there. But within, I said, within about nine, basically, by the end of April, she was pain free, and we had weaned her off her gabapentin. And she's now back doing all the activities that she was before. And though she now sometimes may have the odd pain flare, she is really well equipped to be able to deal with that because she's now no longer fearful of the pain, is a big part of that. But it's that just understanding and educating the patient in that sense of actually, there is things going on from a mechanical and structural level, but more about how that reflects into the nervous system and what we can do about it.

Steven Bruce

I really like what you've said, Pippa, and you know, obviously what Anne said as well, is that, for me, it just reinforces that neither osteopathy nor chiropractic, nor physio, nor orthopaedic surgery has the answer to any of these problems. And, you know, we learn so much from all those other practitioners, you've got a lot to offer. And when Anne was talking about applied Kinesiology and lots of other different aspects of treatment as well. So your patient is now 90% better or?

Pippa Cossens

I mean, I haven't seen her since the end of April. We had a little bit of email conversation, just to reassure her. But actually, as far as I know, she's fine. And she'll be back if and when she needs, but my understanding is that actually her, you know, she's pretty much pain free.

Steven Bruce

Right. Okay.

Pippa Cossens

With no surgery.

Steven Bruce

Fascinatingly, just as I was about to move on, I noticed that Kerry has left the room, which probably means that her internet has let us down slightly. But what I would say is, I've just asked the team, how many people are watching this evening, because of course you can't tell from your sources. And given that we have the competition of the European football tournament going on. I'm amazed to hear that

we've got just under 400 people watching this evening, which is a paltry total, but it's very reassuring that people have found us more interesting than the football. Well, more importantly, they found you more interesting than the football. Now, Justin, can you tell me what's happening with Kerry? Is she coming back in? Here she is. She's back in the lobby. Thank you Pippa. We will come back to you a little bit later on perhaps but if we can, if I am able to turn to Kerry, no, she's gone again. Kerry, you've been ducking in and out which suggests to me that you've had lots of internet problems. But are you okay to proceed now?

Kerry Dowson

I'm back, am I online?

Steven Bruce

You are.

Kerry Dowson

Can you hear me?

Steven Bruce

We can hear you we can see you and we're all agog to hear about the case that you want to bring to the table.

Kerry Dowson

Oh my god, I need help from you. I actually only saw this person last Friday. So it's all fresh in my mind and it was really, you know, she's really lovely, she came bouncing into the practice and you know, short hair and all fresh in her cotton and I looked at this woman that's extraordinarily arty, full of bangles and god knows what else.

Steven Bruce

How old was she?

Kerry Dowson

She was 58 years old. And she basically said that she'd never heard of osteopathy and she tried so many other things and just wanted to know whether I'd be able to help her and what osteopathy was about. So anyway, I said, I explained what we did and got the consent and all the usual stuff that we have to go through, blah blah. And filled in all the forms and like I normally do, I said, you know, what is it that you're looking help for, help with. And she says, I cough all the time. And I produce phlegm. And then there was this rather long silence because I thought, bloody hell. I haven't actually ever treated anybody who coughs all the time. And with phlegm, and normally you go to your doctor, if you have a cough all the time with phlegm.

Steven Bruce

Which we presume she already had done from what you've said.

Kerry Dowson

Exactly. So I, you know, there was really this rather long, long silence, and because I really didn't know what to say. And then plucked up the courage basically to say, so, you know, can you just tell me a little bit more about what's going on? She says, well, you know, I just get a bit of shortness of breath, and I'm tired and I'm exhausted. And I get these very odd feelings in my legs. And I get palpitations. I thought, okay, well, that's quite a lot of information, having not said very much, just coughing. And then she also said that she holds her breath a lot. And I was really rather overwhelmed because as an osteopath, you're looking so much these days at the musculoskeletal things or neurological things that are going on. And I basically, this gamut of emotions of, oh my goodness me that pathological sin. What is this going on? Has she got COPD, has she got cancer, has she had COVID? What is actually going on with her? So that obviously the next question was, who have you seen? And she had basically said that she'd gone, sorry, I'm just looking in my notes here. She'd seen her doctor, she's seen a woman called Charlotte Reno, who'd taken tests. She'd done all lung function tests, she's had CT scans, all blood tests done, absolutely nothing was discovered. She went and saw a specialist respiratory physician who diagnosed her with the laryngeal hypersensitivity. She was then sent off to see a speech therapist where she had great benefits. But let me just go back a thing. So this cough started in, I think the cough started in 2014 when she'd gone to see her GP about a tickle, a little cough, and she's a freelance outside teacher, she teaches geography and she works outside only, which I thought was amazing. She takes people down along the Thames and teaches kids about geography, she is a really delightful person. Very happy person. And so she said, so this started and she says, she just coughs all the time. But whenever she goes and sees somebody, she doesn't ever cough. So I said, you've seen the speech therapist, you've seen the respiratory guy, you've seen the GP, you've seen the other three or four other specialists and they've never ever heard you cough. And she said, no. And I said, am I going to be allowed to hear you cough? She says, I don't know. She was quite retiring, and you know, a bit shy. But eventually, we got a little bit more information out of her. She said in 2015, when the cough started, she hadn't been talking that much. Because she basically started talking a lot more when she was teaching and working outside. So I thought, well, is this a you know, is this a pollen, is this, you know, something that you're inhaling because a cough is a reflex in order to get rid of anything that's dangerous in the body or something makes you sick? And she said, no, absolutely not. I just started coughing and it started off with a tickle. What aggravates it? Cold air at night? Food, sometimes inhaling, sometimes choking, sometimes when she's drinking. When she does exercise. I said, what exercise do you do? She says, I'm not really fit. I used to run marathons. I mean, she looked amazing for 58-year-old woman, just beautiful, really strong. Her body looked really great. So when she was exercising, especially when she went from upright down to go and do floor work. Then her cough really started aggravating. And then I said to her, what has relieved it, so she said the speech therapy has really relieved it. Maybe a little bit of steaming sometimes, always has throat lozenges in her pocket. And learning how to use cough control. My God. You know, I'm really out of my depth here. I don't know what's wrong with this person. She's saying that she's incredibly well and but she has this persistent and chronic cough. So after she's seen all these other people then she went, a couple of years ago she'd been in Spain. And she really started coughing a lot and she was getting shortness of breath, especially as she was climbing up hills and she said to her friends, I can't believe that I've got such short breath and I'm coughing so much. And they all said, you know, it's our age, we all get short of breath as we're going uphill.

Steven Bruce

We've got some great differentials coming in at the moment. We've got a aortic aneurysm, mold allergy, flu jab reaction, asthma, hernia. And I'm sure there'll be lots more as we go through this. So I can't imagine what was going through your mind at the time.

Kerry Dowson

It was like Heathrow before COVID. What is going on here? Anyway, we carried on with her and I just said, so tell me, how are you? She said, well, I'm really well, but I just cough all the time. I thought, and I said, and this has been unexplained, there is no explanation at all, for the last six years, you just cough all the time. When do you cough? I cough when I'm walking, I cough when I'm sitting, I cough when I bend over? I cough when I eat. I cough when I go to the theatre. And I said, so how is this affecting your life? In a psychological way. She says, it's absolutely awful, I'm becoming terribly fearful. I said, are you becoming fearful of social engagements? She said, I don't want to go out, you know, my I become extremely self-conscious. I don't want to teach anymore, because I'm coughing all the time. And I said, have you had COVID? She said, no, I haven't had COVID. And I've been at home with my five children like one does. What five children? She said yes. I said, does coughing affect your bladder? She says no, thank God for that. No stress incontinence. So you've gotten rid of that question. And she'd then been to see a person called Martin Virtual who's a professor of laryngology, I can't pronounce the word. She has no reflux. She has no acid reflux; she has no oesophageal irritation. She just coughs all the time. And the only people that really helped her were speech therapists and the reason why that she came to see me was because although I'm an osteopath, the one thing that a doctor had said to her six years ago was that maybe she needed to learn how to retrain her breathing. Anyway, I just said, I mean, I said, we only have an hour, I'll stretch into my lunch hour, and we can just do a little bit. So I went into the examination with no differential diagnosis at all. I really had so many things popping into my head, but every single box that we would have asked had been ticked, her blood pressure was absolutely fine. She'd had that taken, all the blood tests were fine, absolutely nothing wrong with her. She'd been to everybody. And she's at her wit's end because it's really affecting the quality of her life. So I assessed her breathing, as one does. You know, I asked her about the sputum that she was producing. She said it was white, and sometimes a bit clear and shiny. So there's no pathology there. There's no rust. She doesn't have, she said, it has a little bit of shortness of breath, but not breathlessness that one would expect. I asked her about chest pain. And her chest pain was not chest pain, per se, but pain because of all of her coughing. Actually, when you think about coughing, I don't know any of you. But, you know, when you've tried to suppress a cough when you're in the cinema or in the theatre or somebody's singing beautiful aria and sudden you've got this urge to cough, you really implode an explode, and it really causes lots of irritation in those tissues. So I'm thinking okay, well, we've got to go down a kind of a neurological route here, what is going on and then looking at the structure and function of the structures of breathing, and we're looking at phrenic nerve, we're looking at vagus nerve, we're looking at intercostal nerves, we're looking at the subcostalis, the subcostalis nerves. We're looking at blood supply. We're looking at lymph. I asked her about, you know, breathing with any nose obstructions. Did you sneeze? Did you have any headaches? Nothing. Does she have any stridor, or did she have any laryngeal problems? She said no, but they keep on telling her that she has a laryngeal issue. She doesn't have a bovine cough, nothing. So then I'm thinking, what happens next if we go down the trachea, you know, you haven't got any cancer, you haven't got any tracheal deviation. It also comes down through the trachea here and it has all the chemo centres and mechanoreceptors and, you know, when you're coughing, this whole lung function begins to start

irritating. What the hell is going on? So I asked her to sniff. I love asking people to sniff. Why don't you all have a sniff? All of you, have a little sniff right now. So what happens when you sniff? It's a really great way to get people to assess their breathing, because actually, the second rib should really lift up. But you'll see people who will sniff will go, and nothing happens. Or they take a really big sniff, and you see how their lungs work or how their stomach works. So that was a good thing. Her second rib didn't rise up at all, she took a sniff in, there was just nothing in her upper rib function, there was just no movement at all, in her thoracic cage. Asked her to rotate, she was quite stiff, asked her to flex and extend, nice movement of flexion and extension. But when you think about the mechanics of inside the rib cage, you've got all those wonderful subcostales muscles which sit from the sixth rib down to the 12th rib, and the function that they have with the rotation. And if they're not working, they're not actually going to be giving information into the liver, and into all those wonderful organs around the area, which actually gave information into that phrenic nerve. So none of this rotation is happening in her. She was a runner, she's all backwards and forwards, very little rotation in her thorax, I'm putting my hands on her back, listening to auscultation, no crackles, no weaves, no pops, just the normal stuff that was going on. And I was completely flummoxed. So I said to her right, well, I don't know what's going on with you, I'll go home and I'll do a little bit of research and see and I'll get back to you. But while you're here, I'm just going to take you through just a small breathing exercise, which I would really like you to concentrate on. And we'll do it for about half an hour, we're going to start off with your hands facing upwards. You can all do this with me right now, actually, your hands.

Steven Bruce

Not for half an hour, we can't, we've only got four minutes left.

Kerry Dowson

Well you can start with your hands facing up, and your feet are flat on the floor and you breathe in. And the hands go down and your toes come up. And you breathe out. And you breathe in, hands up and breathe out toes down. And you do this five or six times, just breathing in and breathing out, hands up, toes down. And just begin to feel how your body begins to start changing the energy. We did that for about five minutes. And then we turned it the other way around. So instead of breathing in with hands up, we breathed in with hands down, and feet down. So we changed that. And she became quite tearful. And she then proceeded to tell me that in 2010, her son had had her first son had had a really, really bad accident, a bike accident, her first child out of five. And then a year and a half later, her sister had committed suicide. And then her mother had a mental breakdown. And then her mother died in 2020. And she's basically been in shock. And she's been holding her breath. And she really hasn't been breathing. And she's been suppressing all of these extraordinary feelings that she's had. And it's created a, what is called a chronic, what I found in the short amount of time, it's called a complex respiratory response. So the reticular activating system determines the arousal levels in the body globally. And then you get, and it tells you whether you're up or you're down. And then you've got the local system, the synaptic system, which is this cough reflex. And so the global reticulating activating system is actually not suppressing what's happening at the local response with cough reflex, where the phrenic nerve and the vagus nerve and that's just being, you know, quite reductionist effects things that at a synaptic level, and as you try and suppress this cough the whole time, this local synaptic function is actually been overridden the whole time, which is compounding the problem and creating this continual cough. And it's a response that involves involuntary brainstem inflammation and voluntary quarter control so she can

actually make herself cough. But the cough that she was doing is basically affected by every single little thing that she does in terms of of her life, of her walking of her, everything that we've discussed, so what am I going to be able to do? I don't really no, because what I've read is that there's not a lot of hands on work that you can do with this and that the speech training is really important, but actually, I phoned her this morning and I said, I'm just going to talk a little bit about you tonight. And she said, after having done some of that breath work, she said, I had a hell of a big coughing fit, which she did with me. But she coughed for about seven minutes. She just coughed and she coughed, and she coughed up gunk and sputum. And it was really quite an extraordinary experience. She just coughed and she coughed, and she coughed. And she says, it's the first time she's actually been able to really get rid of stuff like that, in such a short amount of time. And she's been practising the breathing techniques that I've given her at home. And she said, she's had maybe an hour and a half of release, where she hasn't been coughing. So it's basically a perverse synaptic adaptability that she's got in her body. And I don't know whether any of you have experienced this, but I've often had patients who've come in and they've got had this little tick where they, hu um. And they're trying constantly to release this phlegm in their throat. I don't know whether any of you've experienced that. People will get nervous; they get a nervous tic.

Steven Bruce

I see Anne and Pippa nodding as you ask those questions.

Kerry Dowson

And this happens, and I have absolutely no idea that this, this problem existed. And there's not an enormous amount of information about but there was, I did find a paper on chronic cough suppression therapy. There was a thing on slideplayer.com. I mean, God knows how I got on to that. I'm really not somebody who does a huge amount of research, but it was an unexplained cough syndrome by a woman called Surinder Burring. And it comes in with, she's worried about her health. She's concerned, something's wrong. She's often nauseous, she's exhausted. Other people are seriously worried about her welfare. So they will talk about mums cough, everybody's worrying about her, total embarrassment, increasingly self-conscious, often urinary incontinence, absence from work, which she's not doing any more, the impact of the cough, how it disturbs her and how it disturbs others. It was a really very helpful article. So the thing we have to do is educate her about all the different triggers, about how to suppress the cough, we're going to have to deal with the laryngeal hygiene, decrease alcohol, decrease caffeine, what a shame. Avoid mouth breathing, of course, mouth breathing is just really not a good thing to do all the time. So wearing a tape at night, to cover the mouth, but just to allow the little corners of your mouth to be open. So you can breathe out in getting the nose breathing, going through the nitric oxide, and all that sort of stuff, cough control, chewing sweets, and counselling to modify behaviour. And basically, today when I had a quick word with her, she just says, she said, Kerry, actually, you know, those questions that you asked me about my son and my sister and that you were talking about how this trauma could have affected your body. She says she feels the cough is rooted in something psychological, but she thinks it really is a breathing problem. And but not necessarily where it started. And we're just going to explore with you know, another four or five treatments to see whether we can help her So, but for me, the learning for me has been as a complex respiratory response. And that is an inbuilt synaptic perverse adaptability, which I found interesting.

Steven Bruce

Kerry. Everybody has found that interesting. And I don't know about you, but for me, this is a sort of thing that could make you want to be an osteopath or a chiropractor, or it could terrify the life out of you that these people know their anatomy, their physiology so well. And people like Michael Allen in the States that you were talking about, Anne, can think outside the narrow paradigms that conventional medicine often uses. And we've got Sarah Myhill, Dr. Sarah Myhill, was a medical doctor before she deregistered, coming back on the show in a few weeks' time. And she said, one of the things she hates about conventional medicine is that it's not about medicine, it's not about treating patients anymore. It's about treating that narrow frame of symptoms that people come in with. And everything that you've said, and Kerry, what you've said, fits in so closely what Pippa said. And the whole thing is about understanding what the body is doing and thinking about what we can do to fix it. And it's truly inspiring. It really is, you know, there's the psychological. There's the emotional, there's the physical, it's just brilliant. And I thank all three of you for bringing in those cases today. I wish we had more time to do more of it. But we are over our time limit. We had a whole number of suggestions, a lot of suggestions coming in while you were talking, Kerry, about what could have been wrong with that patient. And the number of thank yous, as I'm told in a heavily flagged message here is just enormous from this evening. And I just think people love this because this is inspiring stuff. And it's been great. Wendy has said she's got a couple of patients with ongoing long-term coughs, and she's particularly grateful. And Wendy, get in touch with Kerry, if you need some help. I'm sure she'd be delighted to help. Kerry, I'm sure you've been on the show twice before, but I'd also commend those shows about breathwork. Because again, they were really useful at dealing with the stresses of COVID at the time. And, yeah, well, we just have some great speakers on this show and three of them were in this evening. However, that's it, we've run over time.